

CONFERENCE COMMITTEE REPORT FORM

Austin, Texas

May 25, 2019
Date

Honorable Dan Patrick
President of the Senate

Honorable Dennis Bonnen
Speaker of the House of Representatives

Sirs:

We, Your Conference Committee, appointed to adjust the differences between the Senate and the House of Representatives on SB 1096 have had the same under consideration, and beg to report it back with the recommendation that it do pass in the form and text hereto attached.

Charles Perry
Perry

D. Buckingham
Buckingham

W. Campbell
Campbell

Peter P. Flores
Flores

J. W. Kirkhoist
Kirkhoist

On the part of the Senate

Shirley D. Emerson
Emerson

Pepe Cortez
Cortez

Matt Krause
Krause

Tom Parker
Parker

Shirley D. Emerson
Emerson

On the part of the House

Note to Conference Committee Clerk:

Please type the names of the members of the Conference Committee under the lines provided for signature. Those members desiring to sign the report should sign each of the six copies. Attach a copy of the Conference Committee Report and a Section by Section side by side comparison to each of the six reporting forms. The original and two copies are filed in house of origin of the bill, and three copies in the other house.

CONFERENCE COMMITTEE REPORT

3rd Printing

S.B. No. 1096

A BILL TO BE ENTITLED

AN ACT

relating to the Medicaid managed care program, including the provision of pharmacy benefits.

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

SECTION 1. Section 533.00253, Government Code, is amended by adding Subsections (m) and (n) to read as follows:

(m) The advisory committee or a successor committee shall explore the feasibility of adopting a private duty nursing assessment for use in the STAR Kids managed care program and provide recommendations to the commission on adopting a private duty nursing assessment tool that would streamline the documentation for prior authorization of private duty nursing. This subsection expires September 1, 2021.

(n) The commission, at least once every two years, shall conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care.

SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.002821 to read as follows:

Sec. 533.002821. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT. In addition to the requirements of Section 533.005, a contract between a managed care organization and the

1 commission described by that section must require that,
2 notwithstanding any other law, the organization review and issue
3 determinations on prior authorization requests with respect to a
4 recipient who is hospitalized at the time of the request according
5 to the following time frames:

6 (1) within one business day after receiving the
7 request, except as provided by Subdivisions (2) and (3);

8 (2) within 72 hours after receiving the request if the
9 request is submitted by a provider of acute care inpatient services
10 for services or equipment necessary to discharge the recipient from
11 an inpatient facility; or

12 (3) within one hour after receiving the request if the
13 request is related to poststabilization care or a life-threatening
14 condition.

15 SECTION 3. Section 533.005, Government Code, is amended by
16 amending Subsection (a) and adding Subsection (g) to read as
17 follows:

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

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

25 (2) capitation rates that ensure the cost-effective
26 provision of quality health care;

27 (3) a requirement that the managed care organization

1 provide ready access to a person who assists recipients in
2 resolving issues relating to enrollment, plan administration,
3 education and training, access to services, and grievance
4 procedures;

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

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

13 (6) procedures for recipient outreach and education;

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

19 (A) not later than:

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

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

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

1 or

2 (B) within a period, not to exceed 60 days,
3 specified by a written agreement between the physician or provider
4 and the managed care organization;

5 (7-a) a requirement that the managed care organization
6 demonstrate to the commission that the organization pays claims
7 described by Subdivision (7)(A)(ii) on average not later than the
8 21st day after the date the claim is received by the organization;

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

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

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

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

25 (12) if the commission finds that a managed care
26 organization has violated Subdivision (11), a requirement that the
27 managed care organization reimburse an out-of-network provider for

1 health care services at a rate that is equal to the allowable rate
2 for those services, as determined under Sections 32.028 and
3 32.0281, Human Resources Code;

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

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

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

14 (i) selection and assignment as primary
15 care providers;

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

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

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

1 (15) a requirement that the managed care organization
2 develop, implement, and maintain a system for tracking and
3 resolving all provider appeals related to claims payment, including
4 a process that will require:

5 (A) a tracking mechanism to document the status
6 and final disposition of each provider's claims payment appeal;

7 (B) the contracting with physicians who are not
8 network providers and who are of the same or related specialty as
9 the appealing physician to resolve claims disputes related to
10 denial on the basis of medical necessity that remain unresolved
11 subsequent to a provider appeal;

12 (C) the determination of the physician resolving
13 the dispute to be binding on the managed care organization and
14 provider; and

15 (D) the managed care organization to allow a
16 provider with a claim that has not been paid before the time
17 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
18 claim;

19 (16) a requirement that a medical director who is
20 authorized to make medical necessity determinations is available to
21 the region where the managed care organization provides health care
22 services;

23 (17) a requirement that the managed care organization
24 ensure that a medical director and patient care coordinators and
25 provider and recipient support services personnel are located in
26 the South Texas service region, if the managed care organization
27 provides a managed care plan in that region;

1 (18) a requirement that the managed care organization
2 provide special programs and materials for recipients with limited
3 English proficiency or low literacy skills;

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

7 (20) a requirement that the managed care organization:

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

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

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

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

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

25 (D) regularly, as determined by the commission,
26 submit to the commission and make available to the public a report
27 containing data on the sufficiency of the organization's provider

1 network with regard to providing the care and services described
2 under Section 533.0061(a) and specific data with respect to access
3 to primary care, specialty care, long-term services and supports,
4 nursing services, and therapy services on the average length of
5 time between:

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

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

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

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

19 (B) the organization's provider network
20 includes:

21 (i) a sufficient number of primary care
22 providers;

23 (ii) a sufficient variety of provider
24 types;

25 (iii) a sufficient number of providers of
26 long-term services and supports and specialty pediatric care
27 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 or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(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, except as provided by Paragraph

1 (L)(ii), exclusively employs the vendor drug program formulary and
2 preserves the state's ability to reduce waste, fraud, and abuse
3 under Medicaid;

4 (B) that adheres to the applicable preferred drug
5 list adopted by the commission under Section 531.072;

6 (C) that, except as provided by Paragraph (L)(i),
7 includes the prior authorization procedures and requirements
8 prescribed by or implemented under Sections 531.073(b), (c), and
9 (g) for the vendor drug program;

10 (D) for purposes of which the managed care
11 organization:

12 (i) may not negotiate or collect rebates
13 associated with pharmacy products on the vendor drug program
14 formulary; and

15 (ii) may not receive drug rebate or pricing
16 information that is confidential under Section 531.071;

17 (E) that complies with the prohibition under
18 Section 531.089;

19 (F) under which the managed care organization may
20 not prohibit, limit, or interfere with a recipient's selection of a
21 pharmacy or pharmacist of the recipient's choice for the provision
22 of pharmaceutical services under the plan through the imposition of
23 different copayments;

24 (G) that allows the managed care organization or
25 any subcontracted pharmacy benefit manager to contract with a
26 pharmacist or pharmacy providers separately for specialty pharmacy
27 services, except that:

1 (i) the managed care organization and
2 pharmacy benefit manager are prohibited from allowing exclusive
3 contracts with a specialty pharmacy owned wholly or partly by the
4 pharmacy benefit manager responsible for the administration of the
5 pharmacy benefit program; and

6 (ii) the managed care organization and
7 pharmacy benefit manager must adopt policies and procedures for
8 reclassifying prescription drugs from retail to specialty drugs,
9 and those policies and procedures must be consistent with rules
10 adopted by the executive commissioner and include notice to network
11 pharmacy providers from the managed care organization;

12 (H) under which the managed care organization may
13 not prevent a pharmacy or pharmacist from participating as a
14 provider if the pharmacy or pharmacist agrees to comply with the
15 financial terms and conditions of the contract as well as other
16 reasonable administrative and professional terms and conditions of
17 the contract;

18 (I) under which the managed care organization may
19 include mail-order pharmacies in its networks, but may not require
20 enrolled recipients to use those pharmacies, and may not charge an
21 enrolled recipient who opts to use this service a fee, including
22 postage and handling fees;

23 (J) under which the managed care organization or
24 pharmacy benefit manager, as applicable, must pay claims in
25 accordance with Section 843.339, Insurance Code; ~~and~~

26 (K) under which the managed care organization or
27 pharmacy benefit manager, as applicable:

1 (i) to place a drug on a maximum allowable
2 cost list, must ensure that:

3 (a) the drug is listed as "A" or "B"
4 rated in the most recent version of the United States Food and Drug
5 Administration's Approved Drug Products with Therapeutic
6 Equivalence Evaluations, also known as the Orange Book, has an "NR"
7 or "NA" rating or a similar rating by a nationally recognized
8 reference; and

9 (b) the drug is generally available
10 for purchase by pharmacies in the state from national or regional
11 wholesalers and is not obsolete;

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

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

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

26 (v) must establish a process for
27 eliminating products from the maximum allowable cost list or

1 modifying maximum allowable cost prices in a timely manner to
2 remain consistent with pricing changes and product availability in
3 the marketplace;

4 (vi) must:

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

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

10 (c) if the challenge is successful,
11 make an adjustment in the drug price effective on the date the
12 challenge is resolved[7] and make the adjustment applicable to all
13 similarly situated network pharmacy providers, as determined by the
14 managed care organization or pharmacy benefit manager, as
15 appropriate;

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

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

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

26 (viii) must provide a process for each of
27 its network pharmacy providers to readily access the maximum

allowable cost list specific to that provider; and

(L) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) may not require a prior authorization, other than a clinical prior authorization or a prior authorization imposed by the commission to minimize the opportunity for waste, fraud, or abuse, for or impose any other barriers to a drug that is prescribed to a child enrolled in the STAR Kids managed care program for a particular disease or treatment and that is on the vendor drug program formulary or require additional prior authorization for a drug included in the preferred drug list adopted under Section 531.072;

(ii) must provide for continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the managed care organization's formulary;

(iii) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug that the child's physician recommends for the child's treatment before the managed care organization provides coverage for the recommended drug; and

(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;

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

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

11 (A) subject to Subsection (a-3), the
12 organization has the prior approval of the commission to make the
13 reductions [~~reduction~~]; or

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

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

20 (g) The commission shall provide guidance and additional
21 education to managed care organizations with which the commission
22 enters into contracts described by Subsection (a) regarding
23 requirements under federal law to continue to provide services
24 during an internal appeal, a Medicaid fair hearing, or any other
25 review.

26 SECTION 4. (a) Section 533.002821, Government Code, as
27 added by this Act, and Section 533.005, Government Code, as amended

1 by this Act, apply only to a contract between the Health and Human
2 Services Commission and a managed care organization under Chapter
3 533, Government Code, that is entered into or renewed on or after
4 the effective date of this Act.

5 (b) As soon as practicable after the effective date of this
6 Act but not later than September 1, 2020, the Health and Human
7 Services Commission shall seek to amend contracts entered into with
8 managed care organizations under Chapter 533, Government Code,
9 before the effective date of this Act to include the provisions
10 required by Section 533.002821, Government Code, as added by this
11 Act, and Section 533.005, Government Code, as amended by this Act.

12 SECTION 5. If before implementing any provision of this Act
13 a state agency determines that a waiver or authorization from a
14 federal agency is necessary for implementation of that provision,
15 the agency affected by the provision shall request the waiver or
16 authorization and may delay implementing that provision until the
17 waiver or authorization is granted.

18 SECTION 6. The Health and Human Services Commission is
19 required to implement a provision of this Act only if the
20 legislature appropriates money specifically for that purpose. If
21 the legislature does not appropriate money specifically for that
22 purpose, the commission may, but is not required to, implement a
23 provision of this Act using other appropriations available for that
24 purpose.

25 SECTION 7. This Act takes effect September 1, 2019.

Senate Bill 1096
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

SECTION 1. Section 533.00253, Government Code, is amended as follows:

No equivalent provision.

No equivalent provision.

No equivalent provision.

HOUSE VERSION (IE)

SECTION 1. Same as Senate version except as follows:
[FA1(1)]

(f) The commission shall ensure that the care coordinator for a managed care organization that contracts with the commission to provide health care services to recipients under the STAR Kids managed care program offers a recipient's parent or legally authorized representative the opportunity to review the recipient's completed care needs assessment. The commission shall ensure the review does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services. The commission shall require the parent's or representative's signature to verify the parent or representative received the opportunity to review the assessment with the care coordinator. The managed care organization may not delay the delivery of care pending the signature. The commission shall provide a parent or representative who disagrees with a care needs assessment an opportunity to dispute the assessment with the commission through a peer-to-peer review with the treating physician of choice.

(g) The commission, in consultation with stakeholders, shall redesign the care needs assessment used in the STAR Kids managed care program to ensure the assessment collects useable and actionable data pertinent to a child's physical, behavioral, and long-term care needs. This subsection expires September 1, 2021.

(h) The advisory committee or a successor committee shall provide recommendations to the commission for the redesign of the private duty nursing assessment tools used

CONFERENCE

SECTION 1. Same as Senate version except as follows:

Same as Senate version.

Same as Senate version.

(m) The advisory committee or a successor committee shall explore the feasibility of adopting a private duty nursing assessment for use in the STAR Kids managed care program

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SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

in the STAR Kids managed care program based on observations from other states to be more comprehensive and allow for the streamlining of the documentation for prior authorization of private duty nursing. This subsection expires September 1, 2021. [FA1(2)]

and provide recommendations to the commission on adopting a private duty nursing assessment tool that would streamline the documentation for prior authorization of private duty nursing. This subsection expires September 1, 2021.

(i) Same as Senate version.

(n) Same as Senate version.

SECTION __. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00282, 533.00283, and 533.00284 to read as follows:

Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission described by that section must require that:

SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.002821 to read as follows:

Sec. 533.002821. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT. In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission described by that section must require that, notwithstanding any other law, the organization review and issue determinations on prior authorization requests with respect to a recipient who is hospitalized at the time of the request according to the following time frames:

- (1) before issuing an adverse determination on a prior authorization request, the organization provide the physician requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted;
(2) the organization review and issue determinations on prior authorization requests according to the following time frames:

(i)

No equivalent provision.

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SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

(A) with respect to a recipient who is hospitalized at the time of the request:

- (i) within one business day after receiving the request, except as provided by Subparagraphs (ii) and (iii);
- (ii) within 72 hours after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the recipient from an inpatient facility; or
- (iii) within one hour after receiving the request if the request is related to poststabilization care or a life-threatening condition; or

(B) with respect to a recipient who is not hospitalized at the time of the request, within three business days after receiving the request; and

(3) the organization:

(A) have appropriate personnel reasonably available at a toll-free telephone number to respond to a prior authorization request between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays;

(B) have a telephone system capable of receiving and recording incoming telephone calls for prior authorization requests after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays; and

(C) have appropriate personnel to respond to each call described by Paragraph (B) not later than 24 hours after receiving the call.

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each managed care organization that contracts with the

- (1) within one business day after receiving the request, except as provided by Subdivisions (2) and (3);
- (2) within 72 hours after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the recipient from an inpatient facility; or
- (3) within one hour after receiving the request if the request is related to poststabilization care or a life-threatening condition.

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SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

commission to provide health care services to recipients shall develop and implement a process to conduct an annual review of the organization's prior authorization requirements, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program. In conducting a review, the organization must:

(1) solicit, receive, and consider input from providers in the organization's provider network; and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted.

(b) A managed care organization described by Subsection (a) may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program, unless the organization has reviewed the requirement during the most recent annual review required under this section.

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission for the organization to provide health care services to recipients must include a requirement that the organization establish a process for reconsidering an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation.

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SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

(b) The process for reconsidering an adverse determination on a prior authorization request under this section must:
(1) allow a provider to, not later than the seventh business day following the date of the determination, submit any documentation that the managed care organization identified as insufficient or inadequate;
(2) allow the physician requesting the prior authorization to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and
(3) require the managed care organization to, not later than the first business day following the date the provider submits sufficient and adequate documentation under Subdivision (1), amend the determination to approve the prior authorization request.
(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the managed care organization only if the determination is not amended under Subsection (b)(3).
(d) The process for reconsidering an adverse determination on a prior authorization request under this section does not affect:
(1) any related timelines, including the timeline for an internal appeal or a Medicaid fair hearing; or
(2) any rights of a recipient to appeal a determination on a prior authorization request. [FA4]

SECTION 2. Section 533.005(a), Government Code, is amended. Among other provisions:

SECTION 2. Same as Senate version except as follows:
[FA2(1)-(2)]

SECTION 3. Same as House version except as follows:

Senate Bill 1096
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Section-by-Section Analysis

SENATE VERSION

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

...

(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;

...

(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 ~~[reduction]~~; 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.

HOUSE VERSION (IE)

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

...

(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 *or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability*; [FA3]

(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;

...

(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 ~~[reduction]~~; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; ~~*and*~~ [FA2(3)]

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

CONFERENCE

(a) Substantially the same as House version except does not include Subdivisions (27)-(30).

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(27) a requirement that the managed care organization:
(A) not deny a reasonable prior authorization request or
claim for a technical or minimal error; and
(B) not abuse the appeals process or any other review
process to deter a recipient or provider from requesting
health care services;
(28) a requirement that the managed care organization:
(A) automatically, without a request from a recipient or
program, continue to provide the pre-reduction or pre-
denial level of services to the recipient during an internal
appeal or other review of a reduction in or denial of
services, unless the recipient or the recipient's parent on
behalf of the recipient opts out of the automatic
continuation of services; and
(B) provide the commission and the recipient with a notice
of continuing services;
(29) a requirement that the managed care organization
comply with any applicable review procedure and comply
with the reviewer's determination; and
(30) a requirement that the managed care organization pay
liquidated damages for each substantiated failure to adhere
to contractual requirements.

No equivalent provision.

(g) The commission shall provide guidance and additional
education to managed care organizations regarding
requirements under federal law and Subsection (a)(28) to
continue to provide services during an internal appeal, a
Medicaid fair hearing, or any other review. [FA2(4)]

No equivalent provision.

SECTION __. (a) Sections 533.00282 and 533.00284,
Government Code, as added by this Act, apply only to a

(g) The commission shall provide guidance and additional
education to managed care organizations **with which the**
commission enters into contracts described by Subsection
(a) regarding requirements under federal law to continue to
provide services during an internal appeal, a Medicaid fair
hearing, or any other review.

Same as Senate version. (But see SECTION 4 below.)

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contract between the Health and Human Services Commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act.

(b) The Health and Human Services Commission shall seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act to include the provisions required by Sections 533.00282 and 533.00284, Government Code, as added by this Act. [FA4]

SECTION 3. Section 533.005, Government Code, as amended by this Act, ***applies*** to a contract entered into or renewed on or after the effective date of this Act. ***A contract entered into or renewed before that date is governed by the law in effect on the date the contract was entered into or renewed, and that law is continued in effect for that purpose.***

SECTION 3. Same as Senate version. *(But see the nonamendatory SECTION _ above.)*

SECTION 4. (a) ***Section 533.002821, Government Code, as added by this Act, and*** Section 533.005, Government Code, as amended by this Act, ***apply only*** to a contract ***between the Health and Human Services Commission and a managed care organization under Chapter 533, Government Code, that is*** entered into or renewed on or after the effective date of this Act.

(b) As soon as practicable after the effective date of this Act but not later than September 1, 2020, the Health and Human Services Commission shall seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act to include the provisions required by Section 533.002821, Government Code, as added by this Act, and Section 533.005, Government Code, as amended by this Act.

SECTION 4. 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

SECTION 4. Same as Senate version.

SECTION 5. Same as Senate version.

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the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 5. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

SECTION 6. This Act takes effect September 1, 2019.

SECTION 5. Same as Senate version.

SECTION 6. Same as Senate version.

SECTION 6. Same as Senate version.

SECTION 7. Same as Senate version.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 25, 2019

TO: Honorable Dan Patrick, Lieutenant Governor, Senate
Honorable Dennis Bonnen, Speaker of the House, House of Representatives

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: SB1096 by Perry (Relating to the Medicaid managed care program, including the provision of pharmacy benefits.), **Conference Committee Report**

The fiscal implications of the bill cannot be determined at this time but a cost would be anticipated.

The agency is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the agency may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

The bill would require the Health and Human Services Commission (HHSC) in contracts with Medicaid managed care organizations to prohibit use of non-clinical prior authorizations, or prior authorization imposed by HHSC to minimize fraud, waste, or abuse, or other barriers to a drug prescribed to a child enrolled in STAR Kids if the drug is on the vendor drug program formulary. The bill would also prohibit the use of additional prior authorization for a drug included on the preferred drug list, would provide for continued access to drugs provided to children enrolled in STAR Kids regardless of whether the drug is on the formulary, would prohibit use of protocols that require children enrolled in STAR Kids to first use drugs other than those recommended by their physician, and would require assessment of liquidated damages for failure to comply with these provisions. HHSC would be required to seek to amend contracts to include the provisions of the bill no later than September 1, 2020. According to HHSC, the provisions of the bill may result in utilization of higher cost drugs or drugs not included on the vendor drug program formulary for which federal matching funds may not be available. The extent to which this would occur cannot be determined but a cost would be anticipated.

The bill would also require HHSC to conduct a utilization review of a sample of cases of children enrolled in STAR Kids at least once every two years to ensure that prior authorizations are not being used to negatively impact a recipient's access to care. According to HHSC, additional costs related to utilization review requirements would not be significant and could be absorbed with existing resources. The bill would take effect September 1, 2019.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

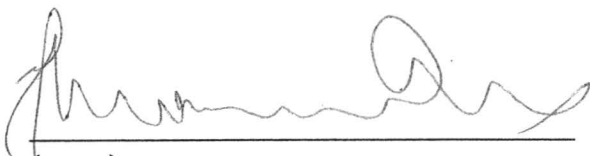
Source Agencies: 529 Health and Human Services Commission

LBB Staff: WP, AKi, EP, MDI, LR

**Certification of Compliance with
Rule 13, Section 6(b), House Rules of Procedure**

Rule 13, Section 6(b), House Rules of Procedure, requires a copy of a conference committee report signed by a majority of each committee of the conference to be furnished to each member of the committee in person or, if unable to deliver in person, by placing a copy in the member's newspaper mailbox at least one hour before the report is furnished to each member of the house under House Rule 13, Section 10(a). The paper copies of the report submitted to the chief clerk under Rule 13, Section 10(b), must contain a certificate that the requirement of Rule 13, Section 6(b), has been satisfied, and that certificate must be attached to the copy of the report furnished to each member under Rule 13, Section 10(d). Failure to comply with this requirement is not subject to a point of order under Rule 13.

I certify that a copy of the conference committee report on SB1096 was furnished to each member of the conference committee in compliance with Rule 13, Section 6(b), House Rules of Procedure, before submission of the paper copies of the report to the chief clerk under Rule 13, Section 10(b), House Rules of Procedure.



(name)

5/25/19

(date)