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12/19/2022

Managed Care

Federal

2021 CONG US S 5015 was introduced in the Senate on September 29, 2022. The proposed bill seeks to amend titles XIX and XXI of the Social Security Act to improve maternal health coverage under Medicaid and CHIP, and for other purposes.

In **Arizona**

2022 AZ H.B. 2211 (NS) was introduced January 20, 2022. The proposed bill, if passed, will require insurers offering Medicare supplement insurance policies to persons who are at least sixty-five years of age must 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**

2021 CA A.B. 1355 (NS), a previously introduced bill, was amended January 3, 2022. Existing law authorizes the State Department of Health Care Services to enter into various types of contracts for the provision of services to beneficiaries, including contracts with a managed care plan. Existing law generally requires Medi-Cal managed care plan contractors to be licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975. The act requires the Department of Managed Health Care to establish the Independent Medical Review System, which generally serves to address grievances involving disputed health care services based on whether the service is medically necessary. The bill would authorize a beneficiary to apply to the department for an Independent Medical Review (IMR) of a decision involving a disputed health care service within 6 months of receipt of the notice of adverse action, and would prohibit a requirement that the beneficiary pay any application or processing fee.

2021 CA A.B. 1995 (NS) was introduced February 10, 2022. Existing law requires that Medi-Cal benefits be provided to optional targeted low-income children, as defined, based on a certain income eligibility threshold. Existing law also establishes the Medi-Cal Access Program, which provides health care services to a woman who is pregnant or in her postpartum period and whose household income is between certain thresholds, and to a child under 2 years of age who is delivered by a mother enrolled in the program. Existing law requires the department to exercise the option, available to the state under federal law, to impose specified monthly premiums, based on income level, for the above-described children and employed persons with disabilities. Existing law requires the department to determine schedules for subscriber contribution amounts for persons enrolled in the Medi-Cal Access Program. This bill would eliminate the premiums and subscriber contributions for the above-described populations.

2021 CA A.B. 2659 (NS), a previously introduced bill, was amended March 21, 2022. Existing law authorizes the holder of a midwifery license or nurse-midwifery certificate to provide prenatal, intrapartum, and postpartum care, as specified. Under existing law, midwifery services and nurse-midwifery services are covered under the Medi-Cal program, subject to utilization controls and other conditions. If passed, this bill will require a Medi-Cal managed care plan to have within its provider network at least one licensed midwife (LM) or and one certified-nurse midwife (CNM) within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries. The bill would exempt a Medi-Cal managed care plan from that requirement for purposes of a given county if no LM or CNM is available in that county or if no LM or CNM in that county accepts Medi-Cal payments. If a Medi-Cal managed care plan is exempt from that requirement, the bill would require the Medi-Cal managed care plan to reevaluate its network adequacy for midwifery care in the county on an annual basis and to make a good faith effort to work with the appropriate professional midwifery organizations

for LMs and CNMs, and their respective licensing and regulatory agencies, to assist in determining the availability of midwives in the county who accept Medi-Cal payments. The bill would also require a Medi-Cal managed care plan to have within its provider network at least one licensed alternative birth center specialty clinic within each county where the Medi-Cal managed care plan provides services to Medi-Cal beneficiaries provided that at least one qualified licensed alternative birth center specialty clinic is available in that county and is willing to contract with the Medi-Cal managed care plan.

2021 CA A.B. 2724 (NS), a previously introduced bill, was amended March 24, 2022. This bill would authorize the State Department of Health Care Services to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for specified eligible beneficiaries in geographic regions designated by the department. Under the bill, except where an AHCSP is already contracted with the department as a Medi-Cal managed care plan as of January 1, 2022, contracts entered into pursuant to these provisions would be effective no sooner than January 1, 2024, as specified.

2021 CA S.B. 1019 (NS), a previously introduced bill, was amended April 18, 2022. Existing law requires a Medi-Cal managed care plan to provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. If passed, this bill would require a Medi-Cal managed care plan to conduct annual outreach and education to its enrollees regarding the mental health benefits that are covered by the plan, and to also develop annual outreach and education to inform primary care physicians regarding those mental health benefits. The bill would also require that the outreach and education efforts be informed by stakeholder engagement and the plan's Population Needs Assessment, as specified, and that the efforts meet cultural and linguistic appropriateness standards and incorporate best practices in stigma reduction. The bill would require the department to review and approve annual outreach and education efforts, to approve them if specified conditions are met, and to consult with stakeholders to develop the standards for the review and approval.

2021 CA S.B. 987 (NS), a previously introduced bill, was amended April 25, 2022. If passed, this bill would require a Medi-Cal managed care plan to include in its contracted provider network at least one National Cancer Institute (NCI)-Designated Cancer Center, as specified, and ensure that any beneficiary diagnosed with a complex cancer diagnosis, as defined, is referred to an NCI-Designated Cancer Center within 15 business days of the diagnosis, unless the beneficiary selects a different cancer treatment provider. Existing law also requires a Medi-Cal managed care plan to give a beneficiary timely and adequate notice of an adverse benefit determination, as defined, in writing consistent with specified federal regulations that set forth, among other things, rules for standard and expedited decisions regarding authorization of services. This bill would require a Medi-Cal managed care plan to give a request for, or related to, treatment pursuant to a complex cancer diagnosis to receive an expedited authorization decision, as specified.

2021 CA S.B. 923 (NS), a previously introduced bill, was amended May 31, 2022. This bill would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, as specified, to require its staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI). The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments. The bill would require an individual to complete a refresher course if a complaint has been filed, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary.

2021 CA A.B. 2242 (NS), a previously amended bill, was amended June 27, 2022. Existing law, the Lanterman-Petris-Short Act (the Act), authorizes the involuntary commitment and treatment of persons with specified mental health disorders for the protection of the persons so committed. This bill, on or before July 1, 2023, would require the State Department of Health Care Services to convene a stakeholder group of entities, including the County Behavioral Health Directors Association of California and the California Hospital Association, among others, to create a model care coordination plan to be followed when discharging those held under temporary holds or a conservatorship. This bill would require the commission to develop, implement, and oversee a public and comprehensive framework for tracking and reporting spending on mental health programs and services from all major fund sources and of program- and service-level and statewide outcome data, as specified. The bill would require counties to report to the commission its expenses in specific categories, including, but not limited to, inpatient care or intensive outpatient services, as well as their unspent funding from all major funding sources. By imposing new reporting requirements on counties, this bill would impose a state-mandated local program.

2021 CA A.B. 186 (NS) was adopted June 30, 2022. Existing law, until January 1, 2026, establishes the Proposition 56 Medi-Cal Physicians and Dentists Loan Repayment Act Program, which requires the department to develop and administer the program to provide loan assistance payments to qualifying, recent graduate physicians and dentists who serve beneficiaries of the Medi-Cal program and other specified health care programs. This bill would rename the program the Medi-Cal Physicians and Dentists Loan Repayment Program and would make conforming changes. The bill would instead make the administratively created Loan Repayment Program Account, within the Healthcare Treatment Fund, continuously appropriated to implement the Medi-Cal Physicians and Dentists Loan Repayment Act Program. The bill would require that the account contain funds appropriated by the Legislature from the Healthcare Treatment Fund. The bill would also establish the Medi-Cal Loan Repayment Program Special Fund in the State Treasury and require the fund to contain funds transferred from the California Electronic Cigarette Excise Tax Fund, as specified, funds collected from remittances by Medi-Cal managed care plans.

2021 CA A.B. 2724 (NS) was enrolled June 30, 2022. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through

various delivery systems, including managed care pursuant to Medi-Cal managed care plan contracts. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill would authorize the department to enter into one or more comprehensive risk contracts with an alternate health care service plan (AHCSP), as defined, to serve as a primary Medi-Cal managed care plan for certain eligible beneficiaries in geographic regions designated by the department, as specified. The bill would authorize the department to contract with an AHCSP as a Medi-Cal managed care plan in any geographic region of the state for which federal approval is available, for which the AHCSP maintains appropriate licensure or an approved exemption from the Department of Managed Health Care, and in which the AHCSP already provides commercial coverage in the individual, small group, or large group market. The bill would, among other things, prohibit the AHCSP from denying enrollment to any of those eligible beneficiaries, unless the department or the Department of Managed Health Care has ordered the AHCSP to cease enrollment in an applicable service area.

2021 CA A.B. 2516 (NS), a previously introduced bill, was amended August 22, 2022. Existing law provides for the Medi-Cal program, administered by the State Department of Health Care Services and under which health care services are provided to low-income individuals pursuant to a schedule of benefits. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law also establishes the Family Planning, Access, Care, and Treatment (Family PACT) Program, administered by the Office of Family Planning within the department, under which comprehensive clinical family planning services are provided to a person who has a family income at or below 200% of the federal poverty level, and who is eligible to receive these services. This bill would expand the coverage requirement for an annual cervical cancer screening test to disability insurance policies that provide coverage for hospital, medical, or surgical benefits and would require a health care service plan contract or disability insurance policy that provides coverage for hospital, medical, or surgical benefits issued, amended, or renewed on or after January 1, 2023, to provide coverage without cost sharing for the HPV vaccine for persons for whom the vaccine is FDA approved.

2021 CA A.B. 2134 (NS), a previously introduced bill, was amended August 24, 2022. Existing law, the Reproductive Privacy Act, prohibits the state from denying or interfering with a person's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the person. The act defines ‘abortion’ as a medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth. This bill would establish the California Reproductive Health Equity Program within the Department of Health Care Access and Information to ensure abortion and contraception services are affordable for and accessible to all patients and to provide financial support for safety net providers of these services. The bill would authorize a Medi-Cal enrolled provider to apply to the department for a grant, and a continuation award after the initial grant, to provide abortion and contraception at no cost or a reduced cost to an individual with a household income at or below 400% of the federal poverty level who is uninsured or has health care coverage that does not include both abortion and contraception, and who is not eligible to receive both abortion and contraception at no cost through the Medi-Cal and Family PACT programs.

2021 CA A.B. 2697 (NS), a previously introduced bill, was amended August 1, 2022. Existing law establishes the Medi-Cal program, which is administered by the State Department of Health Care Services and under which qualified low-income individuals receive health care services through various delivery systems, including fee-for-service and managed care. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. This bill would require the department to implement a community health workers (CHW) and promotores benefit under the Medi-Cal program, subject to receipt of any necessary federal approvals and the availability of federal financial participation. Under the bill, CHW and promotores services would be preventive services, as defined under federal law, available for Medi-Cal beneficiaries in the managed care or fee-for-service delivery system. Under the bill, CHW and promotores services would be designed for the purposes of preventing disease, disability, and other health conditions or their progression, prolonging life, and promoting physical and behavioral health and efficiency.

CA LEGIS 488 (2022) was filed with the Secretary of State on September 23, 2022. This codifies the requirement that community health worker services be a covered Medi-Cal benefit. The bill requires a Medi-Cal managed care plan to engage in outreach and education efforts to enrollees, as determined by the department, but that would include, at a minimum, specified information to enrollees, including, among other things, a description of the community health worker services benefit and a list of providers that are authorized to refer an enrollee to community health worker services. The bill also requires the department, through existing and regular stakeholder processes, to inform stakeholders about, and accept input from stakeholders on, implementation of the community health worker services benefit.

CA LEGIS 545 (2022) was filed with the Secretary of State September 25, 2022. Existing law requires a health care service plan contract or a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health care service plan contract or health insurance policy, to cover the costs of testing and immunization for COVID?19, or a future disease when declared a public health emergency by the Governor, and prohibits the contract or policy from imposing cost sharing or prior authorization requirements for that coverage. Under existing law, the requirement to cover COVID?19 testing and immunizations delivered by an out-of-network provider without cost sharing does not apply to testing and immunizations furnished on or after the expiration of the federal public health emergency. A violation of these provisions by a health care service plan is a crime. This bill will provide that a health care service plan, including a Medi-Cal managed care plan, or disability insurer is not required to cover the cost sharing for COVID?19 testing and immunizations delivered by an out-of-network provider beginning 6 months after the federal public health emergency expires.

2021 CA S.B. 1019 (NS) was enrolled September 1, 2022. Existing law requires a Medi-Cal managed care plan to provide mental health benefits covered in the state plan, excluding those benefits provided by county mental health plans under the Specialty Mental Health Services Waiver. Under existing law, non-specialty mental health services covered by a Medi-Cal managed care plan include, among other things, individual and group mental health evaluation and treatment, psychological testing, and psychiatric consultation, as specified.

This bill requires a Medi-Cal managed care plan, no later than January 1, 2025, to conduct annual outreach and education for its enrollees, based on a plan that the Medi-Cal managed care plan develops and submits to the department, as specified, regarding the mental health benefits that are covered by the Medi-Cal managed care plan. The bill also requires a Medi-Cal managed care plan to also conduct annual outreach and education, based on a plan that it develops, to inform primary care providers regarding those mental health benefits.

2021 CA S.B. 987 (NS) was enrolled September 9, 2022. This bill will, for covered benefits under its contract, require a Medi-Cal managed care plan to, among other things, make a good faith effort to contract with at least one National Cancer Institute (NCI)-designated comprehensive cancer center, site affiliated with the NCI Community Oncology Research Program (NCORP), or qualifying academic cancer center, as specified within each county in which the Medi-Cal managed care plan operates, and authorize any eligible enrollee diagnosed with a complex cancer diagnosis to request a referral to any of those centers to receive medically necessary services unless the enrollee chooses a different cancer treatment provider. The bill requires a Medi-Cal managed care plan to notify all enrollees of their right to request a referral to access to care through any of those centers.

CA LEGIS 822 (2022) was filed with the Secretary of State on September 29, 2022. This bill would require a Medi-Cal managed care plan, a PACE organization, a health care service plan, or a health insurer, and delegated entities, as specified, to require its staff to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care, as defined, for individuals who identify as transgender, gender diverse, or intersex (TGI). The bill would specify the required components of the training and would make use of any training curricula subject to approval by the respective departments. The bill would require an individual to complete a refresher course if a complaint has been filed, and a decision has been made in favor of the complainant, against that individual for not providing trans-inclusive health care, or on a more frequent basis if deemed necessary. The bill will also require a full service health care service plan, an insurer, and a Medi-Cal managed care plan, no later than March 1, 2025, to include information, within or accessible from the plan's or insurer's provider directory, that identifies which of a plan's or insurer's in-network providers have affirmed that they offer and have provided gender-affirming services, as specified. Because a violation of these new requirements would be a crime under the Knox-Keene Health Care Service Plan Act of 1975, the bill would impose a state-mandated local program.

In **Colorado**

2022 CO H.B. 1278 (NS) was engrossed May 4, 2022. The bill creates the behavioral health administration (BHA) in the department of human services (department) to create a coordinated, cohesive, and effective behavioral health system in the state. The BHA will handle most of the behavioral health programs that were previously handled by the office of behavioral health in the department. The bill establishes a commissioner as the head of the BHA and authorizes the commissioner and state board of human services to adopt and amend rules that previously were promulgated by the executive director of the department.

CO LEGIS 22-156 (2022) was approved May 6, 2022. The bill relates to placing limitations on prepaid inpatient health plans, and, in connection therewith, removing prior authorization for outpatient psychotherapy and limiting when a prepaid inpatient health plan can retroactively recover provider payments.

In **Connecticut**

2022 CT H.B. 5001 (NS) was adopted May 23, 2022. The bill is an act related to children's mental health. The Commissioner of Public Health, in consultation with the Commissioner of Children and Families, must develop and implement a plan to waive licensure requirements for a person who:

• is a mental or behavioral health care provider licensed or certified to provide mental or behavioral health care services, or is entitled to provide mental or behavioral health care services under a different designation, in another state having requirements for practicing in such capacity that are substantially similar to or higher than the requirements in effect in this state for practitioners practicing in such capacity; and

• has no disciplinary action or unresolved complaint pending against such person, provided the provisions of any interstate licensure compact regarding a mental or behavioral health care provider adopted by the state shall supersede any plan for waiver of licensure requirements implemented under this section concerning such mental or behavioral health care provider.

In **Delaware**

2021 DE H.B. 303 (NS) was engrossed June 30, 2022. The bill requires all carriers to provide coverage of an annual behavioral health well check, which must be reimbursed through the following common procedural terminology (CPT) codes at the same rate that such CPT codes are reimbursed for the provision of other medical care, provided that reimbursement may be adjusted for payment of claims that are billed by a non-physician clinician so long as the methodology to determine such adjustments is comparable to and applied no more stringently than the methodology for adjustments made for reimbursement of claims billed by non-physician clinicians for other medical care.

In **Florida**

2022 FL S.B. 1080 (NS) was introduced January 11, 2022. The proposed bill will, if passed, authorize Medicaid managed care specialty plans to continue serving certain children whose guardians receive guardianship assistance payments under the Guardianship Assistance Program.

2022 FL S.B. 1950 (NS) was introduced January 18, 2022. The proposed bill is an act relating to the statewide Medicaid managed care program. The proposed bill:

• requires, rather than authorizes, that the reimbursement method for provider service networks be on a prepaid basis;

• deletes a requirement that the Agency for Health Care Administration provide the opportunity for public feedback on a certain waiver application;

• revises requirements relating to the databook published by the agency consisting of Medicaid utilization and spending data; and

• revises provisions relating to agency-defined quality measures under the achieved savings rebate program for Medicaid prepaid plans.

2022 FL H.B. 7047 (NS) was filed January 31, 2022. If passed, the bill will require the Agency for Health Care Administration to determine compliance with essential provider contracting requirements. The bill will also require the agency to withhold supplemental payments under certain circumstances.

In **Hawaii**

2021 HI H.B. 1406 (NS) was prefiled January 13, 2022. If passed, the proposed bill specifies that coverage for telehealth under the State's Medicaid managed care and fee-for-service programs includes psychiatric services delivered via telehealth through a behavioral health care manager who is present in a primary health care provider's office.

2021 HI S.C.R. 116 (NS) was introduced March 11, 2022. The proposed bill requests the auditor to conduct a financial and performance assessment of the managed-care organizations that administer the state's Medicaid program.

In **Illinois**

2021 IL S.B. 3729 (NS) was filed January 21, 2022. The proposed bill relates to insurance drug discount programs. The proposed bill, if passed, states that the Department of Healthcare and Family Services must implement a mechanism for entities participating in the federal drug pricing program and their contracted pharmacies to submit quarterly retrospective utilization files containing the minimum fields necessary to accurately identify the drugs to the Department or its contractor for processing Medicaid drug rebate requests to Medicaid beneficiaries or Medicaid managed care organization enrollees. The proposed bill also provides that the Department or its contractor must use the utilization files to remove 340B claims from the Department's Medicaid drug rebate requests and that the Department shall not require the entities or their contracted pharmacies to use any other method or billing code to identify 340B drugs billed to Medicaid or Medicaid managed care organizations. In provisions concerning pharmacy benefits, provides that a Medicaid managed care organization or pharmacy benefit manager administering or managing benefits on behalf of a Medicaid managed organization shall not include specified provisions in a contract with a covered entity or with any pharmacy owned by or contracted with the covered entity.

2021 IL H.B. 5598 (NS) was filed January 28, 2022. If passed, the bill will amend the Medical Assistance Article of the Illinois Public Aid Code. In a provision exempting ground ambulance services from the managed care medical assistance program, requires the Department of Healthcare and Family Services to arrange the scheduling of ground ambulance services whenever managed care enrollees require transportation assistance. Provides that such services shall be paid (rather than continue to be paid) under the State's traditional fee-for-service program.

2021 IL H.B. 4545 (NS) was engrossed March 4, 2022. If passed, the bill will require the Department of Healthcare and Family Services to explore, by July 1, 2023, the availability of and, if reasonably available, procure technology that:

• allows the Department's Medical Electronic Data Interchange (MEDI) system to update recipient eligibility and coverage information for providers in real time; and

• allows the Department to transmit updated recipient eligibility and coverage information to managed care organizations under contract with the Department to ensure the information contained in the MEDI system corresponds with the information maintained by managed care organizations in their web-based provider portals.

2021 IL H.B. 4595 (NS) was adopted May 13, 2022. The bill provides that a contract between a pharmacy benefit manager or third-party payer and a certain specified covered entity under the federal Public Health Service Act must not contain specified provisions. In provisions concerning pharmacy payments, provides that no later than January 1, 2023, the Department of Healthcare and Family Services must implement a mechanism for entities participating in the federal drug pricing program and their contracted pharmacies to submit quarterly retrospective utilization files containing the minimum fields necessary to accurately identify the drugs to the Department or its contractor for processing Medicaid drug rebate requests to Medicaid beneficiaries or Medicaid managed care organization enrollees. The bill also provides that the Department or its contractor must use the utilization files to remove certain specified claims from the Department's Medicaid drug rebate requests and that the Department must not require the entities or their

contracted pharmacies to use any other method or billing code to identify certain specified drugs billed to Medicaid or Medicaid managed care organizations.

2021 IL H.B. 5013 (NS) was adopted May 27, 2022. The bill provides that in order to maximize the accessibility of preventive prenatal and perinatal health care services, the Department of Healthcare and Family Services must amend its managed care contracts such that an managed care organization must pay for preventive prenatal and perinatal healthcare services rendered by a non-affiliated provider, for which the health plan would pay if rendered by an affiliated provider, at the same rate the Department would pay for such services exclusive of disproportionate share payments and Medicaid percentage adjustments, unless a different rate was agreed upon by the health plan and the non-affiliated provider.

In **Indiana**

2022 IN H.B. 1194 (NS) was introduced January 6, 2022. If passed, the proposed bill will require the office of the secretary of family and social services (office of the secretary) to apply to the United States Department of Health and Human Services for a Medicaid waiver or state plan amendment to implement, not earlier than January 1, 2024, a fee for service integrated care model program for specified category of Medicaid recipients. Sets forth requirements of the program. The bill also sets forth certain requirements, including contract requirements for any contract between the office of the secretary and specified entities, in the operation of a risk based managed care program or integrated care model program for the specified covered population.

2022 IN S.B. 407 (NS), a previously introduced bill, was amended January 21, 022. If passed, the proposed bill will require the office of the secretary of family and social services (office of the secretary) to apply to the United States Department of Health and Human Services for a Medicaid waiver or state plan amendment to implement, not earlier than January 1, 2024, a fee for service integrated care model program for specified category of Medicaid recipients. The proposed bill also sets forth requirements of the program, including contract requirements for any contract between the office of the secretary and specified entities, in the operation of a risk based managed care program or integrated care model program for the specified covered population.

In **Indiana**

2022 IN H.B. 1001 (NS), a previously introduced bill, was amended August 3, 2022. The proposed bill seeks to provide that the postpartum period determined by the office of the secretary of family and social services during which Medicaid coverage is available to a woman must not be less than 12 months beginning on the last day of the pregnancy.

In **Louisiana**

2022 LA H.B. 286 (NS) was introduced March 14, 2022. The proposed bill, if passed, will state that any provider who maintains hospital privileges or is a member of a hospital medical staff with a specified licensed hospital will be considered to have satisfied, and will otherwise be exempt from having to satisfy, any credentialing requirements of a managed care organization.

2022 LA H.B. 286 (NS) was engrossed April 18, 2022. The bill provides with respect to healthcare provider credentialing requirements in Medicaid managed care. The bill also establishes requirements relative to credentialing of certain providers who are affiliated with certain healthcare facilities.

2022 LA H.C.R. 99 (NS) was introduced May 2, 2022. The proposed bill is a resolution to urge and request the Louisiana Department of Health to fully utilize the National Association of State Procurement Officials' ValuePoint process to procure Medicaid managed care information systems and services.

2022 LA S.B. 262 (NS) was engrossed May 19, 2022. The bill states that an insurer, managed care organization, or other payor must not discriminate against an accredited durable medical equipment supplier providing services prescribed by a patient's physician. Notwithstanding any other provision of law to the contrary, an insurer, managed care organization, subcontractor, third-party administrator, or other payor must reimburse durable medical equipment suppliers no less than state Medicaid rates set for these services on a continuous monthly payment basis for the duration of the medical need throughout a patient's valid prescription period.

In **Louisiana**

2022 LA S.B. 59 (NS), a previously introduced bill, was adopted on June 17. This bill a bill relative to claim reviews conducted by Medicaid managed care organizations; to provide for prepayment reviews; to provide for detection and prevention of fraud and abuse in the Medicaid program; to provide for applicability to provide for definitions; and to provide for related matters.

2022 LA S.B. 154 (NS), a previously introduced bill, was adopted on June 16, 2022. This bill requires health insurance coverage of genetic testing for critically ill infants with no diagnosis; to provide for definitions; to provide relative to Medicaid coverage for genetic testing of critically ill infants; to provide for coverage for rapid whole genome sequencing testing of certain infants; to provide for the duties of the secretary of the Louisiana Department of Health; and to provide for related matters. Additionally, subject to the approval of the Centers for Medicare and Medicaid Services, the Louisiana medical assistance program shall include coverage on a fee-for-service basis for rapid whole genome sequencing testing of an infant who is enrolled in a Medicaid managed care plan and meets all of the following criteria:

a) Is one year of age or younger.

b) Has a complex illness of unknown etiology.

c) Is receiving inpatient hospital services in an intensive care unit or in a pediatric care unit.

In **Maryland**

2022 MD S.B. 787 (NS) was introduced February 7, 2022. The proposed bill relates to prohibiting managed care organizations and certain insurers, nonprofit health service plans, and health maintenance organizations from applying a prior authorization requirement for prescription drugs used as postexposure prophylaxis for the prevention of HIV if the drug is prescribed to a victim of an alleged rape or sexual offense; and generally relating to prescription drugs used as postexposure prophylaxis for the prevention of HIV infection and prior authorizations.

2022 MD H.B. 1007 (NS) was introduced February 10, 2022. The proposed bill relates to reimbursement requirements for Maryland Medical Assistance Program and Managed Care Organizations That Use Pharmacy Benefits Managers. The proposed bill seeks to alter the reimbursement levels for drug products that the Maryland Medical Assistance Program is required to establish and that pharmacy benefits managers that contract with a pharmacy on behalf of a managed care organization are required to reimburse the pharmacy. The bill also relates to the Maryland Medical Assistance Program and managed care organizations that use pharmacy benefits managers.

2022 MD H.B. 970 (NS) was engrossed February 27, 2022. The bill will prohibit managed care organizations and certain insurers, nonprofit health service plans, and health maintenance organizations from applying a prior authorization requirement for prescription drugs used as postexposure prophylaxis for the prevention of HIV if the drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines. The bill also relates to prescription drugs used as postexposure prophylaxis for the prevention of HIV infection and prior authorizations.

2022 MD S.B. 207 (NS) was adopted April 21, 2022. The bill relates to cybersecurity standards for insurance carriers and managed care organizations.

2022 MD H.B. 970 (NS) was adopted May 29, 2022. The bill will prohibit managed care organizations and certain insurers, nonprofit health service plans, and health maintenance organizations from applying a prior authorization requirement for prescription drugs used as postexposure prophylaxis for the prevention of HIV if the drug is prescribed for use in accordance with Centers for Disease Control and Prevention guidelines; and generally relating to prescription drugs used as postexposure prophylaxis for the prevention of HIV infection and prior authorizations.

In **Michigan**

2021 MI S.B. 641 (NS) was engrossed September 28, 2022. The bill amends the ‘Social Welfare Act” by requiring the department to ensure the availability of accessible, quality health care for individuals with sickle cell disease or thalassemia and who are enrolled in Medicaid managed care organizations that have a contract with the department to provide services to Medicaid members in the comprehensive health care program.

2021 MI S.B. 1209 (NS) was introduced November 10, 2022. If passed, the proposed bill will require the Department of Human Services to establish focused policies and promulgate focused rules for complex rehabilitation technology products and services. The focused policies and rules must take into consideration the individually configured nature of complex rehabilitation technology and the broad range of services necessary to meet the unique medical and functional needs of an individual with complex medical needs by doing all of the following:

• establishing specific supplier standards for a company or entity that provides complex rehabilitation technology and restricting providing complex rehabilitation technology to only a qualified complex rehabilitation technology supplier or an individual, company, or entity approved by the department, but only if a qualified complex rehabilitative technology supplier is unavailable;

• requiring a complex needs patient receiving a complex rehabilitation manual wheelchair, power wheelchair, or seating component to be evaluated by qualified health care professional and a qualified complex rehabilitation technology professional;

• maintaining payment policies and rates for complex rehabilitation technology to ensure payment amounts are adequate to provide complex needs patients with access to those items. These policies and rates must take into account the significant resources, infrastructure, and staff needed to appropriately provide complex rehabilitation technology to meet the unique needs of a complex needs patient;

• exempting the related complex rehabilitation technology HCPCS billing codes from inclusion in bidding, selective contracting, or similar initiative; and

• requiring that managed care Medicaid plans adopt the regulations and policies outlined in this act and include these regulations and policies in their contracts with qualified complex rehabilitation technology suppliers.

In **Mississippi**

2022 MS H.B. 602 (NS) was introduced January 13, 2022. The proposed bill seeks to restrict the frequency of managed care organizations transferring enrollees to other organizations.

In **New Hampshire**

2021 NH S.B. 422 (NS) was introduced January 5, 2022. If passed, the proposed bill will require 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.

In **New Jersey**

2022 NJ S.B. 1188 (NS) was introduced January 31, 2022. If passed, the bill will revise certain requirements for individual and small employer health benefits plans and for small employer members of multiple employer welfare arrangements.

2022 NJ S.B. 1498 (NS) was introduced February 10, 2022. The proposed bill seeks to require Medicaid managed care organizations to notify certain beneficiaries of maximum coverage for personal care service hours.

2022 NJ A.B. 4012 (NS) was introduced May 16, 2022. If passed, the proposed bill will require Medicaid fee-for-service coverage of managed long term services and supports when beneficiary is pending enrollment in managed care organization. This policy was prompted due to assisted living programs experiencing difficulties receiving reimbursement for established residents who had been determined financially and clinically eligible for Medicaid services, but who were awaiting enrollment in a MCO. Under this scenario, MCO enrollment may require up to 60 days. In response to this concern, the Division of Medical Assistance and Health Services (DMAHS) in the Department of Human Services implemented a new billing procedure intended to avoid a gap in service payment for Medicaid eligible beneficiaries residing in assisted living programs in which assisted living programs are authorized to request FFS payments during this gap period.

2022 NJ A.B. 4073 (NS) was introduced May 26, 2022. The proposed bill seeks to establish a three-year Medicaid demonstration project to pay for certain drugs according to value-based system. The Department of Human Services must establish a three-year demonstration project to employ value-based payment systems for a limited number of prescription drugs covered under the program. Under the demonstration project, the department must enter into purchasing or rebate agreements with the manufacturers of at least three different prescription drugs, which will provide that the total reimbursement paid by the State for such drugs will be based in some part on observed outcomes of the drug's use in patients. The department must require that Medicaid managed care organizations participate in the demonstration program, and shall specify the obligations of the managed care organizations under the demonstration program in the contract between the department and the managed care organizations.

2022 NJ A.B. 4091 (NS) was adopted July 5, 2022. The bill makes County Option Hospital Fee Pilot Program permanent and expands definition of ‘participating county’ under program.

2022 NJ A.B. 4467 (NS) was introduced September 15, 2022. If passed, the bill will establish the Medicaid Managed Care Organization Oversight Program. This bill would require the Division of Medical Assistance and Health Services in the Department of Human Services to establish a Medicaid Managed Care Organization (MCO) Oversight Program to ensure the availability of accessible health care for individuals who are enrolled in the NJ FamilyCare and Medicaid programs. The Office of the State Auditor conducted an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Provider Networks for the period July 1, 2013 to May 31, 2016. Information from the audit indicated that managed care organizations (MCOs) which are contracted with the State to provide health benefits to Medicaid and NJ FamilyCare beneficiaries did not provide adequate access to: general acute care hospital service networks; dental providers; and accurate online provider directories. Additionally, the MCOs were not adequately reporting claims inactivity for providers and had provider panel sizes which exceeded the eligible limits. Furthermore, the audit recommended that the department take certain actions to ensure that the MCOs are meeting the contractual obligations regarding access to quality care and provider availability.

2022 NJ S.B. 3146 (NS) was introduced October 3, 2022. If passed, the proposed bill seeks to increase Medicaid reimbursement rates for private duty nursing services by $4. The bill increases the Medicaid reimbursement rate for PDN services to at least $65 per hour when provided by a registered professional nurse and to at least $53 per hour when provided by a licensed practical nurse. The increased reimbursement rate will apply regardless of whether services are provided under the fee for service delivery system or the managed care delivery system.

2022 NJ A.B. 3792 (NS), a previously introduced bill, was amended October 13, 2022. If passed, the proposed bill will increase Medicaid reimbursement for in-person partial care behavioral health and substance use disorder treatment services, and associated transportation services, for adults.

2022 NJ S.B. 3216 (NS) was introduced October 17, 2022. If passed, the bill will require health insurance carriers to provide network adequacy within health benefits plans.

2022 NJ S.B. 3259 (NS) was introduced October 31, 2022. If passed, the bill will require health insurance coverage for certain obesity treatments. Under the bill, health insurance carriers (including insurance companies, hospital service corporations, medical service corporations, health service corporations, health maintenance organizations authorized to issue health benefits plans in New Jersey, and any entities contracted to administer health benefits in connection with the State Health Benefits Program or School Employees' Health Benefits Program, and the Medicaid Program) will be required to cover certain treatments for obesity. The methods of treatment for which benefits will be provided include preventive care, nutrition counseling, behavioral therapy, bariatric surgery, and anti-obesity medication. For the purpose of this bill, ‘anti-obesity medication’ means any medication approved by the United States Food and Drug Administration that provides for chronic weight management in patents with obesity.

In **New York**

2021 NY S.B. 7909 (NS) was introduced January 19, 2022. If passed, the proposed bill will require Medicaid managed care plans to reimburse retail pharmacies in an amount equal to the fee-for-service rate; allows retail pharmacies the opportunity to participate in another provider's network under the medical assistance program. The proposed bill also seeks to prohibit pharmacy benefit managers from limiting an individual's option to receive medications from non-mail order pharmacies.

2021 NY A.B. 9165 (NS) was introduced January 31, 2022. If passed, the proposed bill will require Medicaid managed care plans to reimburse retail pharmacies in an amount equal to the fee-for-service rate; allows retail pharmacies the opportunity to participate in another provider's network under the medical assistance program; prohibits pharmacy benefit managers from limiting an individual's option to receive medications from non-mail order pharmacies.

2021 NY S.B. 8509 (NS) was introduced March 8, 2022. The proposed bill seeks to direct the department of health to remove the pharmacy benefit from the managed care benefit package. The bill also seeks to provide the pharmacy benefit under the fee for service program.

2021 NY S.B. 8447 (NS) was introduced March 1, 2022. If passed the bill will provide that services provided by school-based health centers must not be provided to medical assistance recipients through managed care programs.

2021 NY A.B. 7200 (NS), a previously introduced bill, was amended February 16, 2022. If passed, the bill will provide that prescription drugs eligible for reimbursement must be provided and paid for under the preferred drug program and the clinical drug review program. The bill also seeks to restore pharmacy benefits under Medicaid managed care.

2021 NY S.B. 9207 (NS) was introduced May 12, 2022. The proposed bill relates to notification of changes to the model contract with managed care providers under the medical assistance program. The proposed bill states that if passed, that whenever the commissioner of health makes changes to the terms, conditions or time frames contained in the model contract with managed care providers in the managed care program, public notice detailing the changes must be provided on the department's website and through publication as a public notice in the state register prior to finalizing such changes or submitting the amended contract to the Centers for Medicare and Medicaid Services for approval, if required. This public notice must also apply to any request for proposals issued by the department for managed care providers to participate in the managed care program.

In **North Carolina**

2021 NC S.B. 408 (NS), a previously introduced bill, was amended/substituted on June 28, 2022. This bill would create he Joint Legislative Committee on Medicaid Rate Modernization and Savings (Committee). The Committee would be required to sue specific data provided from the Department of Health and Human Services, Division of Health Benefits (DHB), to substantiate any information provided by DHB, assess whether DHB is appropriately completing all of the following tasks:

• Monitoring the number of individuals enrolled in Medicaid and reporting that information to the General Assembly on a regular basis.

• Assessing whether Medicaid beneficiaries are appropriately using covered services, including preventative care services.

• Determining whether prepaid health plans and local management entities/managed care organizations (LME/MCOs) are appropriately incentivized to properly manage Medicaid beneficiaries enrolled in standard benefit plans and BH IDD tailored plans, as applicable, including any beneficiaries who are temporarily enrolled in the applicable plan.

In **Pennsylvania**

2021 PA H.B. 1420 (NS), a previously introduced bill, was amended July 7, 2022. The proposed bill seeks to:

• provide for COVID-19 mental health public awareness campaign;

• provide for eligibility and for medical assistance payments for institutional care and providing for resident care and related costs and for pharmacy benefits manager audit and obligations;

• in the aged, further provide for LIFE program and providing for agency with choice;

• in children and youth, further provide for limits on reimbursements to counties;

• in nursing facility assessments, further provide for time periods;

• in managed care organization assessments, further provide for assessment amount; and

• provide for innovative health care delivery models; abrogating regulations.

2021 PA S.B. 225 (NS), a previously introduced bill, was amended October 25, 2022. The bill states that an insurer or MA or CHIP Managed Care plan must make available coverage of at least one prescription drug approved by the United States food and drug administration for use in medication-assisted treatment for opioid use disorders, including coverage of at least one of each of the following without prior authorization:

• buprenorphine/naloxone prescription drug combination product;

• injectable and oral naltrexone; or

• methadone.

2021 PA S.R. 352 (NS) was adopted October 25, 2022. The bill is a resolution directing the Joint State Government Commission to study and issue a report on the specific data, calculations and mechanisms that the Department of Human Services utilizes to determine the amount of Medical Assistance capitation funding that is ultimately paid to drug and alcohol addiction treatment providers within this Commonwealth.

2021 PA H.B. 1630 (NS) was adopted October 28, 2022. The bill states that The Department of the Auditor General may conduct an audit and review of a pharmacy benefits manager that provides pharmacy benefits management to a medical assistance managed care organization under contract with the department. The Department of the Auditor General may review all previous audits completed by the department and shall have access to all documents it deems necessary to complete the review and audit. The bill also states that any information disclosed or produced by a pharmacy benefits manager or a medical assistance managed care organization for the use of the department or the Department of the Auditor General under this section is not be subject to the 'Right-to-Know Law."

In **Rhode Island**

2021 RI S.B. 2073 (NS) was introduced January 25, 2022. If passed, this act would raise Rhode Island Medicaid primary care payment rates to not less than federal Medicare rates for the same service.

2021 RI H.B. 7758 (NS) was introduced March 2, 2022. If passed, this bill will require the auditor general to oversee an audit of Medicaid programs administered by managed care organizations. The auditor general would report findings to the general assembly and the director of the executive office of health and human services (EOHHS) within six (6) months of passage. The director of EOHHS would provide the general assembly with a plan within two (2) years of passage to end privatized managed care and transition to a fee-for-service state-run program if the audit demonstrates the plan would result in savings and better access and health care outcomes.

2021 RI S.B. 2884 (NS) was introduced April 22, 2022. If passed, this act would increase managed care hospital rates for obstetrician deliveries at one hundred ten percent (110%) of the Medicaid fee for service (FFS) rate. The rates in subsequent years would be no less than one hundred ten percent (110%) of the 2021 Medicaid fee for service (FFS) rate. The act would also require policies that permit doulas as part of the care team.

2021 RI S.J.R. 2884 (NS), a previously introduced bill, was amended/substituted June 22, 2022. This bill increases managed care hospital rates for obstetrician deliveries at one hundred ten percent (110%) of the Medicaid fee for service (FFS) rate.

2021 RI H.B. 7244 (NS) was adopted June 30, 2022. The bill relates to Medicare eligible disabled individuals under age 65 eligible for Medicare supplemental policies. The bill also states that Health insurance commissioner may adopt reasonable regulations and standards for Medicare supplemental policies.

In **Tennessee**

2021 TN S.B. 2140 (NS) was introduced February 2, 2022. The proposed bill relates to insurance coverage for prosthetic devices. The bill states that a health insurance entity may require that, if coverage is provided through a managed care plan, the benefits mandated pursuant to this section are covered benefits only if the prosthetic devices are provided by a vendor and prosthetic services are rendered by a provider who contracts with or is designated by the carrier. To the extent that a health insurance entity provides in-network and out-of-network services, the coverage for the prosthetic device must be offered no less extensively.

In **Virginia**

2022 VA H.B. 248 (NS) a previously introduced bill, was amended March 3, 2022. The proposed bill will, if passed, direct the Department of Health, to:

• develop and implement a methodology to review and measure the efficiency and productivity of carriers other than limited scope dental or vision plans and managed care health insurance plans, and

• make available to the public on a website maintained by the nonprofit organization such data and information and other reports collected or produced as a result of implementation of such methodology by July 1, 2023.

2022 VA H.B. 248 (NS) was adopted April 11, 2022. The bill directs the Department of Health, through its contract with the nonprofit organization that compiles and evaluates health care data on behalf of the Commonwealth and in consultation with the Bureau of Insurance of the State Corporation Commission (the Bureau), to develop and implement a methodology to review and measure the efficiency and productivity of health care providers and carriers other than limited scope dental or vision plans and managed care health insurance plans and make available to the public on a website maintained by the nonprofit organization such data and information and other reports collected or produced as a result of implementation of such methodology by July 1, 2023. The bill also requires the Bureau to convene a stakeholder work group to:

• provide input on the development of the methodology required by the act;

• identify additional measures to increase the transparency of information provided to the Bureau by carriers, managed care health insurance plans, and health care providers; and

• determine what additional information should be provided to the nonprofit organization by carriers, managed care health insurance plan providers, and health care providers to foster transparency and competition among both carriers and health care providers and assist consumers in making educated decisions regarding options for health care coverage and access.

2022 VA H.B. 987 (NS) was enrolled April 27, 2022. The bill relates to Medicaid program information accessibility. The bill directs the Board of Medical Assistance Services to require every person that provides program information to ensure that all program information, defined in the bill, be made available in a manner that is accessible to (i) individuals with limited English proficiency through the provision of language access services, including oral interpretation and written translations, and (ii) individuals with disabilities through the provision of auxiliary aids services, when doing so is a reasonable step to providing meaningful access to health care coverage. The bill provides that language access services and auxiliary aids services shall be provided free of charge to such individuals and that information regarding how to receive the language access services and auxiliary aids services must be included with program information documents on a website maintained by the Department of Medical Assistance Services and on the website of every agency of the Commonwealth that disseminates program information. The bill also requires every person that makes program information available to use an objective readability measure approved by the Department to test the readability of its program information documents and requires such persons to make program information documents available to the Department for review upon request. Under current law, use of a specific readability formula is required and a minimum total readability score is prescribed.

2022 VA H.B. 680 (NS) was adopted August 4, 2022. The bill contains a provision for the payment of medical assistance for the dispensing or furnishing of up to a 12-month supply of hormonal contraceptives at one time. Absent clinical contraindications, the Department must not impose any utilization controls or other forms of medical management limiting the supply of hormonal contraceptives that may be dispensed or furnished to an amount less than a 12-month supply. Nothing in this subdivision shall be construed to

• require a provider to prescribe, dispense, or furnish a 12-month supply of self-administered hormonal contraceptives at one time; or

• exclude coverage for hormonal contraceptives as prescribed by a prescriber, acting within his scope of practice, for reasons other than contraceptive purposes.

In **Washington**

2021 WA S.B. 5620 (NS) was prefiled December 30, 2022. The proposed bill states that the health care authority's contracts with managed care organizations must clearly detail each party's requirements for maintaining program integrity and the consequences the managed care organizations face if they do not meet the requirements. The contract must ensure the penalties are adequate to ensure compliance. The authority must follow leading program integrity practices as recommended by the centers for Medicare and Medicaid services, including but not limited to:

• monthly reporting and quarterly meetings with managed care organizations to discuss program integrity issues and findings as well as trends in fraud and other improper payments;

• financial penalties for failure to fulfill program integrity requirements, including liquidated damages;

• directly auditing providers and recovering overpayments;

• ensuring recoveries are properly applied to managed care encounters to ensure accurate future rate setting; and

• ensuring all contracts with managed care organizations are updated as appropriate to reflect program integrity requirements.

2021 WA S.B. 5736 (NS), a previously introduced bill, was amended January 28, 2022. The proposed bill relates to partial hospitalizations and intensive outpatient treatment services for minors.

In **West Virginia**

2022 WV H.B. 4649 (NS) was introduced February 11, 2022. The proposed bill seeks to transfer the operations of the West Virginia Children's Health Insurance Program to the Bureau for Medical Services.

2022 WV H.B. 4698 (NS) was introduced February 15, 2022. The proposed bill seeks to require the West Virginia Medicaid managed care organizations to contract with any otherwise qualified provider.

2022 WV H.B. 4393 (NS) was enrolled March 12, 2022. The bill will increase the managed care tax if the managed care organization receives a rate increase.