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2020 Federal Action

2019 CONG US HR 1425 was read for the second time on September 8, 2020. The proposed bill seeks to amend the Patient Protection and Affordable Care Act to provide for a Improve Health Insurance Affordability Fund to provide for certain reinsurance payments to lower premiums in the individual health insurance market.

2019 CONG US HR 3 was read for the second time on September 8, 2020. The proposed bill seeks to establish a fair price negotiation program, protect the Medicare program from excessive price increases, and establish an out-of-pocket maximum for Medicare part D enrollees, and for other purposes.

2020 State Action

In **Arizona**

2020 AZ H.B. 2428 (NS) was introduced May 19, 2020. The proposed bill seeks to require any insurer that offers Medicare supplement insurance policies to persons who are at least sixty-five years of age shall also offer Medicare supplement insurance policies to persons who are eligible for and enrolled in Medicare due to a disability or end-stage renal disease. All benefits and coverages that apply to a Medicare enrollee who is at least sixty-five years of age must also apply to a Medicare enrollee who is enrolled due to a disability or end-stage renal disease.

In **California**

2019 CA A.B. 910 (NS), a previously introduced bill, was amended January 6, 2020. Existing law requires the department to implement managed mental health care for Medi-Cal beneficiaries through contracts with county mental health plans. Under existing law, the county mental health plans are responsible for providing specialty mental health services to eligible Medi-Cal beneficiaries, and Medi-Cal managed care plans deliver nonspecialty mental health services to those persons. Existing law requires county mental health plans and Medi-Cal managed care plans to be governed by various guidelines, including network adequacy standards and a requirement that a county mental health plan that provides Medi-Cal specialty mental health services enter into a memorandum of understanding with a Medi-Cal managed care plan that provides Medi-Cal health services to some of the same Medi-Cal recipients served by the county mental health plan. Existing regulations provide for a dispute resolution process to be used to resolve matters between a Medi-Cal managed care plan and a county mental health plan. This bill would require a county mental health plan and Medi-Cal managed care plan that are unable to resolve a dispute to submit a request for resolution to the department. The bill would require the department to issue a written decision to the plans within 30 calendar days from receipt of the request. The bill would also prohibit the dispute from delaying the provision of medically necessary services, as specified.

2019 CA A.B. 2042 (NS), a previously introduced bill, was amended March 12, 2020. Existing federal law authorizes specified managed care entities that participate in a state's Medicaid program to cover, for enrollees, services or settings that are in lieu of services and settings otherwise covered under a state plan. This bill would require those mandatorily developed health-plan-and county-specific rates for specified Medi-Cal managed care plan contracts to include in lieu of services and settings provided by the Medi-Cal managed care plan. The bill would require each Medi-Cal managed care plan to disclose the availability of in lieu of services on its internet website and its beneficiary handbook, and to disclose to the department specified information on in lieu of services that are plan specific, including the number of people receiving those services. The bill would require the department to publish that information on its internet website. This bill would, to the extent that federal financial participation is available and any necessary federal approvals have been obtained, expand the schedule of benefits under the Medi-Cal program to include enhanced care management if the service is

provided in person to a beneficiary and, at a minimum, the service includes coordinating primary, acute, behavioral, oral, and long-term services and supports for that person.

2019 CA S.B. 936 (NS), a previously introduced bill, was amended April 3, 2020. This bill would require the Director of Health Care Services to conduct a contract procurement at least once every 5 years if the director contracts with a commercial Medi-Cal managed care plan for the provision of care of Medi-Cal beneficiaries on a state-wide or limited geographic basis, and would authorize the director to extend an existing contract for one year if the director takes specified action, including providing notice to the Legislature, at least one year before exercising that extension. The bill would require the department to perform specified duties, including establishing a stakeholder process in the planning and development of each commercial Medi-Cal managed care contract procurement process, and receiving public comment on the model contract, procurement qualifications, and evaluation criteria.

2019 CA A.B. 2277 (NS), a previously introduced bill, was amended May 2020. Existing law authorizes the department to enter contracts with managed care plans to provide Medi-Cal services. Under existing law, Medi-Cal covers early and periodic screening, diagnostic, and treatment services for individuals under 21 years of age, consistent with federal law. This bill would require any contract between the department and a Medi-Cal managed care plan to impose requirements on the Medi-Cal managed care plan to identify every enrollee who does not have a record of completing those tests at 12 and 24 months of age, and to remind the contracting health care provider who is responsible for performing a periodic health assessment of a child of the need to perform those tests. The bill would require the department to develop and implement procedures, and take enforcement action, as prescribed, to ensure that a Medi-Cal managed care plan performs those duties. If a Medi-Cal managed care plan enrollee who is a child misses a required blood lead screening test at 12 and 24 months of age, the bill would require the Medi-Cal managed care plan to notify specified individuals responsible for that child, including the parent or guardian, about those missed blood lead screening tests, and would require that notification to be included as part of an annual notification on preventive services.

CA LEGIS 216 (2020) was filed with Secretary of State September 28, 2020. Existing law authorizes the department to enter contracts with managed care plans to provide Medi?Cal services, and imposes requirements on the Medi?Cal managed care plans, including network adequacy standards. Under existing law, Medi?Cal covers early and periodic screening, diagnostic, and treatment services for individuals under 21 years of age, consistent with federal law. This bill would require a contract between the department and a Medi?Cal managed care plan to require the Medi?Cal managed care plan, on a quarterly basis, to identify every enrollee who is a child without a record of completing the blood lead screening tests, and to remind the contracting network provider of the requirement to perform the required blood lead screening tests and the requirement to provide the oral or written guidance to a parent or guardian relating to risk of childhood lead poisoning. The bill would require the department to develop and implement procedures to ensure compliance with those requirements would authorize the department to impose sanctions for a violation of those requirements.

2019 CA A.B. 2164 (NS) was enrolled September 1, 2020. Existing law prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when the service may be provided by telehealth, and, for purposes of telehealth, prohibits the department from limiting the type of setting where Medi-Cal services are provided. Existing law authorizes, to the extent that federal financial participation is available, the use of health care services by store and forward under the Medi-Cal program, subject to billing and reimbursement policies developed by the department, and prohibits a requirement of in-person contact between a health care provider and a Medi-Cal patient when these services are provided by store and forward. This bill provides that an federally qualified health center (FQHC) or rural health clinic (RHC) ‘visit’ includes an encounter between an FQHC or RHC patient and a health care provider using telehealth by synchronous interaction or asynchronous store and forward. The bill would specify that an FQHC or RHC is not precluded from establishing a patient who is located within the FQHC's or RHC's federal designated service area through synchronous interaction or asynchronous store and forward as of the date of service if specified requirements are met.

2019 CA A.B. 2100 (NS) was enrolled September 1, 2020. By executive order, the Governor directed the department to transition pharmacy services for Medi-Cal managed care to a fee-for-service benefit by January 1, 2021. Existing law requires the department to convene an advisory group to receive feedback on the changes, modifications, and operational timeframes on the implementation of pharmacy benefits offered in the Medi-Cal program, and to provide regular updates on the pharmacy transition, including a description of changes in the division of responsibilities between the department and managed care plans relating to the transition of the outpatient pharmacy benefit to fee-for-service. This bill requires the department to establish the Independent Prescription Drug Medical Review System (IPDMRS), commencing on January 1, 2021, which generally models the above-described requirements of the Knox-Keene Health Care Service Plan Act. The bill would provide that any Medi-Cal beneficiary grievance involving a disputed health care service is eligible for review under the IPDMRS, and would define ‘disputed health care service’ as any outpatient prescription drug eligible for coverage and payment by the Medi-Cal program that has been denied, modified, or delayed by a decision of the department, or by one of its contracting fiscal intermediaries for the administration of the prescription drug benefit if that entity makes a final decision, in whole or in part, due to a finding that the service is not medically necessary.

2019 CA A.B. 2276 (NS) was adopted September 28, 2020. Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law authorizes the department to enter contracts with managed care plans to provide Medi-Cal services, and imposes requirements on the Medi-Cal managed care plans, including network adequacy standards. Under existing law, Medi-Cal covers early and periodic screening, diagnostic, and treatment services for individuals under 21 years of age, consistent with federal law. Existing law provides for the Medi-Cal program, which

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In **Colorado**

2020 CO H.B. 1384 (NS) was enrolled June 22, 2020. The bill relates to the delay of department implementation of high-fidelity wraparound services for eligible at-risk children unless money is appropriated for the services, and, in connection therewith, reducing appropriations. Subject to available appropriations, the state department must seek federal authorization from the federal centers for Medicare and Medicaid services to provide wraparound services for eligible children and youth who are at risk of out-of-home placement or in an out-of-home placement. Prior to seeking federal authorization, the state department must seek input from relevant stakeholders including counties, managed care entities participating in the statewide managed care system, families of children and youth with behavioral health disorders, communities that have previously implemented wraparound services, mental health professionals, and other relevant departments. The state department must consider tiered care coordination as an approach when developing the wraparound model.

2020 CO H.B. 1237 (NS) was adopted July 11, 2020. The bill states that for a child or youth who obtains eligibility for services under the state's Medicaid program through a dependency and neglect action resulting in out-of-home placement or a juvenile delinquency action resulting in out-of-home placement, the state department must assign the child or youth to the MCE covering the county with jurisdiction over the action. The state department must only change the assignment if the change is requested by the county with jurisdiction over the action or by the child's or youth's legal guardian.

In **Florida**

2020 FL S.B. 1684 (NS) was filed January 10, 2020. The bill will require the Financial Services Commission, in consultation with the Agency for Health Care Administration, to adopt a certain standard form by rule for the verification of credentials of specified health care professionals. The bill will also:

• specify requirements for applicants to qualify for expedited credentialing and for certain payments;

• authorizing a managed care plan to exclude applicants from its participating provider directory or listings while their applications are pending approval; and

• authorizing a civil cause of action for applicants against health insurers or designees under certain circumstances.

2020 FL H.B. 945 (NS) was adopted June 27, 2020. The bill requires the Department of Children and Families and the Agency for Health Care Administration to identify children and adolescents who use crisis stabilization services and to meet behavioral health needs of such children and adolescents. The bill also requires:

• development of plans promoting coordinated system of care for certain services;

• testing of provider network databases maintained by Medicaid managed care plans;

• verification of use of certain strategies and outreach before student is removed from school, school transportation, or school-sponsored activity under specified circumstances; provides exception; and

• the Department of Children and Families and the Agency for Health Care Administration to assess quality of care provided in crisis stabilization units.

In **Illinois**

2019 IL H.B. 4038 (NS) was introduced January 8, 2020. If passed, the proposed bill will provide that the methodologies for reimbursement under the managed care medical assistance program shall not be applicable to facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013. The bill will also provide that covered services provided by facilities licensed under the Specialized Mental Health Rehabilitation Act of 2013 shall be reimbursed at the rates paid under the Illinois Medicaid fee-for-service methodology.

2019 IL H.B. 4140 (NS) was filed January 17, 2020. The proposed bill, if passed, provides that if a Medicaid enrollee of a managed care organization is referred by his or her primary care provider to another provider who was on the in-network referral list provided by the managed care organization for a medical service, the managed care organization must cover the medical service from that provider if it was a covered service on the date of referral.

2019 IL H.B. 4467 (NS) was filed February 3, 2020. If passed, the bill will create the Medicaid Smart Card Pilot Program Act. The bill will require the Director of the Department of Healthcare and Family Services to establish a Medicaid Smart Card Pilot Program to reduce the total amount of expenditures under the State's Medical Assistance Program. The bill will also provide that the pilot program must be designed to reduce the average monthly cost under the State's Medical Assistance Program for recipients within the pilot program area by an amount that is at least sufficient to recover the cost of implementing the pilot program.

2019 IL H.B. 5079 (NS) was introduced February 18, 2020. The proposed legislation relates to coverage for telehealth services. The proposed bill states that certain health benefit policies or plans may not exclude from coverage a medically necessary health care service or procedure delivered by certain providers solely because the health care service or procedure is provided through telehealth (rather than requiring certain policies to meet specified criteria if they provide coverage for telehealth services). The bill also provides that an individual or group policy of accident or health insurance that provides coverage for telehealth services delivered by contracted licensed dietitian nutritionists and contracted certified diabetes educators must also provide coverage for in-home services for senior diabetes patients (rather than requiring an individual or group policy of accident or health insurance that provides coverage for telehealth services to provide coverage for licensed dietitian nutritionists and certified diabetes educators who counsel senior diabetes patients in the patients' homes). The bill also:

• provides payment, reimbursement, and service requirements for telehealth services provided under the State's fee-for-service or managed care medical assistance programs;

• provides that ‘telehealth’ includes telepsychiatry; and

• provides that the Department of Healthcare and Family Services must implement the new provisions 60 days after the effective date of the amendatory Act.

2019 IL S.B. 1864 (NS) was enrolled May 23, 2020. The bill states that the Department may take necessary actions to address the COVID-19 public health emergency to the extent such actions are required, approved, or authorized by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services. Such actions may continue throughout the public health emergency and for up to 12 months after the period ends, and may include, but are not limited to:

• accepting an applicant's or recipient's attestation of income, incurred medical expenses, residency, and insured status when electronic verification is not available;

• eliminating resource tests for some eligibility determinations; suspending redeterminations;

• suspending changes that would adversely affect an applicant's or recipient's eligibility;

• phone or verbal approval by an applicant to submit an application in lieu of applicant signature;

• allowing adult presumptive eligibility;

• allowing presumptive eligibility for children, pregnant women, and adults as often as twice per calendar year;

• paying for additional services delivered by telehealth;

• and suspending premium and co-payment requirements.

In **Indiana**

2020 IN H.B. 1136 (NS) was introduced January 8, 2020. The proposed bill specifies that a managed care organization must cover and pay for claims from an emergency department for an individual's emergency medical condition in compliance with federal law, including:

• Medicaid claims that have been submitted and appealed by providers and hospitals; or

• claims concerning a medical condition that resulted in an individual being admitted to the hospital for observation.

2020 IN S.B. 243 (NS) was introduced January 9, 2020. If passed, the proposed bill will require a provider to include the address where the services were provided for a reimbursement claim to the office of the secretary of family and social services or the managed care organization. The bill also specifies requirements for credentialing a provider for participation in the Medicaid program and establishes a provisional credential for reimbursement purposes until a decision is made on a provider's credentialing application.

2020 IN S.B. 192 (NS) was introduced January 2, 2020. If passed, the bill will require a managed care organization to allow a child Medicaid recipient who has been certified for admission to a psychiatric hospital to be provided certain services that are determined by a treating physician to be necessary for the child for up to seven days before the managed care organization may require a continued review process.

2020 IN H.B. 1236 (NS) was introduced January 13, 2020. The proposed bill seeks to extend the prohibition against the inclusion of certain Medicaid recipients in:

• risk based managed care programs; or

• capitated managed care programs; from June 30, 2020, to June 30, 2021.

In **Iowa**

2019 IA S.S.B. 3189 (NS) was introduced February 18, 2020. The proposed bill relates to participating pharmacy and pharmacist network providers under Medicaid managed care.

In **Kentucky**

2020 KY S.B. 29 (NS) was introduced January 7, 2020. The proposed bill seeks to require Medicaid managed care organizations to provide all payment schedules utilized to reimburse health care providers with whom they have maintained a contractual relationship for the previous three months to the Medicaid Oversight and Advisory Committee on a quarterly basis for the committee's review. The bill also seeks to require that services provided in rural counties be reimbursed at least at the median amount paid to an urban health care provider within the nearest metropolitan statistical area.

2020 KY S.B. 30 (NS), a previously introduced bill, was amended February 5, 2020. If passed, the Department for Medicaid Services will limit the total number of awarded Medicaid managed care contracts to administer the Medicaid program to no more than three managed care organizations.

2020 KY H.B. 477 (NS) was introduced February 24, 2020. The proposed bill seeks to define ‘qualifying health plan’. The bill also seeks to prohibit the Department for Medicaid Services from issuing or renewing a Medicaid managed care contract to any managed care organization or other entity unless the organization or entity offers, or agrees to offer, a qualifying health plan in the same geographic areas that the organization or entity provides Medicaid benefits.

In **Louisiana**

2020 LA H.B. 321 (NS) was prefiled February 27, 2020. The proposed bill relates to the Medicaid managed care program. The bill also seeks to:

• provide for duties of the Louisiana Department of Health in administering the Medicaid managed care program;

• provide relative to the pharmacy programs of Medicaid managed care organizations;

• provide requirements for prescription dispensing rates in such pharmacy programs.

2020 LA H.B. 838 (NS) was introduced March 31, 2020. The proposed bill relates to nonemergency medical transportation services delivered through the Medicaid managed care program. The bill will also require disclosure of payment amounts to certain providers, brokers, and third-party administrators; to provide for administration of nonemergency medical transportation services by Medicaid managed care organizations; to provide requirements for contracts between the Louisiana Department of Health and managed care organizations.

2020 LA H.R. 14 (NS) was introduced October 12, 2020. The proposed bill is a resolution to urge and request the Louisiana Department of Health to study certain aspects of nonemergency medical transportation provided within the Medicaid managed care program of this state and to report findings from the study to the House Committee on Health and Welfare.

2020 LA H.B. 101 (NS) was introduced October 21, 2020. The proposed bill relates to reimbursement rates. If passed, the bill will prohibit a maximum reimbursement cap for certain ventilation treatments. Notwithstanding any provision of law to the contrary, an insurer, managed care company, or other payor shall not set a maximum dollar amount of reimbursement for non-invasive ventilation treatments properly ordered and taking place in an appropriate care setting.

2020 LA H.R. 14 (NS) was enrolled October 19, 2020. The bill is a resolution to urge and request the Louisiana Department of Health to study certain aspects of nonemergency medical transportation provided within the Medicaid managed care program of this state and to report findings from the study to the House Committee on Health and Welfare.

In **Maryland**

2020 MD S.B. 931 (NS) was adopted May 8, 2020. The purpose of the bill is to prohibit the Secretary of Health from considering certain drugs to be specialty drugs for the purpose of providing services under the Maryland Medical Assistance Program; altering the definition of ‘specialty drug’ for the purpose of excluding prescription drugs prescribed to treat certain medical conditions from the authority of certain insurers, nonprofit health service plans, and health maintenance organizations to require a covered specialty drug to be obtained through a certain pharmacy or other sources and to provide coverage for specialty drugs through a managed care system.

In **Minnesota**

2019 MN S.F. 4462 (NS) was introduced April 14, 2020. The proposed bill relates to managed care requirements. If passed, the bill will require managed care plans and county-based purchasing plans to reimburse specified providers of the substance use disorder. The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement.

In **Mississippi**

2020 MS H.B. 1184 (NS) was introduced February 17, 2020. If passed, the proposed bill will require managed care organizations under any managed care program implemented by the division of Medicaid to use a clear set of level of care guidelines in the determination of medical necessity and in all utilization management practices that are consistent with widely accepted professional standards of care. The bill will also prohibit those organizations from using any additional criteria that would result in denial of care that would be determined appropriate and, therefore, medically necessary by the guidelines and certain specified principles.

In **Missouri**

2020 MO H.B. 61 (NS) was introduced August 10, 2020. The proposed bill relates to insurance coverage for mental health conditions. The bill states that a health benefit plan must provide coverage for treatment of a mental health condition and must not establish any rate, term, or condition that places a greater financial burden on an insured for access to treatment for a mental health condition than for access to treatment for a physical health condition. Any deductible or out-of-pocket limits required by a health carrier or health benefit plan must be comprehensive for coverage of all health conditions, whether mental or physical. A health benefit plan may provide coverage for treatment of mental health conditions through a managed care organization; provided that the managed care organization is in compliance with rules adopted by the department of commerce and insurance that assure that the system for delivery of treatment for mental health conditions does not diminish or negate the purpose of this section. The rules adopted by the director must assure that:

• timely and appropriate access to care is available;

• the quantity, location, and specialty distribution of health care providers is adequate; and

• administrative or clinical protocols do not serve to reduce access to medically necessary treatment for any insured.

In **Nebraska**

2019 NE L.B. 956 (NS) was introduced January 13, 2020. The proposed bill seeks to provide duties for managed care organizations under the Medical Assistance Act.

2019 NE L.B. 956 (NS) was enrolled August 4, 2020. The bill provides duties regarding managed care contract changes and change audit provisions under the Medical Assistance Act. The bill states that if a managed care organization makes any material change to a provider contract, the managed care organization shall provide the provider with at least sixty days' notice of the material change. The notice of a material change required under this section must include:

• the effective date of the material change;

• a description of the material change;

• the name, business address, telephone number, and electronic mail address of a representative of the managed care organization to discuss the material change, if requested by the provider;

• notice of the opportunity for a meeting using real-time communication to discuss the proposed changes if requested by the provider, including any mode of telecommunications in which all users can exchange information instantly such as the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing. If requested by the provider, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of real-time communication; and

• notice that upon three material changes in a twelve-month period, the provider may request a copy of the provider contract with material changes consolidated into a single document.

In **New Hampshire**

2019 NH S.B. 531 (NS) was introduced January 8, 2020. If passed, this bill will clarify the prior authorization procedures under group health insurance policies and managed care.

2019 NH S.B. 754 (NS), a previously introduced bill, was amended March 12, 2020. This bill requires the commissioner of the department of health and human services to solicit information and to contract with dental managed care organizations to provide dental care to persons under the Medicaid managed care program.

2019 NH H.B. 1280 (NS) was adopted July 16, 2020. This bill requires insurers to cap the total amount paid for insulin for covered persons. The bill also establishes a wholesale importation program for prescription drugs from Canada by or on behalf of the state. The bill requires the department of health and human services to design the program and obtain federal approval for the program. The bill also:

• establishes a prescription drug affordability board to determine annual public payor spending targets for prescription drugs, develop and implement policies and procedures for the collection of prescription drug price data, implement a register of drug manufacturers for drug pricing data, and establish funding for the board by reasonable user fees and assessments; and

• clarifies the pricing of generic prescription drugs under the law governing consumer protection;

• clarifies the procedure for prior authorization for prescription drugs on the formulary under the managed care law;

• requires insurance coverage for epinephrine autoinjectors; and

• establishes the prescription drug competitive marketplace.

In **New Jersey**

2020 NJ S.B. 235 (NS) was introduced January 14, 2020. If passed, the bill will permit certain managed care organizations to consider cost-effectiveness when placing prescription drug on formulary. A managed care organization that contracts with the Division of Medical Assistance and Health Services in the Department of Human Services to provide pharmacy services under a managed care plan to persons who are eligible for Medicaid may consider a comparison of cost-effectiveness data as a factor, in addition to such other

factors as clinical efficacy and safety, when placing a prescription drug on a formulary, if the managed care organization chooses to operate a formulary.

2020 NJ S.B. 1089 (NS) was introduced January 30, 2020. If passed, the bill will require all Medicaid managed care organization to permit all pharmacies in State to dispense prescriptions for all covered medications.

2020 NJ S.B. 1765 (NS) was introduced February 13, 2020. If passed, the bill will require pharmacy benefits manager providing services within Medicaid program to implement pass-through pricing model and to disclose certain information to DHS and managed care.

2020 NJ A.B. 4082 (NS) was introduced May 7, 2020. If passed, the Department of Banking and Insurance to develop system to require carriers to consult with health care providers on tiered network managed care plans. The Commissioner of Banking and Insurance must develop and maintain a tiered network review system to ensure that a carrier that offers a managed care plan that provides for in-network benefits and for a tiered network must, prior to offering that plan, consults with health care providers regarding the selection standards used for tier placement in accordance with the specified provisions.

2020 NJ A.B. 4387 (NS) was introduced July 6, 2020. The proposed bill seeks to expand NJ FamilyCare to ensure healthcare benefits are available to all uninsured children under 19 years of age who live in New Jersey; appropriates $3 million for outreach, enrollment, and retention regarding NJ FamilyCare.

2020 NJ S.B. 2791 (NS) was introduced July 30, 2020. If passed, the bill will require the Department of Human Services to review and evaluate any existing requirements for Medicaid managed care organizations to contract with any willing provider for the delivery of nursing home services, and determine whether to request State plan amendments or waivers as may be necessary to allow managed care organizations to terminate or suspend a contract with a nursing home that has a history of multiple violations related to State or federal licensure requirements, or that has a history of one or more violations of licensure requirements that resulted in severe adverse health consequences for facility staff or residents. The Department of Human Services must additionally evaluate whether managed care plans can be used to assist the Department of Health in monitoring compliance and quality of care in nursing homes and, if so, shall identify any actions as may be needed to allow managed care plans to assist the Department of Health.

2020 NJ A.B. 4688 (NS) was introduced September 21, 2020. If passed, the bill will codify and establishes certain network adequacy standards for pediatric primary and specialty care in Medicaid program. The bill codifies and establishes certain network adequacy standards for pediatric primary and specialty care in the Medicaid program. The bill defines network adequacy to mean the adequacy of the provider network with respect to the scope and type of health care benefits provided by the managed care plan, the geographic service area covered by the provider network, and access to medical specialists pursuant to the certain standards and in the existing contract between a managed care organization (MCO) and the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services (DHS).

2020 NJ S.B. 3000 (NS) was introduced October 8, 2020. The proposed bill seeks to codify and establishes certain network adequacy standards for pediatric primary and specialty care in Medicaid program. The proposed bill states that a commissioner must only approve the network adequacy of a managed care plan provided by a managed care organization contracted with the Division of Medical Assistance and Health Services in the Department of Human Services to provide benefits under Medicaid if the plan has a sufficient number of pediatric primary care physicians (PCPs) to assure that:

at least two physicians eligible as PCPs are within five miles or 10 minutes driving time or public transit time, whichever is less, of 90 percent of the managed care plan's pediatric enrollees who live in urban counties;

at least two physicians eligible as PCPs are within 10 miles or 15 minutes driving time or public transit time, whichever is less, of 90 percent of the managed care plan's pediatric enrollees who live in non-urban counties; and

100 percent of all pediatric enrollees live no more than 30 minutes from at least one physician eligible as a PCP.

NJ LEGIS 88 (2020) was approved September 16, 2020. The bill established the New Jersey Task Force on Long?Term Care Quality and Safety, which will be tasked with developing recommendations to make changes to the long-term system of care to drive improvements in person-centered care, resident and staff safety, improvements in quality of care and services, workforce engagement and sustainability, and any other appropriate aspects of the long-term system of care in New Jersey as the task force elects to review. The task force must specifically focus on:

expanding home and community-based services and recommending strategies to improve the balance between facility-based services and home and community-based services and supports;

nursing home reforms, including implementing new care models, optimizing nursing home size and configurations to foster resident wellness and infection control, increasing clinical presence in nursing homes, and identifying appropriate nursing home staffing levels for certain resident acuity and special population needs;

maintaining the objectivity of the nursing home survey inspections and the cited deficiency appeals process;

identifying the capital investments needed to support physical plant, technology, and workforce development initiatives in nursing homes; and

broader reforms to the long-term system of care, including developing technology requirements to enable enhanced use of telemedicine and telehealth, instituting workforce engagement and advancement models including career laddering options and structures, increasing the use of Medicaid managed care to drive improvements in quality and oversight of nursing homes, and establishing acuity adjustments for Medicaid managed care payments to nursing homes.

2020 NJ A.B. 4478 (NS), a previously introduced bill, was amended October 26, 2020. If passed, the proposed bill will establish additional requirements for DOH to assess sanctions and impose penalties on nursing homes. The bill will also revise reporting requirements for nursing homes.

2020 NJ A.B. 4965 (NS) was introduced November 12, 2020. If passed, the bill will require health insurance carriers and Medicaid managed care prescription drug plans to utilize consolidated procurement. The bill also requires the State Medicaid Commission must ensure that every Medicaid managed care contract to provide prescription drug benefits, or to authorize the purchase of a contract to provide prescription drug benefits, must:

• provide for the utilization of consolidated procurement of pharmaceutical drugs to the extent appropriate and feasible; and

• require that failure to utilize consolidated procurement of pharmaceutical drugs must be documented, justified, and reported to the Commissioner of Human Services.

In **New York**

2019 NY A.B. 10184 (NS) was introduced March 24, 2020. The proposed bill relates to including accountable care organizations within the definition of a managed care provider.

2019 NY S.B. 1890 (NS), a previously introduced bill, was amended July 16, 2020. The proposed bill provides that services to medical assistance recipients suffering from traumatic brain injuries or qualifying for nursing home diversion and transition services shall be provided outside of managed programs.

2019 NY S.B. 8856 (NS) was introduced July 29, 2020. If passed, the bill will require Medicare and Medicaid managed care providers to provide coverage for certain out-of-network health care. The bill requires a person eligible for or receiving medical assistance who has established a long term relationship with a health care professional has requested the managed care provider to approve a single patient agreement between the patient and the health care professional, even if the health care professional is not a recurring provider under the person's managed provider network. The health care professional must be paid the managed care provider's in-network rates.

2019 NY S.B. 7812 (NS), a previously introduced bill, was amended October 9, 2020. If passed, the proposed bill seeks to provide for the provision of health care services under Medicaid managed care programs by school-based health centers.

2019 NY A.B. 9894 (NS), a previously introduced bill, was amended November 6, 2020. The proposed bill seeks to provide for the provision of health care services under Medicaid managed care programs by school-based health centers.

In **Pennsylvania**

2019 PA H.R. 942 (NS) was introduced July 14, 2020. The bill is a Resolution directing the Legislative Budget and Finance Committee to conduct a study of the availability and accessibility of obstetrical services in Pennsylvania. The resolution directs the committee to report on its study and include in the report examination of the availability of obstetricians and nurse midwives and other health care professionals needed for the care of expectant mothers, the adequacy of access to the full spectrum of prenatal, obstetrical and postpartum care for each region of this Commonwealth and by insurance status, the adequacy of insurer or managed care provider networks for obstetrical services, identification of any standards of care ratios for the number of physicians and nurse midwives per number of expectant mothers and births and comparison to Pennsylvania data, adequacy of insurance coverage for expectant mothers, comparison of the range of Pennsylvania Medical Assistance payments for obstetrical care to Medical Assistance payments made in other states and comparison of Pennsylvania fees paid for obstetrical care by other health care insurers or payors.

2019 PA H.B. 2876 (NS) was introduced September 23, 2020. The proposed bill seeks to further provide for State participation in cooperative Federal programs. The bill also seeks to provide for income for the community spouse, for medical assistance payments for institutional care, for medical assistance payments for home health care, for other medical assistance payments and for medical assistance benefit packages and coverage, copayments, premiums and rates.

2019 PA H.B. 941 (NS), a previously introduced bill, was amended October 20, 2020. The proposed bill seeks to further providing for medical assistance pharmacy services and providing for prescription drug pricing study. The bill states that any managed care organization under contract to the department, or an entity with which the managed care organization contracts, must contract on an equal basis with any pharmacy qualified to participate in the medical assistance program that is willing to comply with the managed care organization's or entity's pharmacy payment rates and terms and to adhere to quality standards established by the managed care organization or entity.

In **Rhode Island**

2019 RI H.B. 7987 (NS) was introduced March 11, 2020. If passed, this act would require every individual or group health insurance contract effective on or after January 1, 2021, to provide coverage to the insured and the insured's spouse and dependents for all FDA-

approved contraceptive drugs, devices and other products, voluntary sterilization procedures, patient education and counseling on contraception and follow-up services as well as Medicaid coverage for a twelve month supply for Medicaid recipients.

2019 RI S.B. 2525 (NS), a previously introduced bill, was amended June 17, 2020. If passed, this bill will have the health insurance commissioner adopt a uniform set of medical criteria for prior authorization and create required forms to be used by a health insurer, including telemedicine coverage. The proposed bill states that during the COVID-19 crisis it has become clear that patients and providers benefit substantially from having access to telemedicine services that are covered by health insurers on the same basis as in-person services. Additionally, There is a need to embrace efforts that will encourage patients, health insurers and healthcare providers to support the use of telemedicine, and that will also encourage all state agencies to evaluate and amend their policies and rules to remove any regulatory barriers prohibiting the use of telemedicine services or reimbursing for such services on a discriminatory basis relative to in-person services.

In **Tennessee**

2019 TN H.B. 1980 (NS) was adopted July 15, 2020. The bill requires the department of health to make available for free on its website its current guidance that has been developed to assist prescribers of opioids in complying with disclosure requirements in current law made to women of childbearing age prior to prescribing more than a three-day supply of an opioid or an opioid dosage that exceeds a total of a 180 morphine milligram equivalent dose.

In **Virginia**

2020 VA H.B. 1428 (NS) was enrolled March 3, 2020. The bill creates the Virginia Health Benefit Exchange, which will be established and operated by a new division within the State Corporation Commission (SCC). The Exchange will facilitate the purchase and sale of qualified health plans and qualified dental plans to qualified individuals and qualified employers. The Exchange must make qualified plans available to qualified individuals and qualified employers by July 1, 2023, unless the SCC postpones this date. The measure authorizes the SCC to review and approve accident and sickness insurance premium rates applicable to health benefit plans in the individual and small group markets and health benefit plans providing health insurance coverage in the individual market through certain non-employer group plans. A health plan will not be required to cover any state-mandated health benefit if federal law does not require it to be covered as part of the essential benefits package. The essential health benefits are items and services included in the benchmark health insurance plan, which is the largest plan in the largest product in the Commonwealth's small group market as supplemented in order to provide coverage for the items and services within the statutory essential health benefits categories.

2020 VA S.B. 902 (NS) was adopted March 11, 2020. The bill provides that every individual who applies for or requests community or institutional long-term services and supports, as defined in the state plan for medical assistance services, may choose to receive services in a community or institutional setting and may choose the setting and provider of long-term care services and supports from a list of approved providers. The bill also clarifies requirements related to the performance of such long-term care services and supports screenings. The Department must require managed care organizations that provide managed long-term services and supports in the Commonwealth to develop the portion of the plan of care addressing the type and amount of long-term services and supports for each recipient. For recipients of long-term services and supports, the managed care organization shall participate in and collaborate with the existing interdisciplinary care team planning process already established pursuant to federal law and regulations in the development of the care plan.

2020 VA H.B. 648 (NS) was adopted April 10, 2020. The bill relates to a prescription monitoring program. The program provides for the mutual exchange of information between the Prescription Monitoring Program and the Emergency Department Care Coordination Program and clarifies that nothing will prohibit the redisclosure of confidential information from the Prescription Monitoring Program or any data or reports produced by the Prescription Monitoring Program disclosed to the Emergency Department Care Coordination Program to a prescriber in an electronic report generated by the Emergency Department Care Coordination Program so long as the electronic report complies with relevant federal law and regulations governing privacy of health information.

2020 VA S.B. 732 (NS) was adopted April 9, 2020. The bill creates the Virginia health benefit exchange, which will be established and operated by a new division within the State Corporation Commission (SCC). The Exchange must facilitate the purchase and sale of qualified health plans and qualified dental plans to qualified individuals and qualified employers. The Exchange must also make qualified plans available to qualified individuals and qualified employers by July 1, 2023, unless the SCC postpones this date. The measure authorizes the SCC to review and approve accident and sickness insurance premium rates applicable to health benefit plans in the individual and small group markets and health benefit plans providing health insurance coverage in the individual market through certain non-employer group plans. The Exchange will be funded by an assessment on health insurers, which is limited to three percent of total monthly premiums, except the SCC may, after a public hearing, adjust the rate as necessary to ensure the Exchange is fully funded. A health plan will not be required to cover any state-mandated health benefit if federal law does not require it to be covered as part of the essential benefits package. The essential health benefits are items and services included in the benchmark health insurance plan.

2020 VA S.B. 568 (NS) was adopted April 10, 2020. The bill relates to medical assistance services; managed care organization contracts with pharmacy benefits managers. Requires the Department of Medical Assistance Services to require a managed care organization with which the Department enters into an agreement for the delivery of medical assistance services to include in any agreement between the managed care organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits

manager or a representative of the pharmacy benefits manager from conducting spread pricing with regard to the managed care organization's managed care plans.

2020 VA H.B. 5046 (NS) was enrolled October 7, 2020. The bill relates to telemedicine services. The bill directs the Board of Medical Assistance Services to amend the state plan for medical assistance services to provide for payment of medical assistance for medically necessary health care services provided through telemedicine services, regardless of the originating site or whether the patient is accompanied by a health care provider at the time such services are provided. The bill also requires each:

• insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis;

• corporation providing individual or group accident and sickness subscription contracts; and

• health maintenance organization providing a health care plan for health care services to provide coverage for telemedicine services regardless of the originating site and whether the patient is accompanied by a health care provider at the time such services are provided.

2020 VA S.B. 5080 (NS) enrolled November 9, 2020. Directs the Board of Medical Assistance Services to amend the state plan for medical assistance services to provide for payment of medical assistance for medically necessary health care services provided through telemedicine services, regardless of the originating site or whether the patient is accompanied by a health care provider at the time such services are provided. 'Originating site' is defined in the bill as any location where the patient is located, including any medical care facility or office of a health care provider, the home of the patient, the patient's place of employment, or any public or private primary or secondary school or postsecondary institution of higher education at which the person to whom services are provided is located. The bill will also require any managed care organization with which the Department enters into an agreement for the provision of medical assistance services to include in any contract between the managed care organization and a pharmacy benefits manager provisions prohibiting the pharmacy benefits manager or a representative of the pharmacy benefits manager from conducting spread pricing with regards to the managed care organization's managed care plans.

In **Washington**

2019 WA S.B. 6087 (NS), a previously introduced bill, was amended February 5, 2020. The proposed bill relates to cost-sharing requirements for coverage of insulin products. A health plan issued or renewed on or after January 1, 2021, that provides coverage for prescription insulin drugs for the treatment of diabetes must cap copayments, deductibles, or other forms of cost sharing for the drug at an amount not to exceed one hundred dollars per thirty-day supply of the drug. Beginning January 1, 2022, for every one hundred dollar increase in the cost of an insulin product for the health plan from the previous plan year, taking into account rebates and other price concessions, the health plan may submit a request to the office of the insurance commissioner, including proper documentation, to raise the cost-sharing amount for a thirty-day supply by five dollars.

In **West Virginia**

2020 WV H.B. 4162 (NS) was introduced January 14, 2020. The proposed bill seeks to require Medicaid and insurance coverage for treatment of pediatric autoimmune neuropsychiatric disorders.

2020 WV S.B. 746 (NS) was adopted March 25, 2020. The bill provides contracted managed care companies access to uniform maternal screening tool. The uniform maternal screening tool must be confidential and shall not be released or disclosed to anyone, including any state or federal agency for any reason other than data analysis of high-risk and at-risk pregnancies for planning purposes by public health officials: Provided, That managed care organizations, with respect to their Medicaid or CHIP plans or contracts, which are reviewed and approved by the Department of Health and Human Resources' Bureau for Medical Services, and the Department of Health and Human Resources' Bureau for Medical Services may be provided data from the screening tool regarding their own covered members. The contracted managed care companies and the Bureau for Medical Services must maintain the confidentiality of the data received.

In **Wisconsin**

2019 WI S.B. 932 (NS) was introduced April 13, 2020. The proposed bill is the state government response to the COVID-19 pandemic. The proposed bill includes provisions waiving requirements for managed care organizations to complete initial and periodic recredentialing of network providers if the providers meet Medical Assistance provider enrollment requirements during the 2019 novel coronavirus public health emergency. The proposed bill also seeks to require managed care organizations to extend preexisting authorizations through which a Medical Assistance recipient has received prior authorization until the termination of the 2019 novel coronavirus public health emergency.