By: Martinez H.B. No. 1088

A BILL TO BE ENTITLED

AN ACT

relating to consumer protection provisions applicable to Medicaid managed care contracts.

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

SECTION 1. Section 533.003(a), Government Code, is amended to read as follows:

(a) In awarding contracts to managed care organizations, the commission shall:

(1) give preference to organizations that have significant participation in the organization's provider network from each health care provider in the region who has traditionally provided care to Medicaid and charity care patients;

(2) give extra consideration to organizations that agree to assure continuity of care for at least three months beyond the period of Medicaid eligibility for recipients;

(3) consider the need to use different managed care plans to meet the needs of different populations;

(4) consider the ability of organizations to process Medicaid claims electronically; [~~and~~]

(5) in the initial implementation of managed care in the South Texas service region, give extra consideration to an organization that either:

(A) is locally owned, managed, and operated, if one exists; or

(B) is in compliance with the requirements of Section 533.004; and

(6) require an organization to provide the commission with a history of reductions in reimbursement rates and covered health care services made by the organization, and consider this history in determining the quality of the proposal for a contract.

SECTION 2. Section 533.005(a), Government Code, is amended to read as follows:

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

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

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

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

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

(5) a requirement that the managed care organization

1 provide information and referral about the availability of
2 educational, social, and other community services that could
3 benefit a recipient;
4 (6) procedures for recipient outreach and education;
5 (7) a requirement that the managed care organization
6 make payment to a physician or provider for health care services
7 rendered to a recipient under a managed care plan not later than the
8 45th day after the date a claim for payment is received with
9 documentation reasonably necessary for the managed care
10 organization to process the claim, or within a period, not to exceed
11 60 days, specified by a written agreement between the physician or
12 provider and the managed care organization;
13 (8) a requirement that the commission, on the date of a
14 recipient's enrollment in a managed care plan issued by the managed
15 care organization, inform the organization of the recipient's
16 Medicaid certification date;
17 (9) a requirement that the managed care organization
18 comply with Section 533.006 as a condition of contract retention
19 and renewal;
20 (10) a requirement that the managed care organization
21 provide the information required by Section 533.012 and otherwise
22 comply and cooperate with the commission's office of inspector
23 general and the office of the attorney general;
24 (11) a requirement that the managed care
25 organization's usages of out-of-network providers or groups of
26 out-of-network providers may not exceed limits for those usages
27 relating to total inpatient admissions, total outpatient services,

and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that the organization use advanced practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network;

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

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

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

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as

1 the appealing physician to resolve claims disputes related to
2 denial on the basis of medical necessity that remain unresolved
3 subsequent to a provider appeal; and
4 (C) the determination of the physician resolving
5 the dispute to be binding on the managed care organization and
6 provider;
7 (16) a requirement that a medical director who is
8 authorized to make medical necessity determinations is available to
9 the region where the managed care organization provides health care
10 services;
11 (17) a requirement that the managed care organization
12 ensure that a medical director and patient care coordinators and
13 provider and recipient support services personnel are located in
14 the South Texas service region, if the managed care organization
15 provides a managed care plan in that region;
16 (18) a requirement that the managed care organization
17 provide special programs and materials for recipients with limited
18 English proficiency or low literacy skills;
19 (19) a requirement that the managed care organization
20 develop and establish a process for responding to provider appeals
21 in the region where the organization provides health care services;
22 (20) a requirement that the managed care organization
23 develop and submit to the commission, before the organization
24 begins to provide health care services to recipients, a
25 comprehensive plan that describes how the organization's provider
26 network will provide recipients sufficient access to:
27 (A) preventive care;

1 (B) primary care;
2 (C) specialty care;
3 (D) after-hours urgent care; and
4 (E) chronic care;
5 (21) a requirement that the managed care organization
6 demonstrate to the commission, before the organization begins to
7 provide health care services to recipients, that:
8 (A) the organization's provider network has the
9 capacity to serve the number of recipients expected to enroll in a
10 managed care plan offered by the organization;
11 (B) the organization's provider network
12 includes:
13 (i) a sufficient number of primary care
14 providers;
15 (ii) a sufficient variety of provider
16 types; and
17 (iii) providers located throughout the
18 region where the organization will provide health care services;
19 and
20 (C) health care services will be accessible to
21 recipients through the organization's provider network to a
22 comparable extent that health care services would be available to
23 recipients under a fee-for-service or primary care case management
24 model of Medicaid managed care;
25 (22) a requirement that the managed care organization
26 develop a monitoring program for measuring the quality of the
27 health care services provided by the organization's provider

1 network that:
2 (A) incorporates the National Committee for
3 Quality Assurance's Healthcare Effectiveness Data and Information
4 Set (HEDIS) measures;
5 (B) focuses on measuring outcomes; and
6 (C) includes the collection and analysis of
7 clinical data relating to prenatal care, preventive care, mental
8 health care, and the treatment of acute and chronic health
9 conditions and substance abuse;
10 (23) subject to Subsection (a-1), a requirement that
11 the managed care organization develop, implement, and maintain an
12 outpatient pharmacy benefit plan for its enrolled recipients:
13 (A) that exclusively employs the vendor drug
14 program formulary and preserves the state's ability to reduce
15 waste, fraud, and abuse under the Medicaid program;
16 (B) that adheres to the applicable preferred drug
17 list adopted by the commission under Section 531.072;
18 (C) that includes the prior authorization
19 procedures and requirements prescribed by or implemented under
20 Sections 531.073(b), (c), and (g) for the vendor drug program;
21 (D) for purposes of which the managed care
22 organization:
23 (i) may not negotiate or collect rebates
24 associated with pharmacy products on the vendor drug program
25 formulary; and
26 (ii) may not receive drug rebate or pricing
27 information that is confidential under Section 531.071;

1 (E) that complies with the prohibition under
2 Section 531.089;
3 (F) under which the managed care organization may
4 not prohibit, limit, or interfere with a recipient's selection of a
5 pharmacy or pharmacist of the recipient's choice for the provision
6 of pharmaceutical services under the plan through the imposition of
7 different copayments;
8 (G) that allows the managed care organization or
9 any subcontracted pharmacy benefit manager to contract with a
10 pharmacist or pharmacy providers separately for specialty pharmacy
11 services, except that:
12 (i) the managed care organization and
13 pharmacy benefit manager are prohibited from allowing exclusive
14 contracts with a specialty pharmacy owned wholly or partly by the
15 pharmacy benefit manager responsible for the administration of the
16 pharmacy benefit program; and
17 (ii) the managed care organization and
18 pharmacy benefit manager must adopt policies and procedures for
19 reclassifying prescription drugs from retail to specialty drugs,
20 and those policies and procedures must be consistent with rules
21 adopted by the executive commissioner and include notice to network
22 pharmacy providers from the managed care organization;
23 (H) under which the managed care organization may
24 not prevent a pharmacy or pharmacist from participating as a
25 provider if the pharmacy or pharmacist agrees to comply with the
26 financial terms and conditions of the contract as well as other
27 reasonable administrative and professional terms and conditions of

1 the contract;

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

7 (J) under which the managed care organization or
8 pharmacy benefit manager, as applicable, must pay claims in
9 accordance with Section 843.339, Insurance Code; [~~and~~]

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

17 (25) a requirement that the managed care organization
18 not reduce reimbursement rates or covered services, including
19 value-added services, during the first year that the managed care
20 organization begins providing health care services to enrollees
21 under the contract;

22 (26) a requirement that the managed care organization
23 notify enrollees by certified mail of any reimbursement rate or
24 covered service reduction not later than the 61st day before the
25 date the reduction will take effect and advise those enrollees of
26 the right to change to a different managed care plan, subject to
27 Section 533.0076, and the necessary steps to do so; and

1 (27) a requirement that a managed care organization
2 restore reimbursement rates and services to the levels in effect at
3 the beginning of the contract term before the managed care
4 organization will be permitted to expand to other areas of the state
5 or receive any state-paid capitation rate or other premium
6 increases.
7 SECTION 3. Section 533.003(a), Government Code, as amended
8 by this Act, applies only to a proposal for a contract submitted by
9 a managed care organization on or after September 1, 2013. A
10 proposal for a contract submitted before that date is governed by
11 the law in effect on the date the proposal was submitted, and that
12 law is continued in effect for that purpose.
13 SECTION 4. (a) The Health and Human Services Commission
14 shall, in a contract between the commission and a managed care
15 organization under Chapter 533, Government Code, that is entered
16 into or renewed on or after the effective date of this Act, require
17 that the managed care organization comply with Section 533.005(a),
18 Government Code, as amended by this Act.
19 (b) The Health and Human Services Commission shall seek to
20 amend contracts entered into with managed care organizations under
21 Chapter 533, Government Code, before the effective date of this Act
22 to require those managed care organizations to comply with Section
23 533.005(a), Government Code, as amended by this Act. To the extent
24 of a conflict between that section and a provision of a contract
25 with a managed care organization entered into before the effective
26 date of this Act, the contract provision prevails.
27 SECTION 5. If before implementing any provision of this Act

1 a state agency determines that a waiver or authorization from a
2 federal agency is necessary for implementation of that provision,
3 the agency affected by the provision shall request the waiver or
4 authorization and may delay implementing that provision until the
5 waiver or authorization is granted.

6 SECTION 6. This Act takes effect immediately if it receives
7 a vote of two-thirds of all the members elected to each house, as
8 provided by Section 39, Article III, Texas Constitution. If this
9 Act does not receive the vote necessary for immediate effect, this
10 Act takes effect September 1, 2013.