

By: Martinez

H.B. No. 1089

A BILL TO BE ENTITLED

AN ACT

relating to a requirement that managed care organizations cover certain medication prescribed to Medicaid recipients enrolled in managed care plans.

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

SECTION 1. 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

1 training, and grievance procedures;

2 (5) a requirement that the managed care organization  
3 provide information and referral about the availability of  
4 educational, social, and other community services that could  
5 benefit a recipient;

6 (6) procedures for recipient outreach and education;

7 (7) a requirement that the managed care organization  
8 make payment to a physician or provider for health care services  
9 rendered to a recipient under a managed care plan not later than the  
10 45th day after the date a claim for payment is received with  
11 documentation reasonably necessary for the managed care  
12 organization to process the claim, or within a period, not to exceed  
13 60 days, specified by a written agreement between the physician or  
14 provider and the managed care organization;

15 (8) a requirement that the commission, on the date of a  
16 recipient's enrollment in a managed care plan issued by the managed  
17 care organization, inform the organization of the recipient's  
18 Medicaid certification date;

19 (9) a requirement that the managed care organization  
20 comply with Section 533.006 as a condition of contract retention  
21 and renewal;

22 (10) a requirement that the managed care organization  
23 provide the information required by Section 533.012 and otherwise  
24 comply and cooperate with the commission's office of inspector  
25 general and the office of the attorney general;

26 (11) a requirement that the managed care  
27 organization's usages of out-of-network providers or groups of

1 out-of-network providers may not exceed limits for those usages  
2 relating to total inpatient admissions, total outpatient services,  
3 and emergency room admissions determined by the commission;

4 (12) if the commission finds that a managed care  
5 organization has violated Subdivision (11), a requirement that the  
6 managed care organization reimburse an out-of-network provider for  
7 health care services at a rate that is equal to the allowable rate  
8 for those services, as determined under Sections 32.028 and  
9 32.0281, Human Resources Code;

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

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

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

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

1           (B) the contracting with physicians who are not  
2 network providers and who are of the same or related specialty as  
3 the appealing physician to resolve claims disputes related to  
4 denial on the basis of medical necessity that remain unresolved  
5 subsequent to a provider appeal; and

6           (C) the determination of the physician resolving  
7 the dispute to be binding on the managed care organization and  
8 provider;

9           (16) a requirement that a medical director who is  
10 authorized to make medical necessity determinations is available to  
11 the region where the managed care organization provides health care  
12 services;

13           (17) a requirement that the managed care organization  
14 ensure that a medical director and patient care coordinators and  
15 provider and recipient support services personnel are located in  
16 the South Texas service region, if the managed care organization  
17 provides a managed care plan in that region;

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

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

24           (20) a requirement that the managed care organization  
25 develop and submit to the commission, before the organization  
26 begins to provide health care services to recipients, a  
27 comprehensive plan that describes how the organization's provider

1 network will provide recipients sufficient access to:

2 (A) preventive care;

3 (B) primary care;

4 (C) specialty care;

5 (D) after-hours urgent care; and

6 (E) chronic care;

7 (21) a requirement that the managed care organization  
8 demonstrate to the commission, before the organization begins to  
9 provide health care services to recipients, that:

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

13 (B) the organization's provider network  
14 includes:

15 (i) a sufficient number of primary care  
16 providers;

17 (ii) a sufficient variety of provider  
18 types; and

19 (iii) providers located throughout the  
20 region where the organization will provide health care services;  
21 and

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

27 (22) a requirement that the managed care organization

1 develop a monitoring program for measuring the quality of the  
2 health care services provided by the organization's provider  
3 network that:

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

7 (B) focuses on measuring outcomes; and

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

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

15 (A) that exclusively employs the vendor drug  
16 program formulary and preserves the state's ability to reduce  
17 waste, fraud, and abuse under the Medicaid program;

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

20 (C) that includes the prior authorization  
21 procedures and requirements prescribed by or implemented under  
22 Sections 531.073(b), (c), and (g) for the vendor drug program;

23 (D) for purposes of which the managed care  
24 organization:

25 (i) may not negotiate or collect rebates  
26 associated with pharmacy products on the vendor drug program  
27 formulary; and

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

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

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

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

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

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

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the

1 financial terms and conditions of the contract as well as other  
2 reasonable administrative and professional terms and conditions of  
3 the contract;

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

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

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

19 (25) a requirement that the managed care organization  
20 not refuse to reimburse a network pharmacy provider for dispensing  
21 a medication prescribed to an enrolled recipient by a physician  
22 that is otherwise covered under the Medicaid program if the  
23 physician reasonably believes the medication is medically  
24 necessary or appropriate.

25 SECTION 2. (a) The Health and Human Services Commission  
26 shall, in a contract between the commission and a managed care  
27 organization under Chapter 533, Government Code, that is entered



1 into or renewed on or after the effective date of this Act, require  
2 that the managed care organization comply with Section 533.005(a),  
3 Government Code, as amended by this Act.

4 (b) The Health and Human Services Commission shall seek to  
5 amend contracts entered into with managed care organizations under  
6 Chapter 533, Government Code, before the effective date of this Act  
7 to require those managed care organizations to comply with Section  
8 533.005(a), Government Code, as amended by this Act. To the extent  
9 of a conflict between that section and a provision of a contract  
10 with a managed care organization entered into before the effective  
11 date of this Act, the contract provision prevails.

12 SECTION 3. If before implementing any provision of this Act  
13 a state agency determines that a waiver or authorization from a  
14 federal agency is necessary for implementation of that provision,  
15 the agency affected by the provision shall request the waiver or  
16 authorization and may delay implementing that provision until the  
17 waiver or authorization is granted.

18 SECTION 4. This Act takes effect immediately if it receives  
19 a vote of two-thirds of all the members elected to each house, as  
20 provided by Section 39, Article III, Texas Constitution. If this  
21 Act does not receive the vote necessary for immediate effect, this  
22 Act takes effect September 1, 2013.