By: Delisi, Hill, McReynolds, Coleman, Truitt, et al. H.B. No. 1771

A BILL TO BE ENTITLED

AN ACT

relating to the Medicaid managed care delivery system.

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

SECTION 1. Section 533.001, Government Code, is amended by amending Subdivisions (2) and (5) and adding Subdivisions (8), (9), and (10) to read as follows:

(2) "Executive commissioner" [~~"Commissioner"~~] means the executive commissioner of the Health and Human Services Commission [~~health and human services~~].

(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 or an integrated care management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(8) "Case management" means the method of identifying, assessing, planning, coordinating, and monitoring recipients with complex, chronic, or high-cost health care needs and the development of a plan of care to coordinate the medical and social support services needed to achieve optimum recipient outcomes in a

cost-effective manner. The term includes disease management.

(9) "Medical home" means a primary care physician or health care provider who:

(A) manages and coordinates all aspects of a recipient's health care; and

(B) has a continuous and ongoing professional relationship with the recipient.

(10) "Service coordination" means a process, independent of providers, to link recipients with the spectrum of medical, functional, and social support services and resources by developing a plan of care to maximize the potential of the recipient to achieve optimal health care, community integration and inclusion, independence, and functionality.

SECTION 2. Section 533.002, Government Code, is amended to read as follows:

Sec. 533.002. PURPOSE. The commission shall implement the Medicaid managed care program as part of the health care delivery system developed under Chapter 532 by contracting with managed care organizations in a manner that, to the extent possible:

(1) improves the health of Texans by:

(A) emphasizing prevention;

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

(C) providing a medical home for recipients;

(D) providing long-term services and supports in the most integrated setting possible; and

(E) promoting consumer control and self-determination through consumer-directed services;

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

(3) encourages the training of and access to primary care physicians and providers;

(4) maximizes cooperation with existing public health entities, including local departments of health;

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

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

(7) reduces administrative, financial, and nonfinancial barriers for recipients and physicians and health care providers participating in the state Medicaid program;

(8) minimizes expenditures not related to the provision of direct care, unless those expenditures will result in better care provided to and improved outcomes for recipients;

(9) ensures that each recipient who needs community and long-term services and supports receives those services and supports in the recipient's local community in accordance with Section 531.0244 or 531.043, to the extent applicable; and

(10) promotes the integration, inclusion, and independence of recipients by providing home and community-based services.

SECTION 3. Section 533.0025, Government Code, is amended by amending Subsections (b), (c), and (d) and adding Subsections

(b-1), (c-1), (c-2), (f), (g), and (h) to read as follows:

(b) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide medical assistance for health care and long-term services and supports [~~for acute care~~] through the most cost-effective model of Medicaid managed care as determined by the commission. If the commission determines that it is more cost-effective, the commission may provide medical assistance for health care and long-term services and supports [~~for acute care~~] in a certain part of this state or to a certain population of recipients using:

(1) a health maintenance organization model[~~, including the acute care portion of Medicaid Star Plus pilot programs~~];

(2) a primary care case management model;

(3) a prepaid health plan model;

(4) an exclusive provider organization model; or

(5) another Medicaid managed care model or arrangement.

(b-1) The executive commissioner may not use a capitated risk model for health care and long-term services and supports for recipients who are aged, blind, or disabled, except in the acute and long-term care integration pilot operating in Harris County on August 31, 2005.

(c) In determining whether a model or arrangement described by Subsection (b) is more cost-effective, the executive commissioner must consider:

(1) the scope, duration, and types of health benefits

or services to be provided in a certain part of this state or to a certain population of recipients;

(2) administrative costs necessary to meet federal and state statutory and regulatory requirements;

(3) the anticipated effect of market competition associated with the configuration of Medicaid service delivery models determined by the commission; [~~and~~]

(4) the gain or loss to this state of a tax collected under Chapter 222 [~~Article 4.11~~], Insurance Code;

(5) the impact, including fiscal impact, to the medical delivery infrastructure of political subdivisions of this state that provide medical assistance, health care, or health care services to recipients or indigent populations; and

(6) the long-term impact to the provider network of the state Medicaid program, including participation in the network by privately practicing physicians, home and community support services agencies, mental health providers, providers of assisted living services, and day activity health providers.

(c-1) The commission shall maintain any primary care case management model implemented on or before January 1, 2005, until the model is replaced by the integrated care management model as provided by Subchapter D.

(c-2) If after January 1, 2005, the commission begins initially providing medical assistance to recipients using a Medicaid managed care model or arrangement, other than an integrated care management model as provided by Subchapter D, the commission must provide an option for those recipients to receive

medical assistance through a primary care case management model of managed care.

(d) If the commission determines that it is not more cost-effective to use a Medicaid managed care model to provide certain types of medical assistance for health care and long-term services and supports [~~for acute care~~] in a certain area or to certain medical assistance recipients as prescribed by this section, the commission shall provide medical assistance for health care and long-term services and supports [~~for acute care~~] through a traditional fee-for-service arrangement.

(f) Before the commission begins initially providing medical assistance through a Medicaid managed care model or arrangement to recipients residing in a certain area of this state, or begins providing medical assistance through a different model or arrangement to recipients in an area served by a Medicaid managed care model or arrangement, the commission shall seek public comments and hold a public hearing in the affected area at least six months before the date the commission intends to begin providing medical assistance through that model or arrangement.

(g) Before the commission begins initially providing medical assistance to recipients through a Medicaid managed care model or arrangement or begins providing medical assistance to recipients through a different model or arrangement, the executive commissioner shall provide to the governor, lieutenant governor, and speaker of the house of representatives a report containing the findings, determinations, evaluations, and weight given by the executive commissioner to each provision the executive

commissioner is required to consider under Subsection (c) before taking that action. A report submitted under this subsection must be made available to the public on the commission's Internet website.

(h) The implementation of any Medicaid managed care model or arrangement does not preclude the operation of any program of all-inclusive care for the elderly (PACE) site under Section 32.053, Human Resources Code.

SECTION 4. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.019 to read as follows:

Sec. 533.019. MEDICAL HOME FOR CERTAIN RECIPIENTS. A recipient who is a child with special health care needs or who is a child or adult with a disability may select a physician who is a subspecialist to act as the recipient's medical home if the subspecialist agrees to serve in that role.

SECTION 5. Chapter 533, Government Code, is amended by adding Subchapter D to read as follows:

SUBCHAPTER D. INTEGRATED CARE MANAGEMENT MODEL

Sec. 533.061. ESTABLISHMENT OF AN INTEGRATED CARE MANAGEMENT MODEL; PILOT PROJECT. (a) The executive commissioner by rule shall establish, and the commission shall conduct and evaluate, a pilot project to determine the cost savings, health benefits, and effectiveness of providing medical assistance through an integrated care management model to the following populations of recipients:

(1) recipients of financial assistance under Chapter 31, Human Resources Code;

(2) pregnant women;

(3) children;

(4) recipients eligible to receive Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq., who are not residents of long-term care facilities;

(5) recipients who are determined eligible for the community-based alternative 1915(c) nursing home waiver services; and

(6) recipients who are dually eligible for Medicaid and Medicare.

(b) For purposes of this section, "integrated care management" includes:

(1) the development and maintenance of a comprehensive network of physicians, hospitals, community clinics, public health providers, home and community support providers, and other providers, as appropriate, to meet the diverse needs of recipients described by Subsection (a) who are participating in the pilot project;

(2) the assignment of recipients to a medical home;

(3) recipient-level reporting, at least quarterly, to physicians or appropriate health care providers of the utilization and costs of health care services, including prescription drug utilization and costs, of recipients described by Subsection (a) who are participating in the pilot project;

(4) health risk assessment screenings for recipients on enrollment in the pilot project and annually after enrollment to identify recipients who have chronic illnesses or diseases or who

are at risk of developing chronic illnesses or diseases and the reporting of the results of the assessment screenings to the recipient's medical home;

(5) care coordination with the recipients' medical home, including the provision of home health services or durable medical equipment;

(6) case management, including coordination of disease management for recipients identified as having chronic health conditions, and prescription drug management;

(7) a mechanism to provide for increased levels of payment to providers who:

(A) adhere to physician-developed, evidence-based, and peer-reviewed clinical guidelines and performance measures;

(B) incorporate early and periodic screening, diagnosis, and treatment services into the medical home;

(C) establish and maintain clinics to treat recipients after normal business hours, as defined by rule of the executive commissioner; and

(D) implement measures to improve patient safety;

(8) a comprehensive quality management program;

(9) outreach initiatives to recruit physicians and health care providers to participate in the Medicaid program;

(10) cost-effective utilization of telemedicine medical services or telehealth services, particularly to improve the management of chronic conditions;

(11) mechanisms to assist recipients to easily identify participating physicians and health care providers, including the posting of a list of participating providers on the Internet;

(12) implementation of a clinically based after-hours nurse telephone hotline;

(13) a functional needs assessment, performed on enrollment and at least annually after enrollment in the most cost-effective manner, to determine community and social support services needed by recipients;

(14) a mechanism to link case management and service coordinators to assure timely communication and care plan collaboration regarding the recipient's medical, functional, and social support needs to maximize optimal health care, independence, and functionality;

(15) aggressive efforts to prevent or delay institutionalization of recipients through the effective utilization of home and community-based support services;

(16) implementation of the Promoting Independence initiative for children and adults to identify persons who wish to leave a nursing facility or other institution and to reside in the community;

(17) the provision of services in the most integrated setting possible that promotes community integration, inclusion, and independence; and

(18) any other features the executive commissioner, with advice from the advisory committee under Section 533.064,

determines will improve a recipient's health outcome and are cost-effective.

(c) The Department of Aging and Disability Services is responsible for the development of policies for the long-term care provisions of the integrated care management model.

(d) In establishing the integrated care management model, the commission shall implement the pilot project in the eight Medicaid managed care service delivery areas of this state where Star Plus would have otherwise been implemented.

Sec. 533.062. CONTRACTING FOR INTEGRATED CARE MANAGEMENT. (a) The commission shall contract with a managed care organization or other qualified organization to perform the components of the integrated care management model specified in Section 533.061(b) to achieve the following goals:

(1) assure proper utilization of services;

(2) promote cost-effective outcomes;

(3) enhance the ability of physicians and health care providers to be effective and responsive in making treatment decisions; and

(4) ensure that services for persons with functional limitations or medical needs and their families assist those persons in achieving and maintaining the greatest possible independence, autonomy, and quality of life through consumer-directed services and self-determination.

(b) In contracting under this section, the commission shall:

(1) require the integrated care management contractor

to use fee-for-service billing systems in existence on August 31, 2005;

(2) incorporate disease management into the integrated care management model utilizing the Medicaid disease management contractor operating in the state as of November 1, 2004, and through the expiration or renewal of the disease management contract in effect on August 31, 2005;

(3) consider the effect a transition to a new contractor will have on the recipients and physicians and health care providers participating in the state Medicaid program; and

(4) make every reasonable attempt to minimize any administrative burden and expense on the physicians and health care providers participating in the pilot project.

(c) The commission may amend contracts to the extent allowed by law.

Sec. 533.063. COST-EFFECTIVENESS OF THE INTEGRATED CARE MANAGEMENT MODEL. (a) In determining whether the integrated care management model achieves cost savings, the commission shall consider:

(1) any savings achieved through disease management programs established under Section 32.059, Human Resources Code, as added by Chapter 208, Acts of the 78th Legislature, Regular Session, 2003;

(2) the appropriate utilization of prescription medications by recipients;

(3) appropriate case management and care coordination by utilization of a medical home;

(4) reductions in inappropriate utilization of emergency rooms by recipients; and

(5) appropriate utilization of home and community-based services by recipients to reduce the need for more-expensive hospital care or long-term institutional care.

(b) The comptroller shall verify the findings of the commission in evaluating the cost savings of the integrated care management model.

(c) Projected cost savings are not to be achieved by reducing eligibility for long-term services below what is currently available in the existing integrated managed care long-term service system.

Sec. 533.064. STATEWIDE INTEGRATED CARE MANAGEMENT ADVISORY COMMITTEE. (a) The executive commissioner shall appoint an advisory committee to assist the executive commissioner in developing the integrated care management model. The executive commissioner shall consult the advisory committee throughout the development of the model, including in relation to the development of proposed rules regarding the components of the integrated care management model specified in Section 533.061(b).

(b) The advisory committee consists of the following members:

(1) three practicing primary care physicians from different geographic areas of this state, including at least two physicians with experience practicing under a primary care case management model of Medicaid managed care;

(2) three practicing subspecialty care physicians

with:

(A) one subspecialist having expertise in treating adults with disabilities;

(B) one subspecialist having expertise in treating children with special health care needs; and

(C) one subspecialist having expertise in chronic care management;

(3) one representative of a federally qualified health center, as defined by 42 U.S.C. Section 1396d(l)(2)(B);

(4) two representatives of hospital districts located in urban areas;

(5) one representative of a children's hospital;

(6) one representative of a home and community support services agency;

(7) one provider of assisted living services;

(8) one consumer representative who is knowledgeable regarding issues affecting pregnant women, children, and families eligible for Medicaid;

(9) one consumer representative who is knowledgeable regarding issues affecting recipients who are dually eligible for Medicaid and Medicare; and

(10) one consumer representative who is knowledgeable regarding issues affecting recipients who are aged, blind, or disabled.

(c) The advisory committee shall establish the following subcommittees composed of one or more members of the advisory committee and one or more persons who do not serve on the advisory

committee:

(1) one subcommittee to provide advice and assistance to the executive commissioner and advisory committee on the specific medical, social, and functional support services and needs of children;

(2) one subcommittee to provide advice and assistance to the executive commissioner and advisory committee on the specific medical, social, and functional support services and needs of adults with disabilities; and

(3) any other subcommittees the advisory committee considers necessary to provide advice and assistance to the executive commissioner and advisory committee on operational and design issues relating to the development and implementation of the integrated care management model.

(d) In making appointments to the subcommittees under Subsection (c), the advisory committee shall assure that each subcommittee provides representation of the broad range of appropriate acute care providers, long-term care providers, and consumers to assure inclusive and diverse input into the development and design of the integrated care management model.

(e) The advisory committee shall meet as necessary to perform the duties required by this section.

(f) A member of the advisory committee may not receive compensation for serving on the committee but is entitled to reimbursement for reasonable and necessary travel expenses incurred by the member while conducting the business of the committee, as provided by the General Appropriations Act.

(g) The advisory committee is not subject to Chapter 551.

Sec. 533.065. REPORT REGARDING INTEGRATED CARE MANAGEMENT MODEL. Not later than January 5, 2007, the commission shall submit to the Legislative Budget Board, the lieutenant governor, and the speaker of the house of representatives a preliminary report containing the commission's findings regarding the implementation of the integrated care management model developed under Section 533.061. The report must include:

(1) information regarding:

(A) recipient and provider satisfaction;

(B) recipient access to primary and subspecialty care services;

(C) recipient access to community and social support services;

(D) recipient outcomes, including health status improvement;

(E) recipient outcomes relating to the Promoting Independence initiative for children and adults;

(F) any cost savings realized from the implementation; and

(G) the fiscal impact to political subdivisions of this state in the areas in which the model is implemented, including any cost savings realized by those entities from the implementation;

(2) recommendations for improvement of the model; and

(3) recommendations on whether to implement the pilot project in other areas of this state.

Sec. 533.066. EXPIRATION OF SUBCHAPTER. This subchapter expires September 1, 2009.

SECTION 6. Section 32.0212, Human Resources Code, is amended to read as follows:

Sec. 32.0212. DELIVERY OF MEDICAL ASSISTANCE. Notwithstanding any other law and subject to Section 533.0025, Government Code, the department shall provide medical assistance for health care and long-term services and supports [~~for acute care~~] through the Medicaid managed care system implemented under Chapter 533, Government Code.

SECTION 7. (a) The executive commissioner of the Health and Human Services Commission shall adopt rules to implement the integrated care management model pilot project established under Section 533.061, Government Code, as added by this Act, not later than December 1, 2005.

(b) Not later than September 1, 2006, the Health and Human Services Commission shall implement the integrated care management pilot project established under Section 533.061, Government Code, as added by this Act.

SECTION 8. The executive commissioner of the Health and Human Services Commission shall appoint the members of the statewide integrated care management advisory committee created under Section 533.064, Government Code, as added by this Act, not later than September 2, 2005.

SECTION 9. If before implementing any provision of this Act a state agency determines that a waiver or other 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.

SECTION 10. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2005.