By: Frank H.B. No. 2658

A BILL TO BE ENTITLED

AN ACT

relating to the operation and administration of the Medicaid managed care program, including requirements for and reimbursement of managed care organizations.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 533.005(a), Government Code, is amended to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that:

(A) include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the plan; and

(B) ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration,

education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan on any claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days,

specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and

32.0281, Human Resources Code;

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician;

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and

1 resolving all provider appeals related to claims payment, including
2 a process that will require:
3 (A) a tracking mechanism to document the status
4 and final disposition of each provider's claims payment appeal;
5 (B) the contracting with physicians who are not
6 network providers and who are of the same or related specialty as
7 the appealing physician to resolve claims disputes related to
8 denial on the basis of medical necessity that remain unresolved
9 subsequent to a provider appeal;
10 (C) the determination of the physician resolving
11 the dispute to be binding on the managed care organization and
12 provider; and
13 (D) the managed care organization to allow a
14 provider with a claim that has not been paid before the time
15 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
16 claim;
17 (16) a requirement that a medical director who is
18 authorized to make medical necessity determinations is available to
19 the region where the managed care organization provides health care
20 services;
21 (17) a requirement that the managed care organization
22 ensure that a medical director and patient care coordinators and
23 provider and recipient support services personnel are located in
24 the South Texas service region, if the managed care organization
25 provides a managed care plan in that region;
26 (18) a requirement that the managed care organization
27 provide special programs and materials for recipients with limited

English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

(20) a requirement that the managed care organization:

(A) develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a) and specific data with respect to access

to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated;

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that, subject to the provider access standards established under Section 533.0061:

(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types;

(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and

(iv) providers located throughout the region where the organization will provide health care services;

1 and
2 (C) health care services will be accessible to
3 recipients through the organization's provider network to a
4 comparable extent that health care services would be available to
5 recipients under a fee-for-service or primary care case management
6 model of Medicaid managed care;
7 (22) a requirement that the managed care organization
8 develop a monitoring program for measuring the quality of the
9 health care services provided by the organization's provider
10 network that:
11 (A) incorporates the National Committee for
12 Quality Assurance's Healthcare Effectiveness Data and Information
13 Set (HEDIS) measures or, as applicable, the national core
14 indicators adult consumer survey and the national core indicators
15 child family survey for individuals with an intellectual or
16 developmental disability;
17 (B) focuses on measuring outcomes; and
18 (C) includes the collection and analysis of
19 clinical data relating to prenatal care, preventive care, mental
20 health care, and the treatment of acute and chronic health
21 conditions and substance abuse;
22 (23) subject to Subsection (a-1), a requirement that
23 the managed care organization develop, implement, and maintain an
24 outpatient pharmacy benefit plan for its enrolled recipients:
25 (A) that, except as provided by Paragraph
26 (L)(ii), exclusively employs the vendor drug program formulary and
27 preserves the state's ability to reduce waste, fraud, and abuse

1 under Medicaid;
2 (B) that adheres to the applicable preferred drug
3 list adopted by the commission under Section 531.072;
4 (C) that, except as provided by Paragraph (L)(i),
5 includes the prior authorization procedures and requirements
6 prescribed by or implemented under Sections 531.073(b), (c), and
7 (g) for the vendor drug program;
8 (C-1) that does not require a clinical,
9 nonpreferred, or other prior authorization for any antiretroviral
10 drug, as defined by Section 531.073, or a step therapy or other
11 protocol, that could restrict or delay the dispensing of the drug
12 except to minimize fraud, waste, or abuse;
13 (D) for purposes of which the managed care
14 organization:
15 (i) may not negotiate or collect rebates
16 associated with pharmacy products on the vendor drug program
17 formulary; and
18 (ii) may not receive drug rebate or pricing
19 information that is confidential under Section 531.071;
20 (E) that complies with the prohibition under
21 Section 531.089;
22 (F) under which the managed care organization may
23 not prohibit, limit, or interfere with a recipient's selection of a
24 pharmacy or pharmacist of the recipient's choice for the provision
25 of pharmaceutical services under the plan through the imposition of
26 different copayments;
27 (G) that allows the managed care organization or

1 any subcontracted pharmacy benefit manager to contract with a
2 pharmacist or pharmacy providers separately for specialty pharmacy
3 services, except that:
4 (i) the managed care organization and
5 pharmacy benefit manager are prohibited from allowing exclusive
6 contracts with a specialty pharmacy owned wholly or partly by the
7 pharmacy benefit manager responsible for the administration of the
8 pharmacy benefit program; and
9 (ii) the managed care organization and
10 pharmacy benefit manager must adopt policies and procedures for
11 reclassifying prescription drugs from retail to specialty drugs,
12 and those policies and procedures must be consistent with rules
13 adopted by the executive commissioner and include notice to network
14 pharmacy providers from the managed care organization;
15 (H) under which the managed care organization may
16 not prevent a pharmacy or pharmacist from participating as a
17 provider if the pharmacy or pharmacist agrees to comply with the
18 financial terms and conditions of the contract as well as other
19 reasonable administrative and professional terms and conditions of
20 the contract;
21 (I) under which the managed care organization may
22 include mail-order pharmacies in its networks, but may not require
23 enrolled recipients to use those pharmacies, and may not charge an
24 enrolled recipient who opts to use this service a fee, including
25 postage and handling fees;
26 (J) under which the managed care organization or
27 pharmacy benefit manager, as applicable, must pay claims in

1 accordance with Section 843.339, Insurance Code;
2 (K) under which the managed care organization or
3 pharmacy benefit manager, as applicable:
4 (i) to place a drug on a maximum allowable
5 cost list, must ensure that:
6 (a) the drug is listed as "A" or "B"
7 rated in the most recent version of the United States Food and Drug
8 Administration's Approved Drug Products with Therapeutic
9 Equivalence Evaluations, also known as the Orange Book, has an "NR"
10 or "NA" rating or a similar rating by a nationally recognized
11 reference; and
12 (b) the drug is generally available
13 for purchase by pharmacies in the state from national or regional
14 wholesalers and is not obsolete;
15 (ii) must provide to a network pharmacy
16 provider, at the time a contract is entered into or renewed with the
17 network pharmacy provider, the sources used to determine the
18 maximum allowable cost pricing for the maximum allowable cost list
19 specific to that provider;
20 (iii) must review and update maximum
21 allowable cost price information at least once every seven days to
22 reflect any modification of maximum allowable cost pricing;
23 (iv) must, in formulating the maximum
24 allowable cost price for a drug, use only the price of the drug and
25 drugs listed as therapeutically equivalent in the most recent
26 version of the United States Food and Drug Administration's
27 Approved Drug Products with Therapeutic Equivalence Evaluations,

also known as the Orange Book;

(v) must establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(vi) must:

(a) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

(b) respond to a challenge not later than the 15th day after the date the challenge is made;

(c) if the challenge is successful, make an adjustment in the drug price effective on the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager, as appropriate;

(d) if the challenge is denied, provide the reason for the denial; and

(e) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period;

(vii) must notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail;

1 and
2 (viii) must provide a process for each of
3 its network pharmacy providers to readily access the maximum
4 allowable cost list specific to that provider; and
5 (L) under which the managed care organization or
6 pharmacy benefit manager, as applicable:
7 (i) may not require a prior authorization,
8 other than a clinical prior authorization or a prior authorization
9 imposed by the commission to minimize the opportunity for waste,
10 fraud, or abuse, for or impose any other barriers to a drug that is
11 prescribed to a child enrolled in the STAR Kids managed care program
12 for a particular disease or treatment and that is on the vendor drug
13 program formulary or require additional prior authorization for a
14 drug included in the preferred drug list adopted under Section
15 531.072;
16 (ii) must provide for continued access to a
17 drug prescribed to a child enrolled in the STAR Kids managed care
18 program, regardless of whether the drug is on the vendor drug
19 program formulary or, if applicable on or after August 31, 2023, the
20 managed care organization's formulary;
21 (iii) may not use a protocol that requires a
22 child enrolled in the STAR Kids managed care program to use a
23 prescription drug or sequence of prescription drugs other than the
24 drug that the child's physician recommends for the child's
25 treatment before the managed care organization provides coverage
26 for the recommended drug; and
27 (iv) must pay liquidated damages to the

commission for each failure, as determined by the commission, to comply with this paragraph in an amount that is a reasonable forecast of the damages caused by the noncompliance;

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan;

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reductions; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; and

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

SECTION 2. Sections 533.0063(b) and (c), Government Code, are amended to read as follows:

(b) A [~~Except as provided by Subsection (c), a~~] managed care organization is required to send a paper form of the organization's provider network directory for the program only to a recipient who

requests to receive the directory in paper form. If a recipient requests to receive the directory in paper form, the managed care organization shall mail to the recipient the most recent paper form of the directory not later than the fifth business day after the date the organization receives the recipient's request.

(c) At least annually, a [A] managed care organization [participating in the STAR + PLUS Medicaid managed care program or STAR Kids Medicaid managed care program established under Section 533.00253] shall include in the organization's outreach efforts directed at and educational materials sent to recipients enrolled in a managed care plan offered by the organization a written or verbal offer allowing each recipient to elect to receive the organization's[, for a recipient in that program, issue a] provider network directory for the program, including any updates to the directory, in paper form [unless the recipient opts out of receiving the directory in paper form].

SECTION 3. Section 32.025(g), Human Resources Code, is amended to read as follows:

(g) The application form adopted under this section must include:

(1) for an applicant who is pregnant, a question regarding whether the pregnancy is the woman's first gestational pregnancy; [and]

(2) for an applicant who may be enrolled in a Medicaid managed care plan under Chapter 533, Government Code, an option for an applicant to elect to receive the provider network directory, including any updates to the directory, associated with the plan in

1 which the applicant is enrolled in paper form; and
2 (3) a question regarding the applicant's preferences
3 for being contacted, as follows:
4 "If you are determined eligible for benefits, your
5 managed care organization or health plan provider may contact you
6 by telephone, text message, or e-mail about health care matters,
7 including reminders for appointments and information about
8 immunizations or well check visits. All preferred methods of
9 contact listed on this application will be shared with your managed
10 care organization or health plan provider. Please indicate below
11 your preferred methods of contact in order of preference, with the
12 number 1 being the most preferable method:
13 (1) By telephone (if contacted by cellular telephone,
14 the call may be autodialed or prerecorded, and your carrier's usage
15 rates may apply)? Yes No
16 Telephone number: ______________
17 Order of preference: 1 2 3 (circle a number)
18 (2) By text message (a free autodialed service, but
19 your carrier may charge message and data rates)? Yes No
20 Cellular telephone number: _______________
21 Order of preference: 1 2 3 (circle a number)
22 (3) By e-mail? Yes No
23 E-mail address: ____________________
24 Order of preference: 1 2 3 (circle a number)".
25 SECTION 4. (a) Section 533.005(a), Government Code, as
26 amended by this Act, applies only to a contract between the Health
27 and Human Services Commission and a managed care organization that

is entered into or renewed on or after the effective date of this Act.

(b) To the extent permitted by the terms of the contract, the Health and Human Services Commission shall seek to amend a contract entered into before the effective date of this Act with a managed care organization to comply with Section 533.005(a), Government Code, as amended by this Act.

SECTION 5. As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall adopt a revised application form for medical assistance benefits that conforms to the requirements of Section 32.025(g), Human Resources Code, as amended by this Act.

SECTION 6. Using existing resources, the Commission shall conduct a study to assess the impact of revising Star+Plus capitation for managed long term care from payment based on site of care to a blended rate. The study will assess how revising the method of calculating the capitation impacts consumers' choice of setting as well as conduct an actuarial analysis of the impact on program spending. The study shall take into consideration the experience of other states utilizing a blended rate for Medicaid managed long term care. The Commission shall provide a report with their findings to the Speaker, Lieutenant Governor, House Human Services Committee and Senate Health and Human Services Committee.

SECTION 7. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or

1 authorization and may delay implementing that provision until the
2 waiver or authorization is granted.
3 SECTION 8. This Act takes effect September 1, 2021.