SENATE BILL 206

50TH LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 2011

INTRODUCED BY

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AN ACT

RELATING TO MEDICAL ASSISTANCE; REQUIRING THE HUMAN SERVICES DEPARTMENT TO PROVIDE MEDICAL ASSISTANCE THROUGH DIRECT CONTRACTS OR BY OPERATING A NETWORK OF SERVICE PROVIDERS; AMENDING, REPEALING AND ENACTING SECTIONS OF THE NMSA 1978.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

SECTION 1. [NEW MATERIAL] MEDICAL ASSISTANCE--DIRECT CONTRACTING.--

A. The human services department shall provide medical coverage to recipients of medicaid, the children's health insurance program and the state coverage insurance program through contract with service providers or by operating a network of service providers. The human services department shall not contract with a managed care organization to carry out the provisions of this section.

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B. For the purposes of this section:

(1) "managed care organization" means a person that provides health care and related services pursuant to a risk-based prepaid capitation agreement; and

(2) "service provider" means an individual, or a network of individuals, licensed or certified to provide behavioral or physical health care or other medicaid-related services.

SECTION 2. Section 27-2-12.13 NMSA 1978 (being Laws 2003, Chapter 315, Section 1) is amended to read:

"27-2-12.13. MEDICAID REFORM--PROGRAM CHANGES.--

A. The department shall carry out the medicaid program changes as recommended by the medicaid reform committee that was established pursuant to Laws 2002, Chapter 96, as follows:

(1) develop a uniform preferred drug list for the state's medicaid prescription drug benefit and integrate all medicaid programs or services administered by the medical assistance division of the department to its use;

(2) work with other agencies to integrate the use of the uniform preferred drug list as described in Paragraph (1) of this subsection to other health care programs, including the department of health, the publicly funded health care agencies of the Health Care Purchasing Act, state agencies that purchase prescription drugs and other public or private

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purchasers of prescription drugs with whom the state can enter into an agreement for the use of a uniform preferred drug list;

(3) identify entities that are eligible to participate in the federal drug pricing program under Section 340b of the federal Public Health Service Act. The department shall make a reasonable effort to assist the eligible entities to enroll in the program and to purchase prescription drugs under the federal drug pricing program. The department shall ensure that entities enrolled in the federal drug pricing program are reimbursed for drugs purchased for use by medicaid recipients at acquisition cost and that the purchases are not included in a rebate program;

(4) work toward the development of a prescription drug purchasing cooperative to combine the buying power of the state's medicaid program, the publicly funded health care agencies of the Health Care Purchasing Act, the department of health, the corrections department and other potential public or private purchasers, including other states, to obtain the best price for prescription drugs. The administration and price negotiation of the prescription drug purchasing cooperative shall be consolidated under a single agency as determined by the governor;

(5) in consultation and collaboration with the department of health and medicaid providers and contractors, develop a program to expand the use of community health

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promoters. The community health promoters shall assist selected medicaid recipients in understanding the requirements of the medicaid program; ensuring that recipients are seeking and receiving primary and preventive health care services; following health care providers' orders or recommendations for medication, diet and exercise; and keeping appointments for examinations and diagnostic examinations;

(6) require that [~~the managed care organizations~~] medicaid providers provide or strengthen disease management programs for medical assistance recipients through closer coordination with and assistance to primary care and safety net providers and seek to adopt uniform key health status indicators. The department shall ensure that [~~the managed care organizations~~] medicaid providers make reasonable efforts and actively seek the expanded participation in disease management programs of primary care providers and other health care providers, particularly in underserved areas;

(7) ensure that case management services are provided to assist medicaid recipients in accessing needed medical, social and other services. The department shall require that [~~managed care organizations~~] medicaid providers provide or strengthen case management services through closer coordination with and assistance to primary care and safety net providers. The case management services shall be targeted to specific classes of individuals or individuals in specific

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areas where medicaid costs or utilization demonstrate a lack of health care management or coordination;

(8) design a pilot disease management program for the fee-for-service population. The department shall ensure that the disease management program is based on key health status indicators, accountability for clinical benefits and demonstrated cost savings;

(9) continue the personal care option with increased consumer awareness of consumer-directed services as a choice in addition to consumer-delegated services;

(10) expand the program of all-inclusive care for the elderly to a rural or urban area with a population less than four hundred thousand to the extent resources are available;

(11) in conjunction with the department of health, the children, youth and families department and the [~~state agency on~~] aging and long-term services department, coordinate the state's long-term care services, including health and social services and assessment and information and referral development for recipients through an appropriate transition process;

(12) develop a fraud and abuse detection and recovery plan that ensures cooperation, sharing of information and general collaboration among the medicaid fraud control unit of the attorney general, [~~the managed care organizations~~]

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medicaid providers, consumer groups and the department to identify, prevent or recover medicaid reimbursement obtained through fraudulent or inappropriate means;

(13) work with other agencies to identify other state-funded health care programs and services that may be reimbursable under medicaid and to ensure that the programs and services meet the requirements for federal funding;

(14) in conjunction with Indian health service facilities or tribally operated health care facilities pursuant to Section 638 of the Indian Self-Determination and Education Assistance Act [~~medicaid managed care organizations~~] and medicaid providers, ensure that Indian health service facilities and tribally operated facilities are utilized to the extent possible for services that are eligible for a one hundred percent federal medical assistance percentage match;

(15) review the payment methodologies for eligible federally qualified health centers that provide the maximum allowable medicaid reimbursement;

(16) ensure that primary care clinics engaged in medicaid-related outreach and enrollment activities are appropriately reimbursed under medicaid;

(17) assess a premium on selected medicaid recipients who meet criteria as determined by the department;

(18) assess tiered co-payments on emergency room services in amounts comparable to those assessed for the

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same services by commercial health insurers or health maintenance organizations, except that no co-payment shall be imposed if the patient is admitted as a hospital inpatient as a result of the emergency room evaluation. The emergency room provider shall make a good faith effort to collect the co-payment from the patient. The co-payment shall apply to all medicaid recipients [~~in the managed care system or the fee-for-service system~~];

(19) assess tiered co-payments on selected higher-cost prescription drugs to provide incentives for greater use of generic prescription drugs when there is a generic or lower-cost equivalent available;

(20) assess a co-payment on the purchase of selected prescription drugs that are not on the uniform preferred drug list as described in Paragraph (1) of this subsection;

(21) consider the impact of cost-sharing requirements on medicaid recipients' access to health care. The department shall ensure that premiums and co-payments described in Paragraphs (17) through (20) of this subsection are in compliance with federal requirements;

(22) provide vision benefits for adults that do not exceed one routine eye exam and one set of corrective lenses in a twelve-month period or more than one frame for corrective lenses in a twenty-four-month period, except as

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medically warranted;

(23) review its prescription drug policies to ensure that pharmacists have the flexibility for and are not discouraged from using generic prescription drugs when there is a generic or lower-cost equivalent available; and

(24) review its nursing home eligibility criteria to ensure that consideration of income, trusts and other assets are the maximum permissible under federal law.

B. The department shall, to the extent possible, combine or coordinate similar initiatives in this section or in other medicaid reform committee recommendations to avoid duplication or conflict. The department shall give preference to those initiatives that provide significant cost savings while protecting the quality and access of medicaid recipients' health care services.

C. The department shall ensure compliance with federal requirements for implementation of the medicaid reform committee's recommendations. The department shall request a federal waiver as may be necessary to comply with federal requirements.

D. As used in this section:

(1) "case management" means services that ensure care coordination among the patient, the primary care provider and other providers involved in addressing the patient's health care needs, including care plan development,

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communication and monitoring;

(2) "community health promoters" means persons trained to promote health and health care access among low-income persons and medically underserved communities;

(3) "disease management" means health care services, including patient education, monitoring, data collection and reporting, designed to improve health outcomes of medicaid recipients in defined populations with selected chronic diseases;

(4) "drug purchasing cooperative" means a collaborative procurement process designed to secure prescription drugs at the most advantageous prices and terms;

[~~(5) "fee-for-service" means a traditional method of paying for health care services under which providers are paid for each service rendered;~~

~~(6) "managed care system" refers to the program for medicaid recipients required by Section 27-2-12.6 NMSA 1978;~~

~~(7)~~] (5) "medicaid" means the joint federal-state health coverage program pursuant to Title 19 or Title 21 of the federal act;

(6) "medicaid provider" means an individual, or a network of individuals, licensed or certified to provide behavioral or physical health care or other medicaid-related services;

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[~~(8)~~] (7) "preferred drug list" means a list of prescription drugs for which the state will make payment without prior authorization or additional charge to the medicaid recipient and that is based on clinical evidence for efficacy and meets the department's cost-effectiveness criteria;

[~~(9)~~] (8) "primary care clinics" means facilities that provide the first level of basic or general health care for an individual's health needs, including diagnostic and treatment services, and includes federally qualified health centers or federally qualified health center look-alikes as defined in Section 1905 of the federal act and designated by the federal department of health and human services, community-based health centers, rural health clinics and other eligible programs under the Rural Primary Health Care Act;

[~~(10)~~] (9) "primary care provider" means a health care practitioner acting within the scope of [~~his~~] the primary care provider's license who provides the first level of basic or general health care for a person's health needs, including diagnostic and treatment services, initiates referrals to other health care practitioners and maintains the continuity of care when appropriate; and

[~~(11)~~] (10) "waiver" means the authority granted by the secretary of the federal department of health

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and human services, upon the request of the state, that allows exceptions to the state medicaid plan requirements and allows a state to implement innovative programs or activities."

SECTION 3. Section 27-11-2 NMSA 1978 (being Laws 1998, Chapter 30, Section 2) is amended to read:

"27-11-2. DEFINITIONS.--As used in the Medicaid Provider Act:

A. "department" means the human services department;

[~~B. "managed care organization" means a person eligible to enter into risk-based prepaid capitation agreements with the department to provide health care and related services;~~

~~C.~~] B. "medicaid" means the medical assistance program established pursuant to Title 19 of the federal Social Security Act and regulations issued pursuant to that act;

[~~D.~~] C. "medicaid provider" means a person [~~including a managed care organization~~] operating under contract with the department to provide medicaid-related services to recipients;

[~~E.~~] D. "person" means an individual or other legal entity;

[~~F.~~] E. "recipient" means a person whom the department has determined to be eligible to receive medicaid-related services;

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[~~G.~~] F. "secretary" means the secretary of human services; and

[~~H.~~] G. "subcontractor" means a person who contracts with a medicaid provider to provide medicaid-related services to recipients."

SECTION 4. REPEAL.--Section 27-2-12.6 NMSA 1978 (being Laws 1994, Chapter 62, Section 22) is repealed.

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