By: Coleman H.B. No. 2705

A BILL TO BE ENTITLED

AN ACT

relating to the state Medicaid program.

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

SECTION 1. Section 32.024, Human Resources Code, is amended by adding Subsection (x) to read as follows:

(x) In its rules and standards governing the vendor drug program, and in accordance with Section 531.02106, Government Code, the department shall provide for cost-sharing by recipients of prescription drug benefits under the medical assistance program in a manner that ensures that recipients with higher levels of income are required to pay progressively higher percentages of the costs of prescription drugs. In implementing cost-sharing provisions required by this subsection, the department may not require a pharmacy participating in the vendor drug program to collect copayments or other cost-sharing payments from recipients for remittance to the department, but shall allow the pharmacy to retain the payments as a component of the reimbursement provided to the pharmacy under the program.

SECTION 2. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0247 to read as follows:

Sec. 32.0247. ELIGIBILITY OF CERTAIN ALIENS. (a) The department shall provide medical assistance in accordance with 8 U.S.C. Section 1612(b), as amended, to a person who:

(1) is a qualified alien, as defined by 8 U.S.C.

Sections 1641(b) and (c), as amended;

(2) meets the eligibility requirements of the medical assistance program;

(3) entered the United States on or after August 22, 1996; and

(4) has resided in the United States for a period of five years after the date the person entered as a qualified alien.

(b) If authorized by federal law, the department shall provide pregnancy-related medical assistance to the maximum extent permitted by the federal law to a person who is pregnant and is a lawfully present alien as defined by 8 C.F.R. Section 103.12, as amended, including a battered alien under 8 U.S.C. Section 1641(c), as amended, regardless of the date on which the person entered the United States. The department shall comply with any prerequisite imposed under the federal law for providing medical assistance under this subsection.

SECTION 3. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0252 to read as follows:

Sec. 32.0252. CONTRACT TO PROVIDE ELIGIBILITY DETERMINATION SERVICES. (a) To the extent allowed by federal law, and except as otherwise provided by this section, the department may contract for the provision of medical assistance eligibility services with:

(1) a hospital district created under the authority of Sections 4-11, Article IX, Texas Constitution;

(2) a hospital authority created under the authority of Chapter 262 or 264, Health and Safety Code, that uses resources

to provide health care services to indigent persons to some extent;

(3) a hospital owned and operated by a municipality or county or by a hospital authority created under Chapter 262 or 264, Health and Safety Code;

(4) a medical school operated by this state;

(5) a medical school that receives state money under Section 61.093, Education Code, or a chiropractic school that receives state money under the General Appropriations Act;

(6) a teaching hospital operated by The University of Texas System;

(7) a county that is required to provide health care assistance to eligible county residents under Subchapter B, Chapter 61, Health and Safety Code;

(8) a governmental entity that is required to provide money to a public hospital under Section 61.062, Health and Safety Code;

(9) a county with a population of more than 400,000 that provides money to a public hospital and that is not included in the boundaries of a hospital district;

(10) a hospital owned by a municipality and leased to and operated by a nonprofit hospital for a public purpose;

(11) a hospital that receives Medicaid disproportionate share payments;

(12) a community mental health and mental retardation center;

(13) a local mental health or mental retardation authority;

(14) a local health department or public health district;

(15) a school-based health center;

(16) a community health center; and

(17) a federally qualified health center.

(b) The department may contract with an entity described by Subsection (a) for the entity to designate one or more employees of the entity to process medical assistance application forms and conduct client interviews for eligibility determinations.

(c) Except as provided by Subsection (d), the contract must require each designated employee to submit completed application forms to the appropriate agency as determined by the department to finally determine eligibility and to enroll eligible persons in the program. A designated employee may not make a final determination of eligibility or enroll an eligible person in the program.

(d) Notwithstanding Subsection (c), the commissioner may apply for federal authorization to allow a designated employee of an entity described by Subsection (a) to make a final determination of eligibility or enroll an eligible person in the program.

(e) The department may:

(1) monitor the eligibility and application processing program used by an entity with which the department contracts; and

(2) provide on-site supervision of the program for quality control.

(f) The Health and Human Services Commission shall ensure that there are adequate protections to avoid a conflict of interest

with an entity described by Subsection (a) that has a contract for eligibility services and also has a contract, either directly or through an affiliated entity, as a managed care organization for the Medicaid program or for the child health plan program under Chapter 62, Health and Safety Code. The commission shall ensure that there are adequate protections for recipients to freely choose a health plan without being inappropriately induced to join an entity's health plan.

SECTION 4. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Sections 32.057, 32.061 and 32.062 to read as follows:

Sec. 32.057. DEMONSTRATION PROJECT FOR PERSONS WITH HIV INFECTION OR AIDS. (a) In this section, "AIDS" and "HIV" have the meanings assigned by Section 81.101, Health and Safety Code.

(b) The department shall establish a demonstration project to provide a person with HIV infection or AIDS with the following services and medications through the medical assistance program:

(1) services provided by a physician, physician assistant, advanced practice nurse, or other health care provider specified by the department;

(2) medications not included in the formulary for the HIV medication program operated by the department, but determined to be necessary for treatment of a condition related to HIV infection or AIDS;

(3) vaccinations for hepatitis B and pneumonia;

(4) pap smears, colposcopy, and other diagnostic procedures necessary to monitor gynecologic complications

resulting from HIV infection or AIDS in women;

(5) hospitalization;

(6) laboratory and other diagnostic services, including periodic testing for CD4+ T-cell counts, viral load determination, and phenotype or genotype testing if clinically indicated; and

(7) other laboratory and radiological testing necessary to monitor potential toxicity of therapy.

(c) The department shall establish the demonstration project in at least two counties with a high prevalence of HIV infection and AIDS. The department shall ensure that the demonstration project is financed using funds made available by the counties in which the department establishes the demonstration project. The manner in which a county makes funds available may include an option for the county to be able to certify the amount of funds considered available instead of sending the funds to the state.

(d) A person is eligible to participate in the demonstration project if the person:

(1) has been diagnosed with HIV infection or AIDS by a physician;

(2) is under 65 years of age;

(3) has a net family income that is at or below 200 percent of the federal poverty level;

(4) is a resident of a county included in the project or, subject to guidelines established by the department, is receiving medical care for HIV infection or AIDS through a facility

located in a county included in the project;

(5) is not covered by a health benefits plan offering adequate coverage, as determined by the department; and

(6) is not otherwise eligible for medical assistance at the time the person's eligibility for participation in the demonstration project is determined.

(e) Participation in the demonstration project does not entitle a participant to other services provided under the medical assistance program.

(f) The department shall establish an appropriate enrollment limit for the demonstration project and may not allow participation in the project to exceed that limit. Once the limit is reached, the department:

(1) shall establish a waiting list for enrollment in the demonstration project; and

(2) may allow eligible persons on the waiting list to enroll solely in the HIV medication program operated by the department.

(g) The department shall ensure that a participant in the demonstration project is also enrolled in the HIV medication program operated by the department.

(h) Notwithstanding any other provision of this section, the department shall provide each participant in the project with a six-month period of continuous eligibility for participation in the project.

(i) Not later than December 1 of each even-numbered year, the department shall submit a biennial report to the legislature

regarding the department's progress in establishing and operating the demonstration project.

(j) Not later than December 1, 2008, the department shall evaluate the cost-effectiveness of the demonstration project, including whether the services and medications provided offset future higher costs for project participants. If the results of the evaluation indicate that the project is cost-effective, the department shall incorporate a request for funding for the expansion of the project into additional counties or throughout the state, as appropriate, in the department's budget request for the next state fiscal biennium.

(k) This section expires September 1, 2014.

Sec. 32.061. DEMONSTRATION PROJECT FOR CERTAIN MEDICATIONS AND RELATED SERVICES. (a) The department shall establish a demonstration project to provide to a person through the medical assistance program psychotropic medications and related laboratory and medical services necessary to conform to a prescribed medical regime for those medications.

(b) A person is eligible to participate in the demonstration project if the person:

(1) has been diagnosed as having a mental impairment, including schizophrenia or bipolar disorder, that is expected to cause the person to become a disabled individual, as defined by Section 1614(a) of the federal Social Security Act (42 U.S.C. Section 1382c), as amended;

(2) is at least 19 years of age, but not more than 64 years of age;

(3) has a net family income that is at or below 200 percent of the federal poverty level;

(4) is not covered by a health benefits plan offering adequate coverage, as determined by the department; and

(5) is not otherwise eligible for medical assistance at the time the person's eligibility for participation in the demonstration project is determined.

(c) To the extent allowed by federal law, and except as otherwise provided by this section, the department may contract for the provision of eligibility services for the demonstration project with a local mental health authority.

(d) Notwithstanding any other provision of this section, the department shall provide each participant in the demonstration project with a 12-month period of continuous eligibility for participation in the project.

(e) Participation in the demonstration project does not entitle a participant to other services provided under the medical assistance program.

(f) The department shall establish an appropriate enrollment limit for the demonstration project and may not allow participation in the project to exceed that limit. Once the limit is reached, the department shall establish a waiting list for enrollment in the demonstration project.

(g) To the extent permitted by federal law, the department may require a participant in the demonstration project to make cost-sharing payments for services provided through the project.

(h) To the maximum extent possible, the department shall use

existing resources to fund the demonstration project.

(i) Not later than December 1 of each even-numbered year, the department shall submit a biennial report to the legislature regarding the department's progress in establishing and operating the demonstration project.

(j) Not later than December 1, 2008, the department shall evaluate the cost-effectiveness of the demonstration project, including whether the preventive drug treatments and related services provided under the project offset future long-term care costs for project participants. If the results of the evaluation indicate that the project is cost-effective, the department shall incorporate a request for funding for the continuation of the program in the department's budget request for the next state fiscal biennium.

(k) This section expires September 1, 2014.

Sec. 32.062. DEMONSTRATION PROJECT FOR WOMEN'S HEALTH CARE SERVICES. (a) The department shall establish a five-year demonstration project through the medical assistance program to expand access to preventive health and family planning services for women. A woman eligible under Subsection (b) to participate in the demonstration project may receive preventive health and family planning services, including:

(1) medical history;

(2) physical examinations;

(3) counseling and education on contraceptive methods that includes:

(4) provision of contraceptives;

(5) health screenings, including screening for:

(A) diabetes;

(B) cervical cancer;

(C) breast cancer;

(D) sexually transmitted diseases;

(E) hypertension;

(F) cholesterol; and

(G) tuberculosis;

(6) risk assessment; and

(7) referral of medical problems to appropriate providers.

(b) A woman is eligible to participate in the demonstration project if the woman:

(1) is 18 years of age or older;

(2) has a net family income that is at or below 185 percent of the federal poverty level; and

(3) is not otherwise eligible for the medical assistance program.

(c) The department shall develop procedures for determining and certifying presumptive eligibility for a woman eligible under Subsection (b). The department shall integrate these procedures with current procedures to minimize duplication of effort by providers, the department, and other state agencies.

(d) The department shall provide for 12 months of continuous eligibility for a woman eligible under Subsection (b).

(e) The department shall compile a list of potential funding sources a client can use to help pay for treatment for health

problems:

(1) identified using services provided to the client under the demonstration project; and

(2) for which the client is not eligible to receive treatment under the medical assistance program.

(f) Not later than December 1 of each even-numbered year, the department shall submit a report to the legislature that includes a statement of the department's progress in establishing and operating the demonstration project.

(g) To the extent required by federal budget neutrality requirements, the department may establish an appropriate enrollment limit for the demonstration project.

(h) This section expires September 1, 2009.

(b) The state agency responsible for implementing the demonstration projects required by Sections 32.057, 32.061, and 32.062, Human Resources Code, as added by this Act, shall request and actively pursue any necessary waivers or authorizations from the Centers for Medicare and Medicaid Services or other appropriate entities to enable the agency to implement the demonstration project not later than September 1, 2004. The agency may delay implementing the demonstration project until the necessary waivers or authorizations are granted.

SECTION 5. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02101 through 531.02107 to read as follows:

Sec. 531.02101. TRANSFER AUTHORITY RELATING TO ADMINISTRATION OF MEDICAID PROGRAM. (a) To the extent that

reorganization is necessary to achieve the goals of increased administrative efficiency, increased accountability, or cost savings in the Medicaid program or to otherwise improve the health of residents of this state, the commission, subject to Subsection (b), may transfer any power, duty, function, program, activity, obligation, right, contract, record, employee, property, or appropriation or other money relating to administration of the Medicaid program from a health and human services agency to the commission.

(b) A transfer authorized by Subsection (a) may not take effect unless approved by the Medicaid legislative oversight committee created under Section 531.02102.

(c) The commission must notify the Legislative Budget Board and the governor's office of budget and planning not later than the 30th day before the effective date of a transfer authorized by Subsection (a).

Sec. 531.02102. MEDICAID LEGISLATIVE OVERSIGHT COMMITTEE. (a) The Medicaid legislative oversight committee is composed of:

(1) five members of the senate appointed by the lieutenant governor; and

(2) five members of the house of representatives appointed by the speaker of the house of representatives.

(b) A member of the Medicaid legislative oversight committee serves at the pleasure of the appointing official.

(c) The lieutenant governor and speaker of the house of representatives shall appoint the presiding officer of the Medicaid legislative oversight committee on an alternating basis. The

presiding officer shall serve a two-year term expiring February 1 of each odd-numbered year.

(d) The Medicaid legislative oversight committee shall:

(1) meet not more than quarterly at the call of the presiding officer; and

(2) review and approve or reject any transfer proposed by the commission of a power, duty, function, program, activity, obligation, right, contract, record, employee, property, or appropriation or other money relating to administration of the Medicaid program from a health and human services agency to the commission.

(e) The Medicaid legislative oversight committee may use staff of standing committees in the senate and house of representatives with appropriate jurisdiction, the Department of Information Resources, the state auditor, the Texas Legislative Council, and the Legislative Budget Board in carrying out its responsibilities.

Sec. 531.02103. MEDICAID PROGRAM: STRATEGIES FOR IMPROVING BUDGET CERTAINTY AND COST SAVINGS. (a) To achieve administrative efficiency and cost savings in the Medicaid program, the commission shall develop and implement strategies to improve management of the cost, quality, and use of services provided under the program. The strategies developed and implemented under this section may include:

(1) expansion of an enhanced primary care case management model to areas of the state and to populations currently subject to fee-for-service arrangements;

(2) use of medical case management for complex medical cases;

(3) mandatory enrollment of some or all Medicaid recipients who receive Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) into a STAR + Plus pilot program in an area of the state served by a STAR pilot program as of January 1, 2001, or into an alternate managed care model developed by the commission;

(4) use of telemedicine for children and other persons with special health care needs;

(5) use of copayments and other mechanisms to encourage responsible use of health care services under the program, provided that implementation occurs in accordance with Section 531.02106;

(6) use of procurement initiatives such as selective contracting as a mechanism for obtaining provider services under the program, provided that the initiatives may not apply to a Class A community independent pharmacy or a Class A community chain pharmacy with 10 or fewer pharmacies;

(7) expansion of the program of all-inclusive care for the elderly (PACE), as authorized by Section 4802 of the Balanced Budget Act of 1997 (Pub. L. No. 105-33), as amended, to additional sites;

(8) use of disease management and drug therapy management for Medicaid recipients with chronic diseases, including congestive heart failure, chronic obstructive pulmonary disease, asthma, and diabetes;

(9) use of cost controls in the provision of pharmaceutical services as necessary to ensure appropriate pricing, cost-effective use of pharmaceutical products, and the state's greatest entitlement to rebates from pharmaceutical manufacturers;

(10) use of competitive pricing for medical equipment and supplies, including vision care equipment and supplies;

(11) expansion of the health insurance premium payment reimbursement system (HIPPS);

(12) reduction of hospital outlier payments; and

(13) any other strategy designed to improve the quality and cost-effectiveness of the Medicaid program.

(b) The commission shall consult with local communities, providers, consumers, and other affected parties in the development and implementation of strategies under Subsection (a). The commission shall use existing state or local advisory committees for this purpose.

(c) The commission shall hold public hearings at least quarterly regarding the development and implementation of strategies under Subsection (a) and the development of agency procedures and necessary state plan amendments or waivers. If the commission proposes to adopt a rule necessary to implement a strategy under Subsection (a), the commission shall adopt the rule in accordance with Chapter 2001 and hold any public hearing required by that chapter.

Sec. 531.02105. TEXAS HEALTH STEPS PROGRAM. The commission shall:

(1) take all actions necessary to simplify:

(A) provider enrollment in the Texas Health Steps program;

(B) reporting requirements relating to the Texas Health Steps program; and

(C) billing and coding procedures so that Texas Health Steps program processes are more consistent with commercial standards;

(2) in consultation with providers of Texas Health Steps program services, develop mechanisms to promote accurate, reliable, and timely reporting of examinations of children conducted under the program to managed care organizations and other appropriate entities;

(3) in consultation with providers of Texas Health Steps program services, develop a mechanism to promote incorporation of Texas Health Steps program services into a child's medical home; and

(4) require the external quality monitoring organization to evaluate the Texas Health Steps program using information available from all relevant sources and prepare periodic reports regarding the program for submission by the commission to the legislature.

Sec. 531.02106. LIMITS ON MEDICAID COST-SHARING. Before requiring Medicaid recipients to make copayments or comply with other cost-sharing requirements, the commission by rule shall establish monthly limits on total copayments and other cost-sharing requirements.

Sec. 531.02107. AUTHORIZATION FOR EXPANDED MEDICAID COST-SHARING. (a) Notwithstanding any other law, the commissioner may request federal authorization to require all Medicaid recipients to make copayments or comply with other cost-sharing requirements for all services provided under the program in accordance with that authorization.

(b) As soon as possible after the effective date of this Act, the lieutenant governor and the speaker of the house of representatives shall appoint the members of the Medicaid legislative oversight committee created by Section 531.02102, Government Code, as added by this Act. The speaker of the house of representatives shall appoint the initial presiding officer of the committee.

SECTION 6. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02131 to read as follows:

Sec. 531.02131. COMMUNITY OUTREACH CAMPAIGN. (a) The commission shall conduct a community outreach campaign to provide information relating to the availability of Medicaid coverage for children and adults and to promote enrollment of eligible children and adults in Medicaid.

(b) The commission may combine the community outreach campaign under this section with any other state outreach campaign or educational activity relating to health care and available health care coverage.

SECTION 7. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02192 to read as follows:

Sec. 531.02192. HEALTH BENEFITS COVERAGE FOR CERTAIN

LOW-INCOME PARENTS. (a) The commission shall develop and implement a demonstration project with a statewide program in which health benefits coverage is provided to an individual who:

(1) is the parent of a child receiving medical assistance under the state Medicaid program or of a child enrolled in the state child health plan program under Chapter 62, Health and Safety Code;

(2) has a family income that is at or below 200 percent of the federal poverty level; and

(3) is not covered by health insurance or another type of health benefit plan other than a health benefit plan other than a health benefit plan that is administered by or on behalf of a local governmental entity.

(b) The commission shall ensure that the program is designed and administered in a manner that qualifies for federal funding and is financed using state money and money made available by local governmental entities to the commission for federal matching purposes. Local money described by this subsection includes tax or other revenue spent to provide indigent health care services to eligible individuals before they were eligible to receive health benefits coverage under this section and any other resources made available to the commission under this section for federal matching purposes.

(c) In establishing the demonstration project with a statewide phase-in, the commission shall:

(1) develop a health benefit plan to provide coverage for health care services to eligible individuals that:

(A) requires plan coverage to be purchased using a combination of local, federal, and state contributions;

(B) provides a benefits package that is similar to the state child health plan program benefits; and

(C) to the extent possible eliminates coverage for duplicative or extraordinary services; and

(2) not later than the 180th day before the date on which the commission plans to begin to provide health coverage to recipients through the program, appoint an advisory committee to provide recommendations on the implementation and operation of the program, including the development of the health benefit plan.

(d) The advisory committee described by Subsection (c)(2) must be composed of representatives of:

(1) local governmental entities that make funds available to the commission in accordance with this section;

(2) insurance companies and health maintenance organizations eligible to offer health benefits coverage under the health benefit plan; and

(3) health consumer advocates.

(e) In developing the health benefit plan under Subsection (c)(1), the commission must include provisions intended to discourage:

(1) employers and other persons from electing to discontinue offering coverage for individuals under employee or other group health benefit plans; and

(2) individuals with access to adequate health benefit plan coverage, other than coverage under the health benefit plan

developed under Subsection (c)(1), from electing not to obtain or to discontinue that coverage.

(f) At the request of the commission, the Texas Department of Insurance shall provide any necessary assistance with the development of the health benefit plan under Subsection (c)(1).

(g) The commission shall:

(1) adopt an application form and application procedures for requesting health benefit plan coverage under this section;

(2) develop eligibility determination and enrollment procedures for the program; and

(3) select the health benefit plan providers under the program through a competitive procurement process.

(h) The commission shall adopt rules as necessary to implement this section.

SECTION 8. The heading to Chapter 533, Government Code, is amended to read as follows:

CHAPTER 533. DEVELOPMENT AND IMPLEMENTATION OF MEDICAID MANAGED CARE PROGRAM

SECTION 9. Subchapter A, Chapter 533, Government Code, is amended by amending Sections 533.001 and 533.002 and adding Sections 533.0021, 533.0022, 533.0023, and 533.0024 to read as follows:

Sec. 533.001. Definitions. In this chapter:

(1) "Commission" means the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program, as appropriate.

(2) "Commissioner" means the commissioner of health and human services.

(3) "Health and human services agencies" has the meaning assigned by Section 531.001.

(4) "Managed care organization" means a person who is authorized or otherwise permitted by law to arrange for or provide a managed care plan. The term includes a health care system established under Chapter 20C, Insurance Code.

(5) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network and a health care system established under Chapter 20C, Insurance Code. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(6) "Recipient" means a recipient of medical assistance under Chapter 32, Human Resources Code.

(7) "Health care service region" or "region" means a Medicaid managed care service area as delineated by the commission.

Sec. 533.002. MEDICAID HEALTH CARE DELIVERY SYSTEM. The commission may develop a health care delivery system that restructures the delivery of health care services provided under the state Medicaid program.

Sec. 533.0021. DESIGN AND DEVELOPMENT OF HEALTH CARE

DELIVERY SYSTEM. In developing the health care delivery system under this chapter, the commission shall:

(1) design the system in a manner that:

(A) improves the health of the people of this state by:

(i) emphasizing prevention;

(ii) promoting continuity of care; and

(iii) providing a medical home for recipients;

(B) ensures that each recipient receives high-quality, comprehensive health care services in the recipient's local community; and

(C) ensures that the community is given an opportunity to provide input and participate in the implementation of the system in the health care service region by holding public hearings in the community at which the commission takes public comment from all persons interested in the implementation of the system;

(2) to the extent that is cost-effective to this state and local governments:

(A) maximize the financing of the state Medicaid program by obtaining federal matching funds for all resources or other money available for matching;

(B) expand Medicaid eligibility to include persons who were eligible to receive indigent health care services through the use of those resources or other money available for matching before expansion of eligibility; and

(C) develop a sliding scale copayment schedule for recipients based on income and other factors determined by the commissioner; and

(3) develop and prepare the waiver or other documents necessary to obtain federal authorization for the system.

Sec. 533.0022. PURPOSE. The commission shall implement the Medicaid managed care program as part of the health care delivery system developed under this chapter [~~Chapter 532~~] by contracting with managed care organizations in a manner that, to the extent possible:

(1) accomplishes the goals described by Section 533.0021 [~~improves the health of Texans by:~~

[~~(A) emphasizing prevention;~~

[~~(B) promoting continuity of care; and~~

[~~(C) providing a medical home for recipients;~~

[~~(2) ensures that each recipient receives high quality, comprehensive health care services in the recipient's local community~~];

(2) [~~(3)~~] encourages the training of and access to primary care physicians and providers;

(3) [~~(4)~~] maximizes cooperation with existing public health entities, including local departments of health and community mental health and mental retardation centers established under Chapter 534, Health and Safety Code;

(4) [~~(5)~~] provides incentives to managed care organizations to improve the quality of health care services for recipients by providing value-added services; [~~and~~]

(5) [~~(6)~~] reduces administrative and other nonfinancial barriers for recipients in obtaining health care services; and

(6) controls the costs associated with the state Medicaid program.

Sec. 533.0023. RULES FOR HEALTH CARE DELIVERY SYSTEM. (a) The commissioner of insurance shall adopt rules as necessary or appropriate to carry out the functions of the Texas Department of Insurance under this chapter.

(b) The commissioner of health and human services shall adopt rules and obtain public input in accordance with Chapter 2001 before making substantive changes to policies or programs under the Medicaid managed care program.

Sec. 533.0024. RESOLUTION OF IMPLEMENTATION ISSUES. The commission shall conduct a meeting at least quarterly with managed care organizations that contract with the commission under this chapter and health care providers to identify and resolve implementation issues with respect to the Medicaid managed care program.

SECTION 10. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0035 to read as follows:

Sec. 533.0035. LIMITATION ON NUMBER OF CONTRACTS AWARDED. The commission shall:

(1) evaluate the number of managed care organizations with which the commission contracts to provide health care services in each health care service region, focusing particularly on the market share of those managed care organizations; and

(2) limit the number of contracts awarded to managed care organizations under this chapter in a manner that promotes the successful implementation of the delivery of health care services through the state Medicaid managed care program.

SECTION 11. (a) Section 533.005, Government Code, is amended to read as follows:

Sec. 533.005. REQUIRED CONTRACT PROVISIONS. 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 and provider payment 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; [~~and~~]

(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 investigations and enforcement;

(11) a process by which the commission is required to:

(A) provide in writing to the managed care organization the projected fiscal impact on the state and managed care organizations that contract with the commission under this chapter of proposed Medicaid managed care program, benefit, or

contract changes; and

(B) negotiate in good faith regarding appropriate operational and financial changes to the contract with the managed care organization before implementing those changes;

(12) a requirement that the managed care organization providing services to recipients under a Medicaid STAR + Plus pilot program:

(A) have an appropriate number of clinically trained case managers within the Medicaid STAR + Plus pilot program service delivery area to manage medically complex patients; and

(B) implement disease management programs that address the medical conditions of Medicaid the STAR + Plus pilot program population, including persons with HIV infection, AIDS, or sickle cell anemia;

(13) a requirement that the renewal date of the contract coincide with the beginning of the state fiscal year; and

(14) a requirement that the managed care organization reimburse health care providers for an appropriate emergency medical screening that is within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, and that is provided to determine whether:

(A) an emergency medical or psychiatric condition exists; and

(B) additional medical examination and treatment is required to stabilize the emergency medical or psychiatric condition.

(b) The changes in law made by Section 533.005, Government Code, as amended by this Act, apply to a contract between the Health and Human Services Commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act. A contract that is entered into or renewed before the effective date of this Act is governed by the law in effect on the date the contract was entered into or renewed, and the former law is continued in effect for that purpose.

SECTION 12. (a) Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.0051, 533.0076, 533.0091, 533.0131, and 533.016 through 533.0207 to read as follows:

Sec. 533.0051. CONTRACT RENEWAL. Before renewing a contract with a managed care organization under this chapter, the commission shall consider:

(1) the managed care organization's:

(A) overall contract compliance;

(B) implementation of simplified administrative processes for health care providers and recipients;

(C) compliance with statutory requirements to promptly reimburse health care providers for covered services provided under the Medicaid managed care program;

(D) compliance with the requirements under Article 3.70-3C, Insurance Code, as added by Chapter 1260, Acts of the 75th Legislature, Regular Session, 1997, and Section 14, Texas Health Maintenance Organization Act (Article 20A.14, Vernon's Texas Insurance Code), to identify advanced practice nurses and physician assistants as providers in the managed care

organization's provider network;

(E) financial performance; and

(F) participation in the state child health plan under Chapter 62, Health and Safety Code; and

(2) the level of satisfaction of recipients and health care providers with the managed care organization.

Sec. 533.0076. LIMITATIONS ON RECIPIENT DISENROLLMENT. (a) Except as provided by Subsections (b) and (c), and to the extent permitted by federal law, the commission may prohibit a recipient from disenrolling in a managed care plan under this chapter and enrolling in another managed care plan during the 12-month period after the date the recipient initially enrolls in a plan.

(b) At any time before the 91st day after the date of a recipient's initial enrollment in a managed care plan under this chapter, the recipient may disenroll in that plan for any reason and enroll in anther managed care plan under this chapter.

(c) The commission shall allow a recipient who is enrolled in a managed care plan under this chapter to disenroll in that plan at any time for cause in accordance with federal law.

Sec. 533.0091. UNIFORM STANDARDS FOR IDENTIFYING RECIPIENTS WITH DISABILITIES OR CHRONIC CONDITIONS. (a) The commission shall collaborate with managed care organizations that contract with the commission under this chapter to develop a uniform screening tool to be used by the managed care organizations to identify adult recipients with disabilities or chronic health conditions and assist those recipients in accessing health care services.

(b) The commission, in cooperation with the Texas Department of Health, by rule shall adopt criteria by which to classify a child with certain health conditions as a child with special health care needs. In adopting the criteria, the commission must include children who have:

(1) severe disabilities;

(2) severe mental or emotional disorders;

(3) medically complex or fragile health conditions; or

(4) rare or chronic health conditions that are likely to last at least one year and result in limitations on the child's functioning and activities when compared to other children of the same age who do not have those conditions.

(c) The commission, in cooperation with the Texas Department of Health, shall:

(1) monitor and assess health care services provided under the state Medicaid managed care program and the medical assistance program under Chapter 32, Human Resources Code, to children with special health care needs as determined by the criteria adopted under Subsection (b);

(2) adopt specific quality of care standards applicable to health care services provided under the state Medicaid managed care program to children described by Subdivision (1); and

(3) undertake initiatives to develop, test, and implement optimum methods for the delivery of appropriate, comprehensive, and cost-effective health care services under the state Medicaid managed care program to children described by

Subdivision (1), including initiatives to:

(A) coordinate health care services with educational programs and other social and community services; and

(B) promote family involvement and support.

Sec. 533.016. INTERAGENCY SHARING OF INFORMATION. (a) The commission shall require a health and human services agency implementing the Medicaid managed care program to provide to each other health and human services agency implementing the program information reported to the agency by a managed care organization or health care provider providing services to recipients.

(b) Except as prohibited by federal law, the commission, each health and human services agency implementing the Medicaid managed care program, and the Texas Department of Insurance shall share confidential information, including financial data, that relates to or affects a person who proposes to contract with or has contracted with a state agency or a contractor of a state agency for the purposes of this chapter.

(c) Information shared between agencies under Subsection (b) remains confidential and is not subject to disclosure under Chapter 552.

Sec. 533.017. REDUCTION AND COORDINATING OF REPORTING REQUIREMENTS AND INSPECTION PROCEDURES. (a) The commission shall:

(1) streamline on-site inspection procedures of managed care organizations contracting with the commission under this chapter;

(2) streamline reporting requirements for managed care organizations contracting with the commission under this

chapter, including:

(A) combining information required to be reported into a quarterly management report;

(B) eliminating unnecessary or duplicative reporting requirements; and

(C) to the extent feasible, allowing managed care organizations contracting with the commission under this chapter to submit reports electronically;

(3) require managed care organizations contracting with the commission under this chapter to streamline administrative processes required of health care providers, including:

(A) simplifying and standardizing, to the extent reasonably feasible, the forms providers are required to complete, including forms for preauthorization for covered services;

(B) eliminating unnecessary or duplicative reporting requirements; and

(C) encouraging the adoption of collaboratively developed uniform forms; and

(4) designate one entity to which managed care organizations contracting with the commission under this chapter may report encounter data.

(b) Except as provided by Subsection (d), the commission and the Texas Department of Insurance and contractors of the commission or department may not schedule, initiate, prepare for, or conduct a documentary, electronic, or on-site review, a readiness, compliance, or performance review, or any other review, audit, or examination of a managed care organization contracting with the

commission under this chapter until:

(1) the commission, the department, and, if appropriate, each health and human services agency implementing a part of the Medicaid managed care program enter into a memorandum of understanding under Section 533.018; and

(2) the agencies described by Subdivision (1) provide that memorandum to the managed care organization.

(c) Notwithstanding Subsection (b), the commission or the Texas Department of Insurance may take any action:

(1) otherwise authorized by law to protect the safety of a recipient; or

(2) with respect to a managed care organization determined to be in a hazardous financial condition.

(d) The commission and the Texas Department of Insurance may review monthly, quarterly, or annual reports required to be filed by managed care organizations contracting with the commission under this chapter.

Sec. 533.018. MEMORANDUM OF UNDERSTANDING REGARDING COORDINATION OF REPORTING REQUIREMENTS AND INSPECTION PROCEDURES. (a) The commission, the Texas Department of Insurance, and, if appropriate, each health and human services agency implementing a part of the Medicaid managed care program shall enter into a memorandum of understanding that outlines methods to:

(1) maximize interagency coordination in conducting reviews of managed care organizations contracting with the commission under this chapter; and

(2) eliminate and prevent duplicative monitoring,

reporting, reviewing of forms, regulation, and enforcement policies and processes with respect to those managed care organizations.

(b) The memorandum of understanding under this section must:

(1) maximize the use of electronic filing of information by managed care organizations contracting with the commission under this chapter;

(2) specify the process by which the commission and the Texas Department of Insurance will jointly schedule a single on-site visit that satisfies the requirements of all state agencies regarding regularly scheduled, comprehensive compliance monitoring of and enforcement efforts with respect to managed care organizations contracting with the commission under this chapter;

(3) require that interagency orientation and training are scheduled and conducted to ensure that agency staff members are familiar with the obligation to eliminate and prevent duplicative monitoring and enforcement activities; and

(4) ensure coordination to eliminate and prevent duplication regarding policy development and implementation, procurement, cost estimates, electronic systems issues, and monitoring and enforcement activities with respect to managed care organizations that serve recipients as well as enrollees in the state child health plan under Chapter 62, Health and Safety Code.

Sec. 533.019. INTEGRATED OPERATIONAL AND FINANCIAL AUDIT INSTRUMENT. (a) The commission and the Texas Department of Insurance shall develop and use an integrated operational and

financial audit instrument for regularly scheduled, comprehensive, on-site readiness, performance, or compliance reviews, or other reviews, audits, or examinations of managed care organizations that contract with the commission under this chapter.

(b) In developing the integrated operational and financial audit instrument, the commission and the Texas Department of Insurance must include:

(1) a method to assess compliance with each applicable federal and state law and each applicable accreditation and contractual requirement, including financial, actuarial, operational, and quality of care requirements, the agencies are authorized to enforce at least on a periodic basis;

(2) a method to assess compliance of documents, records, and electronic files the commission or the Texas Department of Insurance requires managed care organizations that contract with the commission under this chapter to submit for review, either before or as an alternative to an on-site review, audit, or examination; and

(3) a method to assess compliance through on-site reviews, audits, and examinations, including document review, electronic systems testing or review, and observation and interviews of managed care organization employees.

(c) The commission and the Texas Department of Insurance may contract on a competitive bid basis with a consultant not affiliated with the commission or department to develop the integrated operational and financial audit instrument required by this section.

Sec. 533.020. PREAUTHORIZATION FOR CERTAIN SERVICES NOT REQUIRED. The commission, in consultation with physicians, hospitals, and managed care organizations contracting with the commission under this chapter, shall develop:

(1) a process by which the managed care organizations eliminate preauthorization processes for covered services that are considered to be routine services; and

(2) a process by which to notify health care providers of covered services under the Medicaid managed care program for which preauthorization is not required.

Sec. 533.0201. UTILIZATION REVIEW UNDER PRIMARY CARE CASE MANAGEMENT NETWORK. To the extent allowed by federal law, the commission shall require a managed care organization that contracts with the commission under this chapter and that provides health care services to recipients through a primary care case management network to conduct utilization review of those services in accordance with Article 21.58A, Insurance Code.

Sec. 533.0202. NOTICE OF DETERMINATIONS MADE BY UTILIZATION REVIEW AGENTS. (a) In this section, "utilization review agent" has the meaning assigned by Section 2, Article 21.58A, Insurance Code.

(b) A utilization review agent shall notify a recipient or a person acting on behalf of the recipient and the recipient's health care provider of a utilization review determination in accordance with this section and Section 5(a), Article 21.58A, Insurance Code, with respect to services provided under the state Medicaid managed care program.

(c) If the utilization review agent makes an adverse

determination, the notice required by this section must include:

(1) the principal reasons for the adverse determination;

(2) the clinical basis for the adverse determination;

(3) a description or the source of the screening criteria used as guidelines in making the determination; and

(4) a description of the procedure for the complaint and appeal process, including a description provided to the recipient of:

(A) the recipient's right to a Medicaid fair hearing at any time; and

(B) the procedures for appealing an adverse determination at a Medicaid fair hearing.

(d) The utilization review agent must provide notice of an adverse determination:

(1) to the recipient and the recipient's health care provider of record by telephone or electronic transmission not later than the next business day after the date the determination is made if the recipient is hospitalized when the determination is made, to be followed not later than the third business day after the date the determination is made by a written notice of the determination;

(2) to the recipient and the recipient's health care provider of record by written notice not later than the third business day after the date the determination is made if the recipient is not hospitalized when the determination is made; or

(3) to the recipient's treating physician or health

care provider within the time appropriate to the circumstances that relate to the delivery of the services and the condition of the patient, but not later than one hour after the recipient's treating physician or provider requests poststabilization care following emergency treatment.

(e) The commissioner shall adopt rules to implement this section.

Sec. 533.0203. COMPLAINT INFORMATION. (a) The commission, in cooperation with the Texas Department of Insurance and any other appropriate entity, shall collect complaint data, including complaint resolution rates, regarding managed care organizations contracting with the commission under this chapter. In entering into or renewing a contract with a managed care organization under this chapter, the commission may include provisions in the contract to accomplish the purposes of this section.

(b) The commission shall report on a quarterly basis the complaint data collected under Subsection (a) to the state Medicaid managed care advisory committee under Subchapter C.

(c) Not later than December 1 of each even-numbered year, the commission shall report to the legislature the complaint data collected under Subsection (a). The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law.

Sec. 533.0204. PROVIDER REPORTING OF ENCOUNTER DATA. The commission shall collaborate with managed care organizations that contract with the commission and health care providers under the organizations' provider networks to develop incentives and

mechanisms to encourage providers to report complete and accurate encounter data to managed care organizations in a timely manner.

Sec. 533.0205. QUALIFICATIONS OF CERTIFIER OF ENCOUNTER DATA. (a) The person acting as the state Medicaid director shall appoint a person as the certifier of encounter data.

(b) The certifier of encounter data must have:

(1) demonstrated expertise in estimating premium payment rates paid to a managed care organization under a managed care plan; and

(2) access to actuarial expertise, including expertise in estimating premium payment rates paid to a managed care organization under a managed care plan.

(c) A person may not be appointed under this section as the certifier of encounter data if the person participated with the commission in developing premium payment rates for managed care organizations under managed care plans in this state during the three-year period before the date the certifier is appointed.

Sec. 533.0206. CERTIFICATION OF ENCOUNTER DATA. (a) The certifier of encounter data shall certify the completeness, accuracy, and reliability of encounter data for each state fiscal year.

(b) The commission shall make available to the certifier all records and data the certifier considers appropriate for evaluating whether to certify the encounter data. The commission shall provide to the certifier selected resources and assistance in obtaining, compiling, and interpreting the records and data.

Sec. 533.0207. IMPLEMENTATION OF CERTAIN MANAGED CARE PLANS

IN CERTAIN COUNTIES. (a) Notwithstanding any other law, before implementing a Medicaid managed care plan that uses capitation as a method of payment in a county with a population of less than 100,000, the commission must determine that implementation is economically efficient.

(b) Notwithstanding Subsection (a), the commission may continue implementation of a Medicaid managed care plan described by Subsection (a) in a county with a population of less than 100,000 if implementation of the plan in the county was in progress on January 1, 2001.

(c) Not later than March 1, 2004, the Health and Human Services Commission and each appropriate health and human services agency implementing part of the Medicaid managed care program under Chapter 533, Government Code, shall complete the requirements for reducing and coordinating reporting requirements and inspection procedures as required by Section 533.017, Government Code, as added by this Act.

(d) Not later than March 1, 2004, the Health and Human Services Commission, the Texas Department of Insurance, and each appropriate health and human services agency implementing a part of the Medicaid managed care program under Chapter 533, Government Code, shall enter into the memorandum of understanding required by Section 533.018, Government Code, as added by this Act.

(e) Not later than March 1, 2004, the Health and Human Services Commission and the Texas Department of Insurance shall develop the integrated operational and financial audit instrument required by Section 533.019, Government Code, as added by this Act.

(f) The changes in law made by Section 533.0202, Government Code, as added by this Act, apply to a contract between the Health and Human Services Commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act. A contract that is entered into or renewed before the effective date of this Act is governed by the law in effect on the date the contract was entered into or renewed, and the former law is continued in effect for that purpose.

(g) Not later than January 1, 2004, the person acting as the state Medicaid director shall appoint the certifier of Medicaid managed care encounter data required by Section 533.0205, Government Code, as added by this Act.

SECTION 13. Subsection (a), Section 533.041, Government Code, is amended to read as follows:

(a) The commission shall appoint a state Medicaid managed care advisory committee. The advisory committee consists of representatives of:

(1) hospitals;

(2) managed care organizations;

(3) primary care providers;

(4) state agencies;

(5) consumer advocates representing low-income recipients;

(6) consumer advocates representing recipients with a disability;

(7) parents of children who are recipients;

(8) rural providers;

(9) advocates for children with special health care needs;

(10) pediatric health care providers, including specialty providers;

(11) long-term care providers, including nursing home providers;

(12) obstetrical care providers;

(13) community-based organizations serving low-income children and their families; [~~and~~]

(14) community-based organizations engaged in perinatal services and outreach;

(15) medically underserved communities; and

(16) community mental health and mental retardation centers established under Subchapter A, Chapter 534, Health and Safety Code.

SECTION 14. (a) Subject to Subsection (b) of this section, if before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

(b) Implementation of Sections 32.057, 32.061, and 32.062, Human Resources Code, as added by this Act, is governed by Section 4 of this Act. Implementation of Section 533.02192, Government Code, as added by this Act, is governed by Section 7 of this Act.

SECTION 15. Not later than September 1, 2003, the Health and

Human Services Commission shall request and actively pursue any necessary waivers from a federal agency or any other appropriate entity to enable the commission to implement the program established under Section 531.02192, Government Code, as added by this Act. The commission may delay implementing the program described by that section until the necessary waivers or authorizations are granted.

SECTION 16. The Health and Human Services Commission is not required to implement Section 531.0219, Government Code, as added by this Act, unless a specific appropriation for the implementation is provided in the General Appropriations Act, Acts of the 78th Legislature, Regular Session, 2003.

SECTION 17. Except as otherwise provided by this Act, this Act takes effect September 1, 2003, and applies to a person receiving medical assistance on or after that date regardless of the date on which the person began receiving that medical assistance.