By: Nelson S.B. No. 1188

Substitute the following for S.B. No. 1188:

By: Dawson C.S.S.B. No. 1188

A BILL TO BE ENTITLED

AN ACT

relating to the medical assistance program and the provision of related services.

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

SECTION 1. COMMUNITY COLLABORATION. Subchapter A, Chapter 531, Government Code, is amended by adding Section 531.020 to read as follows:

Sec. 531.020. OFFICE OF COMMUNITY COLLABORATION. The executive commissioner shall establish within the commission an office of community collaboration. The office is responsible for:

(1) collaborating with community, state, and federal stakeholders to improve the elements of the health care system that are involved in the delivery of Medicaid services; and

(2) sharing with Medicaid providers, including hospitals, any best practices, resources, or other information regarding improvements to the health care system.

SECTION 2. MEDICAID FINANCING. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02113 to read as follows:

Sec. 531.02113. OPTIMIZATION OF MEDICAID FINANCING. The commission shall ensure that the Medicaid finance system is optimized to:

(1) maximize the state's receipt of federal funds;

(2) create incentives for providers to use preventive

care;

(3) increase and retain providers in the system to maintain an adequate provider network;

(4) more accurately reflect the costs borne by providers; and

(5) encourage the improvement of the quality of care.

(b) Section 32.042, Human Resources Code, is amended by amending Subsections (a), (b), (d), and (e) and adding Subsection (b-1) to read as follows:

(a) An insurer shall maintain a file system that contains:

(1) the name, address, including claim submission address, group policy number, employer's mailing address, social security number, and date of birth of each enrollee, beneficiary, subscriber, or policyholder covered by the insurer; and

(2) the name, address, including claim submission address, and date of birth of each dependent of each enrollee, beneficiary, subscriber, or policyholder covered by the insurer.

(b) The state's Medicaid third-party recovery division shall identify state medical assistance recipients who have third-party health coverage or insurance as provided by this subsection. The department may:

(1) [~~shall~~] provide to an insurer Medicaid data tapes that identify medical assistance recipients and request that the insurer identify each enrollee, beneficiary, subscriber, or policyholder of the insurer whose name also appears on the Medicaid data tape; or

(2) request that an insurer provide to the department

identifying information for each enrollee, beneficiary, subscriber, or policyholder of the insurer.

(b-1) An insurer from which the department requests information under Subsection (b) shall provide that information, except that the [~~An insurer shall comply with a request under this subsection not later than the 60th day after the date the request was made. An~~] insurer is only required [~~under this subsection~~] to provide the department with the information maintained under Subsection (a) by the insurer or made available to the insurer from the plan. A plan administrator is subject to Subsection (b) and shall provide information under that [~~this~~] subsection to the extent the information [~~described in this subsection~~] is made available to the plan administrator from the insurer or plan.

(d) An insurer shall provide the information required under Subsection (b)(1) [~~this section~~] only if the department certifies that the identified individuals are applicants for or recipients of services under Medicaid or are legally responsible for an applicant for or recipient of Medicaid services.

(e) The department shall enter into an agreement to reimburse an insurer or plan administrator for necessary and reasonable costs incurred in providing information requested under Subsection (b)(1), not to exceed $5,000 for each data match made under that subdivision. If the department makes a data match using information provided under Subsection (b)(2), the department shall reimburse the insurer or plan administrator for reasonable administrative expenses incurred in providing the information. The reimbursement for information under Subsection (b)(2) may not

exceed $5,000 for initially producing information with respect to a person, or $200 for each subsequent production of information with respect to the person [~~this section~~]. The department may enter into an agreement with an insurer or plan administrator [~~insurers~~] that provides procedures for requesting and providing information under this section. An agreement under this subsection may not be inconsistent with any law relating to the confidentiality or privacy of personal information or medical records. The procedures agreed to under this subsection must state the time and manner the procedures take effect.

(c) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0424 to read as follows:

Sec. 32.0424. CLAIMS FOR REIMBURSEMENT TO MEDICAL ASSISTANCE PROGRAM. (a) In this section, "insurer" and "plan administrator" have the meanings assigned by Section 32.042.

(b) An insurer or plan administrator may not apply a point of sale, timely filing, or out-of-network limitation, restriction, or provision, or any other plan limitation, restriction, or provision, that results in the rejection or denial of a claim by the medical assistance program for reimbursement as authorized by federal or state law for a health care benefit paid by the program.

(c) An insurer or plan administrator that may have primary liability with respect to a health care benefit provided under the medical assistance program to a person may not impose on the department or a designee of the department any kind of fee, charge, or expense to process a claim by the program for reimbursement for the benefit.

(d) The Health and Human Services Commission shall:

(1) examine the possibility of using existing state funds, including existing state funds for the county indigent health care program and the area health education centers in this state, on health-related programs to maximize receipt of additional federal Medicaid funds;

(2) subject to availability of funds, increase Medicaid reimbursement rates for hospitals and physicians to better align those rates with Medicare and private-pay reimbursement rates;

(3) examine the possibility of a program under which intergovernmental transfers are used to support graduate medical education in support of the Medicaid program and, if cost-effective, implement that program;

(4) examine the possibility of a program that includes comprehensive outpatient rehabilitation facilities in the prospective payment systems methodology and, if cost-effective, implement that program;

(5) examine the possibility of developing Medicaid waivers for intergovernmental transfers from local entities similar to those used in the demonstration projects under Chapter 534, Government Code;

(6) examine the possibility of developing a Medicaid waiver program to allow local governmental entities as well as private employers to buy into the Medicaid or children's health insurance programs and, if cost-effective, implement that program;

(7) examine the possibility of using employer

contributions and donations to expand eligibility and funding for the Medicaid and children's health insurance programs and, if cost-effective, implement that option; and

(8) examine the possibility of providing a tax incentive in the form of an ad valorem, franchise, or sales tax credit for employers to enable those employers to pay the state's portion of the premiums for Medicaid or children's health insurance for employees whose family income does not exceed 200 percent of the federal poverty limit and, if cost-effective, implement that option.

(e) If the Health and Human Services Commission chooses to increase reimbursement rates for any providers under Subsection (d)(2) of this section, the commission shall give priority to providers serving medically underserved areas, those who treat a high volume of Medicaid patients, and those who provide care that is an alternative to care in an emergency department.

SECTION 3. COLLECTION AND ANALYSIS OF INFORMATION. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02141 to read as follows:

Sec. 531.02141. MEDICAID INFORMATION COLLECTION AND ANALYSIS. (a) The commission shall make every effort to improve data analysis and integrate available information associated with the Medicaid program. The commission shall use the decision support system in the commission's center for strategic decision support for this purpose and shall modify or redesign the system to allow for the data collected by the Medicaid program to be used more systematically and effectively for Medicaid program evaluation and

policy development. The commission shall develop or redesign the system as necessary to ensure that the system:

(1) incorporates program enrollment, utilization, and provider data that are currently collected;

(2) allows data manipulation and quick analysis to address a large variety of questions concerning enrollment and utilization patterns and trends within the program;

(3) is able to obtain consistent and accurate answers to questions;

(4) allows for analysis of multiple issues within the program to determine whether any programmatic or policy issues overlap or are in conflict;

(5) includes predefined data reports on utilization of high-cost services that allow program management to analyze and determine the reasons for an increase or decrease in utilization and immediately proceed with policy changes, if appropriate; and

(6) includes any encounter data with respect to recipients that a managed care organization that contracts with the commission under Chapter 533 receives from a health care provider under the organization's provider network.

(b) The commission shall ensure that all Medicaid data sets created or identified by the decision support system are made available on the Internet to the extent not prohibited by federal or state laws regarding medical privacy or security. If privacy concerns exist or arise with respect to making the data sets available on the Internet, the system and the commission shall make every effort to make the data available through that means either by

removing information by which particular individuals may be identified or by aggregating the data in a manner so that individual records cannot be associated with particular individuals.

(b) The Health and Human Services Commission shall allow for sufficient opportunities for stakeholder input in the modification or redesign of the decision support system in the commission's center for strategic decision support as required by Section 531.02141, Government Code, as added by this section. The commission may provide these opportunities through:

(1) existing mechanisms, such as regional advisory committees or public forums; and

(2) meetings involving state and local agencies and other entities involved in the planning, management, or delivery of health and human services in this state.

SECTION 4. ADMINISTRATIVE PROCESSES AND AUDIT REQUIREMENTS. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02411 and 531.02412 to read as follows:

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in the Medicaid program and shall use technology and efficient business practices to decrease those burdens. In addition, the commission shall make every effort to improve the business practices associated with the administration of the Medicaid program by any method the commission determines is

cost-effective, including:

(1) expanding the utilization of the electronic claims payment system;

(2) developing an Internet portal system for prior authorization requests;

(3) encouraging Medicaid providers to submit their program participation applications electronically;

(4) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers may conveniently apply to the program;

(5) working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in the Medicaid program; and

(6) encouraging the increased use of medical technology by providers, including increasing their use of:

(A) electronic communications between patients and their physicians or other health care providers;

(B) electronic prescribing tools that provide up-to-date payer formulary information at the time a physician or other health care practitioner writes a prescription and that support the electronic transmission of a prescription;

(C) ambulatory computerized order entry systems that facilitate physician and other health care practitioner orders at the point of care for medications and laboratory and radiological tests;

(D) inpatient computerized order entry systems to reduce errors, improve health care quality, and lower costs in a

hospital setting;

(E) regional data-sharing to coordinate patient care across a community for patients who are treated by multiple providers; and

(F) electronic intensive care unit technology to allow physicians to fully monitor hospital patients remotely.

Sec. 531.02412. SERVICE DELIVERY AUDIT MECHANISMS. (a) The commission shall make every effort to ensure the integrity of the Medicaid program. To ensure that integrity, the commission shall:

(1) perform risk assessments of every element of the Medicaid program and audit those elements of the program that are determined to present the greatest risks;

(2) ensure that sufficient oversight is in place for the Medicaid medical transportation program;

(3) ensure that a quality review assessment of the Medicaid medical transportation program occurs; and

(4) evaluate the Medicaid program with respect to use of the metrics developed through the Texas Health Steps performance improvement plan to guide changes and improvements to the program.

(b) This section does not affect the duty of the Texas Department of Transportation to manage the delivery of transportation services, including the delivery of transportation services for clients of health and human services programs.

(b) To further encourage the use of medical technology by providers under the Medicaid program, the Health and Human Services Commission may enter into a written agreement with a manufacturer,

as defined by Section 531.070, Government Code, to accept as a program benefit in lieu of supplemental rebates, as defined by Section 531.070, Government Code, the manufacturer's operation of a pilot program under which the manufacturer supplies those providers with a graphical electronic medical record system and evaluates the benefits and cost-effectiveness of the system. The program must be operated in a manner that is acceptable to the commission and must be designed to test the benefits and cost-effectiveness on a sufficiently large scale. The manufacturer shall report the results of the program, including an analysis of the program's benefits and cost-effectiveness, to the commission. The commission shall report those results to the 80th Legislature not later than January 15, 2007.

(c) The Health and Human Services Commission shall examine options for standardizing and simplifying the interaction between the Medicaid system and providers regardless of the service delivery system through which a provider provides services and, using existing resources, implement any options that are anticipated to increase the quality of care and contain costs.

SECTION 5. LONG-TERM CARE SERVICES. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.083 and 531.084 to read as follows:

Sec. 531.083. MEDICAID LONG-TERM CARE SYSTEM. The commission shall ensure that the Medicaid long-term care system provides the broadest array of choices possible for recipients while ensuring that the services are delivered in a manner that is cost-effective and makes the best use of available funds. The

commission shall also make every effort to improve the quality of care for recipients of Medicaid long-term care services by:

(1) evaluating the need for expanding the provider base for consumer-directed services and, if the commission identifies a demand for that expansion, encouraging area agencies on aging, independent living centers, and other potential long-term care providers to become providers through contracts with the Department of Aging and Disability Services;

(2) ensuring that all recipients who reside in a nursing facility are provided information about end-of-life care options and the importance of planning for end-of-life care; and

(3) developing policies to encourage a recipient who resides in a nursing facility to receive treatment at that facility whenever possible, while ensuring that the recipient receives an appropriate continuum of care.

Sec. 531.084. MEDICAID LONG-TERM CARE COST CONTAINMENT STRATEGIES. (a) The commission shall make every effort to achieve cost efficiencies within the Medicaid long-term care program. To achieve those efficiencies, the commission shall:

(1) establish a fee schedule for reimbursable incurred medical expenses for dental services controlled in long-term care facilities;

(2) implement a fee schedule for reimbursable incurred medical expenses for durable medical equipment in nursing facilities and ICF-MR facilities;

(3) implement a durable medical equipment fee schedule action plan;

(4) establish a system for private contractors to secure and coordinate the collection of Medicare funds for recipients who are dually eligible for Medicare and Medicaid;

(5) create additional partnerships with pharmaceutical companies to obtain discounted prescription drugs for Medicaid recipients; and

(6) develop and implement a system for auditing the Medicaid hospice care system that provides services in long-term care facilities to ensure correct billing for pharmaceuticals.

(b) The executive commissioner and the commissioner of aging and disability services shall jointly appoint persons to serve on a work group to assist the commission in developing the fee schedule required by Subsection (a)(1). The work group must consist of providers of long-term care services, including dentists and long-term care advocates.

(c) In developing the fee schedule required by Subsection (a)(1), the commission shall consider:

(1) the need to ensure access to dental services for residents of long-term care facilities who are unable to travel to a dental office to obtain care;

(2) the most recent Comprehensive Fee Report published by the National Dental Advisory Service;

(3) the difficulty of providing dental services in long-term care facilities;

(4) the complexity of treating medically compromised patients; and

(5) time-related and travel-related costs incurred by

dentists providing dental services in long-term care facilities.

(d) The commission shall annually update the fee schedule required by Subsection (a)(1).

(b) The Health and Human Services Commission shall examine:

(1) the possibility of implementing a program to expand Medicaid home health benefits to include speech pathology services, intravenous therapy, and chemotherapy treatments and, if cost-effective, implement that program;

(2) the possibility of implementing a program to provide respite and other support services to individuals providing daily assistance to persons with Alzheimer's disease or dementia to reduce caregiver burnout and, if cost-effective, implement that program;

(3) the possibility of implementing a program to offer services through state schools to recipients who are living in the community and a program to use funding for community-based services to pay for the services from the state schools and, if cost-effective, implement those programs;

(4) in conjunction with the Department of Aging and Disability Services, the possibility of implementing a program to simplify the administrative procedures for regulating nursing facilities and, if cost-effective, implement that program; and

(5) the possibility of using fee schedules, prior approval processes, and alternative service delivery options to ensure appropriate utilization and payment for Medicaid services and, if cost-effective, implement those schedules, processes, and options.

(c) The Health and Human Services Commission shall study and determine whether polypharmacy reviews for Medicaid recipients receiving long-term care services could identify inappropriate pharmaceutical usage patterns and lead to controlled costs.

(d) Prior to developing and adopting the fee schedule required by Subdivision (1), Subsection (a), Section 531.084, Government Code, as added by this section, the Health and Human Services Commission shall make every effort to expedite the approval of dental treatment plans and the approval and payment of reimbursable incurred medical expenses for dental services provided to residents of long-term care facilities.

SECTION 6. MEDICAID MANAGED CARE. (a) Section 533.005, Government Code, is amended by amending Subsection (a) and adding Subsection (c) to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation [~~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;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise

comply and cooperate with the commission's office of inspector general [~~investigations and enforcement~~];

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission; [~~and~~]

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

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

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

(c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be

outside of regular business hours for purposes of Subsection (a)(14).

(b) Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.0071 and 533.0072 to read as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve the administration of these contracts, the commission shall:

(1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program;

(2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments and other payments made to managed care organizations with respect to enrollees who leave the managed care program; and

(4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by:

(A) where possible, decreasing the duplication of administrative reporting requirements for the managed care

organizations, such as requirements for the submission of encounter data, quality reports, historically underutilized business reports, and claims payment summary reports;

(B) allowing managed care organizations to provide updated address information directly to the commission for correction in the state system;

(C) requiring consistency and uniformity among managed care organization policies, including policies relating to the preauthorization process, lengths of hospital stays, filing deadlines, levels of care, and case management services; and

(D) reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications.

Sec. 533.0072. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) The commission shall prepare and maintain a record of each enforcement action initiated by the commission that results in a sanction, including a penalty, being imposed against a managed care organization for failure to comply with the terms of a contract to provide health care services to recipients through a managed care plan issued by the organization.

(b) The record must include:

(1) the name and address of the organization;

(2) a description of the contractual obligation the

organization failed to meet;

(3) the date of determination of noncompliance;

(4) the date the sanction was imposed;

(5) the maximum sanction that may be imposed under the contract for the violation; and

(6) the actual sanction imposed against the organization.

(c) The commission shall post and maintain the records required by this section on the commission's Internet website in English and Spanish. The records must be posted in a format that is readily accessible to and understandable by a member of the public. The commission shall update the list of records on the website at least quarterly.

(d) The commission may not post information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(e) A record prepared under this section may not include information that is excepted from disclosure under Chapter 552.

(f) The executive commissioner shall adopt rules as necessary to implement this section.

(c) The Health and Human Services Commission shall reevaluate the case management fee used in the primary care case management program and shall make recommendations to the Legislative Budget Board if the commission finds that a different rate is appropriate.

(d) The Health and Human Services Commission shall examine:

(1) the feasibility and cost-effectiveness of

establishing a sliding-scale case management fee for the primary care case management program based on primary care provider performance;

(2) the operational efficiency, health outcomes, case management, and cost-effectiveness of the primary care case management program and adopt any necessary changes to maximize health outcomes and cost-effectiveness; and

(3) the mechanism used to encourage hospital participation in the primary care case management program and adopt alternative policies if current policies are determined to be ineffective.

(e) The Health and Human Services Commission shall make every effort to improve the delivery of health care services to recipients enrolled in the Medicaid managed care program by evaluating the following actions for a determination of cost-effectiveness and pursuing those actions if they are determined to be cost-effective:

(1) adding a Medicaid managed care contract requirement that requires each managed care plan to work with the commission and health care providers to improve the immunization rate of Medicaid clients and the reporting of immunization information for inclusion in ImmTrac;

(2) to the extent permitted by federal law, allowing managed care organizations access to the previous claims history of a new enrollee that is maintained by a claims administrator if the new managed care organization enrollee was formerly a recipient under the Medicaid fee for service or primary care case management

system;

(3) encouraging managed care organizations to operate nurse triage telephone lines and to more effectively notify enrollees that the lines exist and inform enrollees regarding how to access those lines;

(4) creating more rigorous contract standards for managed care organizations to ensure that children have clinically appropriate alternatives to emergency room services outside of regular office hours;

(5) developing more effective mechanisms to identify and control the utilization of program services by enrollees who are found to have abused the services; and

(6) studying the impact on the program of enrollees who have a history of high or abusive use of program services and incorporating the most effective methods of curtailing that activity while assuring that those enrollees receive adequate health services.

(f) Section 533.005, Government Code, as amended by this section, applies only 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 section. A contract between the commission and an organization that is entered into or renewed before the effective date of this section 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) Section 533.0072, Government Code, as added by this

section, applies only to a sanction imposed on or after the effective date of this section.

SECTION 7. SELECTION OF MEDICAL ASSISTANCE PROVIDERS. Subsection (f), Section 32.027, Human Resources Code, is amended to read as follows:

(f) The executive commissioner of the Health and Human Services Commission [~~department~~] by rule may [~~shall~~] develop a system of selective contracting with health care providers for the provision of nonemergency inpatient hospital services to a recipient of medical assistance under this chapter. In implementing this subsection, the executive commissioner [~~department~~] shall:

(1) seek input from consumer representatives and from representatives of hospitals licensed under Chapter 241, Health and Safety Code, and from organizations representing those hospitals; and

(2) ensure that providers selected under the system meet the needs of a recipient of medical assistance under this chapter.

SECTION 8. OPTIMIZATION OF CASE MANAGEMENT SYSTEMS. (a) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0551 to read as follows:

Sec. 32.0551. OPTIMIZATION OF CASE MANAGEMENT SYSTEMS. The Health and Human Services Commission shall:

(1) create and coordinate staffing and other administrative efficiencies for case management initiatives across the commission and health and human services agencies, as defined

by Section 531.001, Government Code; and

(2) optimize federal funding revenue sources and maximize the use of state funding resources for case management initiatives across the commission and health and human services agencies.

(b) The Health and Human Services Commission shall evaluate the cost-effectiveness of developing intensive case management and targeted interventions for all Medicaid recipients who are aged, blind, or disabled.

(c) The Health and Human Services Commission shall identify Medicaid programs or protocols in existence on the effective date of this section that are not resulting in their anticipated cost savings or quality outcomes. The commission shall enhance or replace these programs or protocols with targeted strategies that have demonstrated success in improving coordination of care and cost savings within similar Medicaid recipient populations.

(d) The Health and Human Services Commission shall evaluate the cost-effectiveness of including within Medicaid disease management programs in existence on the effective date of this section additional diseases, such as chronic kidney disease or end-stage renal disease, additional chronic medical conditions, such as severe pain that requires management, and other strategies, such as home health services for children with chronic conditions that are not included in the existing disease management programs and the use of schools and school nurses to manage chronic medical conditions of children. In evaluating the cost-effectiveness of including other diseases, conditions, and strategies, the

commission may review existing data from the provider of disease management services under Section 32.059, Human Resources Code, as added by Chapter 208, Acts of the 78th Legislature, Regular Session, 2003. The commission may also research the experiences of other states, insurance companies, and managed care organizations and review other sources of data the commission determines is appropriate. The commission shall expand Medicaid disease management programs and related programs to include the diseases, conditions, and strategies that the commission determines under this subsection will be cost-effective.

(e) The Health and Human Services Commission shall conduct a study to determine the feasibility of combining the utilization management, case management, care coordination, high-cost targeting, provider incentives, and other quality and cost-control measures implemented with respect to the Medicaid program under a single federal waiver, which may be a waiver under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) or a waiver under Section 1115(a) of that Act (42 U.S.C. Section 1315(a)). If the commission determines that the combination is feasible, the commission shall develop the combined program and seek the appropriate approval from the Centers for Medicare and Medicaid Services.

SECTION 9. EDUCATION CAMPAIGN. (a) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.071 to read as follows:

Sec. 32.071. RECIPIENT AND PROVIDER EDUCATION. (a) The department shall develop and implement a comprehensive medical

assistance education campaign for recipients and providers to ensure that care is provided in such a way as to improve patient outcomes and maximize cost-effectiveness. The department shall ensure that educational information developed under this section is demographically relevant and appropriate for each recipient or provider to whom the information is provided.

(b) The comprehensive medical assistance education campaign must include elements designed to encourage recipients to obtain, maintain, and use a medical home and to reduce their use of high-cost emergency department services for conditions that can be treated through primary care or nonemergency physicians or other providers. The campaign must include the dissemination of educational information through newsletters and emergency department staff members and at local health fairs, unless the department determines that these methods of dissemination are not effective in increasing recipients' appropriate use of the health care system.

(c) The department shall evaluate whether certain risk groups may disproportionately increase their appropriate use of the health care system as a result of targeted elements of an education campaign. If the department determines that certain risk groups will respond with more appropriate use of the system, the department shall develop and implement the appropriate targeted educational elements.

(d) The department shall develop a system for reviewing recipient prescription drug use and educating providers with respect to that drug use in a manner that emphasizes reducing

inappropriate prescription drug use and the possibility of adverse drug interactions.

(e) The department shall coordinate the medical assistance education campaign with area health education centers, federally qualified health centers, as defined by 42 U.S.C. Section 1396d(l)(2)(B), and other stakeholders who use public funds to educate recipients and providers about the health care system in this state. The department shall make every effort to maximize state funds by working through these partners to maximize receipt of additional federal funding for administrative and other costs.

(f) The department shall coordinate with other state and local agencies to ensure that community-based health workers, health educators, state eligibility determination employees who work in hospitals and other provider locations, and promoters are used in the medical assistance education campaign, as appropriate.

(g) The department shall ensure that all state agencies that work with recipients, all administrative persons who provide eligibility determination and enrollment services, and all service providers use the same curriculum for recipient and provider education, as appropriate.

(b) In developing the comprehensive medical assistance education campaign under Section 32.071, Human Resources Code, as added by this section, the Health and Human Services Commission shall ensure that private entities participating in the Medicaid program, including vendors providing claims administration, eligibility determination, enrollment services, and managed care services, are involved to the extent those entities' participation

is useful.

(c) The Health and Human Services Commission shall identify all funds being spent on the effective date of this section on education for Medicaid recipients. The commission shall integrate these funds into the comprehensive medical assistance education campaign under Section 32.071, Human Resources Code, as added by this section.

SECTION 10. MAXIMIZATION OF FEDERAL RESOURCES. The Health and Human Services Commission shall make every effort to maximize the receipt and use of federal health and human services resources for the office of community collaboration established under Section 531.020, Government Code, as added by this Act, and the decision support system in the commission's center for strategic decision support.

SECTION 11. IMPLEMENTATION; WAIVER. (a) The Health and Human Services Commission shall make every effort to take each action and implement each reform required by this Act as soon as possible. Except as otherwise provided by this subsection and Subsection (d) of this section, the commission shall take each action and implement each reform required by this Act not later than September 1, 2007. Any action of the commission taken to justify implementing or ignoring the reforms required by this Act must be defensible, but need not be exhaustive.

(b) Not later than December 1, 2005, the Health and Human Services Commission shall submit a report to the governor and to the presiding officers of the standing committees of the senate and house of representatives having primary jurisdiction over health

and human services that specifies the strategies the commission or an appropriate health and human services agency, as defined by Section 531.001, Government Code, will use to examine, study, evaluate, or otherwise make a determination relating to a reform or take another action required by this Act.

(c) Except as provided by Subsection (b) of this section, for each provision of this Act that requires the Health and Human Services Commission or a health and human services agency, as defined by Section 531.001, Government Code, to examine the possibility of making changes to the Medicaid program, to study an aspect of the Medicaid program, to evaluate the cost-effectiveness of a proposed reform, or to otherwise make a determination before implementing a reform, the Health and Human Services Commission shall submit a report to the governor and to the presiding officers of the standing committees of the senate and house of representatives having primary jurisdiction over health and human services that includes the criteria used and the results obtained by the commission or health and human services agency in taking the required action. The report must be delivered not later than September 1, 2007.

(d) 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.

SECTION 12. EFFECTIVE DATE. This Act takes effect

September 1, 2005.