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A BILL TO BE ENTITLED

AN ACT

relating to required access to care and provider network provisions in a contract between the Health and Human Services Commission and a Medicaid managed care organization.

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

SECTION 1. Section 533.005, Government Code, is amended by amending Subsection (a) and adding Subsection (e) 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 ensure access to and 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 utilization [~~usages~~] of out-of-network providers or groups of out-of-network providers may not exceed limits determined by the commission, including limits [~~for those usages~~] relating to:

(A) total inpatient admissions, total outpatient services, and emergency room admissions [~~determined by the commission~~];

(B) acute care services not described by Paragraph (A); and

(C) long-term services and supports;

(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

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

1 provide special programs and materials for recipients with limited
2 English proficiency or low literacy skills;
3 (19) a requirement that the managed care organization
4 develop and establish a process for responding to provider appeals
5 in the region where the organization provides health care services;
6 (20) a requirement that the managed care organization:
7 (A) develop and submit to the commission, before
8 the organization begins to provide health care services to
9 recipients, a comprehensive plan that describes how the
10 organization's provider network complies with the provider access
11 standards established under Section 533.0061;
12 (B) as a condition of contract retention and
13 renewal:
14 (i) continue to comply with the provider
15 access standards established under Section 533.0061; and
16 (ii) make substantial efforts, as
17 determined by the commission, to mitigate or remedy any
18 noncompliance with the provider access standards established under
19 Section 533.0061;
20 (C) pay liquidated damages for each failure, as
21 determined by the commission, to comply with the provider access
22 standards established under Section 533.0061 in amounts that are
23 reasonably related to the noncompliance; and
24 (D) <u>annually</u> [~~regularly, as determined by the~~
25 ~~commission,~~] submit to the commission and make available to the
26 public a report containing data on the sufficiency of the
27 organization's provider network with regard to providing the care

1 and services described under Section 533.0061(a) and specific data
2 with respect to access to primary care, specialty care, long-term
3 services and supports, nursing services, and therapy services on:
4 (i) the average length of time between[:
5 [(i)] the date a provider requests prior
6 authorization for the care or service and the date the organization
7 approves or denies the request; [and]
8 (ii) the average length of time between the
9 date the organization approves a request for prior authorization
10 for the care or service and the date the care or service is
11 initiated; and
12 (iii) the number of providers who are
13 accepting new patients;
14 (21) a requirement that the managed care organization
15 demonstrate to the commission, before the organization begins to
16 provide health care services to recipients, that, subject to the
17 provider access standards established under Section 533.0061:
18 (A) the organization's provider network has the
19 capacity to serve the number of recipients expected to enroll in a
20 managed care plan offered by the organization;
21 (B) the organization's provider network
22 includes:
23 (i) a sufficient number of primary care
24 providers;
25 (ii) a sufficient variety of provider
26 types;
27 (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; and

(C) health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that exclusively employs the vendor drug program formulary and preserves the state's ability to reduce

1 waste, fraud, and abuse under Medicaid;
2 (B) that adheres to the applicable preferred drug
3 list adopted by the commission under Section 531.072;
4 (C) that includes the prior authorization
5 procedures and requirements prescribed by or implemented under
6 Sections 531.073(b), (c), and (g) for the vendor drug program;
7 (D) for purposes of which the managed care
8 organization:
9 (i) may not negotiate or collect rebates
10 associated with pharmacy products on the vendor drug program
11 formulary; and
12 (ii) may not receive drug rebate or pricing
13 information that is confidential under Section 531.071;
14 (E) that complies with the prohibition under
15 Section 531.089;
16 (F) under which the managed care organization may
17 not prohibit, limit, or interfere with a recipient's selection of a
18 pharmacy or pharmacist of the recipient's choice for the provision
19 of pharmaceutical services under the plan through the imposition of
20 different copayments;
21 (G) that allows the managed care organization or
22 any subcontracted pharmacy benefit manager to contract with a
23 pharmacist or pharmacy providers separately for specialty pharmacy
24 services, except that:
25 (i) the managed care organization and
26 pharmacy benefit manager are prohibited from allowing exclusive
27 contracts with a specialty pharmacy owned wholly or partly by the

1 pharmacy benefit manager responsible for the administration of the
2 pharmacy benefit program; and
3 (ii) the managed care organization and
4 pharmacy benefit manager must adopt policies and procedures for
5 reclassifying prescription drugs from retail to specialty drugs,
6 and those policies and procedures must be consistent with rules
7 adopted by the executive commissioner and include notice to network
8 pharmacy providers from the managed care organization;
9 (H) under which the managed care organization may
10 not prevent a pharmacy or pharmacist from participating as a
11 provider if the pharmacy or pharmacist agrees to comply with the
12 financial terms and conditions of the contract as well as other
13 reasonable administrative and professional terms and conditions of
14 the contract;
15 (I) under which the managed care organization may
16 include mail-order pharmacies in its networks, but may not require
17 enrolled recipients to use those pharmacies, and may not charge an
18 enrolled recipient who opts to use this service a fee, including
19 postage and handling fees;
20 (J) under which the managed care organization or
21 pharmacy benefit manager, as applicable, must pay claims in
22 accordance with Section 843.339, Insurance Code; and
23 (K) under which the managed care organization or
24 pharmacy benefit manager, as applicable:
25 (i) to place a drug on a maximum allowable
26 cost list, must ensure that:
27 (a) the drug is listed as "A" or "B"

1 rated in the most recent version of the United States Food and Drug
2 Administration's Approved Drug Products with Therapeutic
3 Equivalence Evaluations, also known as the Orange Book, has an "NR"
4 or "NA" rating or a similar rating by a nationally recognized
5 reference; and

6 (b) the drug is generally available
7 for purchase by pharmacies in the state from national or regional
8 wholesalers and is not obsolete;

9 (ii) must provide to a network pharmacy
10 provider, at the time a contract is entered into or renewed with the
11 network pharmacy provider, the sources used to determine the
12 maximum allowable cost pricing for the maximum allowable cost list
13 specific to that provider;

14 (iii) must review and update maximum
15 allowable cost price information at least once every seven days to
16 reflect any modification of maximum allowable cost pricing;

17 (iv) must, in formulating the maximum
18 allowable cost price for a drug, use only the price of the drug and
19 drugs listed as therapeutically equivalent in the most recent
20 version of the United States Food and Drug Administration's
21 Approved Drug Products with Therapeutic Equivalence Evaluations,
22 also known as the Orange Book;

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

1 (vi) must:
2 (a) provide a procedure under which a
3 network pharmacy provider may challenge a listed maximum allowable
4 cost price for a drug;
5 (b) respond to a challenge not later
6 than the 15th day after the date the challenge is made;
7 (c) if the challenge is successful,
8 make an adjustment in the drug price effective on the date the
9 challenge is resolved, and make the adjustment applicable to all
10 similarly situated network pharmacy providers, as determined by the
11 managed care organization or pharmacy benefit manager, as
12 appropriate;
13 (d) if the challenge is denied,
14 provide the reason for the denial; and
15 (e) report to the commission every 90
16 days the total number of challenges that were made and denied in the
17 preceding 90-day period for each maximum allowable cost list drug
18 for which a challenge was denied during the period;
19 (vii) must notify the commission not later
20 than the 21st day after implementing a practice of using a maximum
21 allowable cost list for drugs dispensed at retail but not by mail;
22 and
23 (viii) must provide a process for each of
24 its network pharmacy providers to readily access the maximum
25 allowable cost list specific to that provider;
26 (24) a requirement that the managed care organization
27 and any entity with which the managed care organization contracts

1 for the performance of services under a managed care plan disclose,
2 at no cost, to the commission and, on request, the office of the
3 attorney general all discounts, incentives, rebates, fees, free
4 goods, bundling arrangements, and other agreements affecting the
5 net cost of goods or services provided under the plan;
6 (25) a requirement that the managed care organization
7 not implement significant, nonnegotiated, across-the-board
8 provider reimbursement rate reductions unless:
9 (A) subject to Subsection (a-3), the
10 organization has the prior approval of the commission to make the
11 reductions [~~reduction~~]; or
12 (B) the rate reductions are based on changes to
13 the Medicaid fee schedule or cost containment initiatives
14 implemented by the commission; and
15 (26) a requirement that the managed care organization
16 make initial and subsequent primary care provider assignments and
17 changes.
18 (e) In addition to the requirements specified by Subsection
19 (a), a contract described by that subsection must provide that if
20 the managed care organization has an ownership interest in a health
21 care provider in the organization's provider network, the
22 organization:
23 (1) must include in the provider network at least one
24 other health care provider of the same type in which the
25 organization does not have an ownership interest unless the
26 organization is able to demonstrate to the commission that the
27 provider included in the provider network is the only provider

1 located in an area that meets requirements established by the
2 commission relating to the time and distance a recipient is
3 expected to travel to receive services; and
4 (2) may not give preference in authorizing referrals
5 to the provider in which the organization has an ownership interest
6 as compared to other providers of the same or similar services
7 participating in the organization's provider network.
8 SECTION 2. Section 533.005, Government Code, as amended by
9 this Act, applies to a contract entered into or renewed on or after
10 the effective date of this Act. A contract entered into or renewed
11 before that date is governed by the law in effect on the date the
12 contract was entered into or renewed, and that law is continued in
13 effect for that purpose.
14 SECTION 3. If before implementing any provision of this Act
15 a state agency determines that a waiver or authorization from a
16 federal agency is necessary for implementation of that provision,
17 the agency affected by the provision shall request the waiver or
18 authorization and may delay implementing that provision until the
19 waiver or authorization is granted.
20 SECTION 4. This Act takes effect September 1, 2019.