By: Rodriguez S.B. No. 337

A BILL TO BE ENTITLED

AN ACT

relating to coordination of services provided by Medicaid managed care organizations and certain community centers and local mental health or mental retardation authorities.

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

training, and grievance procedures;

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

(6) procedures for recipient outreach and education;

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

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

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

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

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

out-of-network providers may not exceed limits for those usages 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 the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal; and

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

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

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

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

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

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

network will provide recipients sufficient access to:

(A) preventive care;

(B) primary care;

(C) specialty care;

(D) after-hours urgent care; and

(E) chronic care;

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

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

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types; and

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

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

(22) a requirement that the managed care organization

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

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

(B) focuses on measuring outcomes; and

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

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

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

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

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

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

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

1 (ii) may not receive drug rebate or pricing
2 information that is confidential under Section 531.071;
3 (E) that complies with the prohibition under
4 Section 531.089;
5 (F) under which the managed care organization may
6 not prohibit, limit, or interfere with a recipient's selection of a
7 pharmacy or pharmacist of the recipient's choice for the provision
8 of pharmaceutical services under the plan through the imposition of
9 different copayments;
10 (G) that allows the managed care organization or
11 any subcontracted pharmacy benefit manager to contract with a
12 pharmacist or pharmacy providers separately for specialty pharmacy
13 services, except that:
14 (i) the managed care organization and
15 pharmacy benefit manager are prohibited from allowing exclusive
16 contracts with a specialty pharmacy owned wholly or partly by the
17 pharmacy benefit manager responsible for the administration of the
18 pharmacy benefit program; and
19 (ii) the managed care organization and
20 pharmacy benefit manager must adopt policies and procedures for
21 reclassifying prescription drugs from retail to specialty drugs,
22 and those policies and procedures must be consistent with rules
23 adopted by the executive commissioner and include notice to network
24 pharmacy providers from the managed care organization;
25 (H) under which the managed care organization may
26 not prevent a pharmacy or pharmacist from participating as a
27 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<u>; and</u>
19 <u>(25) a requirement that the managed care organization</u>
20 <u>coordinate the care of each recipient who is receiving services</u>
21 <u>through the managed care organization and through a community</u>
22 <u>center created under Subchapter A, Chapter 534, Health and Safety</u>
23 <u>Code, or local mental health or mental retardation authority with</u>
24 <u>the community center or authority, as applicable</u>.
25 SECTION 2. Section 533.0352(d), Health and Safety Code, is
26 amended to read as follows:
27 (d) In developing the local service area plan, the local

mental health or mental retardation authority shall:

(1) solicit information regarding community needs from:

(A) representatives of the local community;

(B) consumers of community-based mental health and mental retardation services and members of the families of those consumers;

(C) consumers of services of state schools for persons with mental retardation, members of families of those consumers, and members of state school volunteer services councils, if a state school is located in the local service area of the local authority; and

(D) other interested persons; [~~and~~]

(2) consider:

(A) criteria for assuring accountability for, cost-effectiveness of, and relative value of service delivery options;

(B) goals to minimize the need for state hospital and community hospital care;

(C) goals to ensure a client with mental retardation is placed in the least restrictive environment appropriate to the person's care;

(D) opportunities for innovation to ensure that the local authority is communicating to all potential and incoming consumers about the availability of services of state schools for persons with mental retardation in the local service area of the local authority;

1 (E) goals to divert consumers of services from
2 the criminal justice system;
3 (F) goals to ensure that a child with mental
4 illness remains with the child's parent or guardian as appropriate
5 to the child's care; and
6 (G) opportunities for innovation in services and
7 service delivery; and
8 (3) include strategies in the plan that are designed
9 to coordinate the care of each consumer who is receiving services
10 through the local mental health or mental retardation authority and
11 through a Medicaid managed care organization with the managed care
12 organization.
13 SECTION 3. Section 534.001, Health and Safety Code, is
14 amended by adding Subsection (e-1) to read as follows:
15 (e-1) The executive commissioner shall require that a
16 community center include in the center's plan a requirement that
17 the center coordinate the care of each person who is receiving
18 services from the center and through a Medicaid managed care
19 organization with the managed care organization.
20 SECTION 4. If before implementing any provision of this Act
21 a state agency determines that a waiver or authorization from a
22 federal agency is necessary for implementation of that provision,
23 the agency affected by the provision shall request the waiver or
24 authorization and may delay implementing that provision until the
25 waiver or authorization is granted.
26 SECTION 5. This Act takes effect September 1, 2013.