By: Nelson S.B. No. 1188

A BILL TO BE ENTITLED

AN ACT

relating to the medical assistance and children's health insurance programs.

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 Sections 531.02113 and 531.082 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.

Sec. 531.082. ENHANCED REIMBURSEMENT RATES FOR CERTAIN MEDICAL ASSISTANCE PROVIDERS. (a) In adopting standards for rates for medical assistance payments under Chapter 32, Human Resources Code, as required by Section 531.021(b)(2), the executive commissioner shall establish a program under which providers under the medical assistance program are offered enhanced reimbursement rates in accordance with this section for implementing technological improvements or participating in other quality improvement activities.

(b) A physician, health clinic, hospital, or other provider under the medical assistance program may receive a reimbursement rate that is two percent higher than the rate for medical assistance payments that the provider would otherwise receive if the physician, clinic, hospital, or other provider uses a system by which medical records are maintained in an electronic format, rather than in the hard-copy format traditionally used by health care providers. The use of general electronic recordkeeping systems or practice management applications is not sufficient to qualify a provider for the enhanced reimbursement rate under this subsection.

(c) A physician, health clinic, hospital, or other provider

under the medical assistance program may receive a reimbursement rate that is two percent higher than the rate for medical assistance payments that the provider would otherwise receive if the physician, clinic, hospital, or other provider uses a computerized physician order-entry system for pharmaceuticals and other pharmacy orders. To be eligible for the enhanced reimbursement rate under this subsection, a provider must use a system that is designed to allow the prescribing physician to directly enter the orders into the system.

(d) A health clinic or hospital that is a provider under the medical assistance program may receive a reimbursement rate that is three percent higher than the rate for medical assistance payments that the provider would otherwise receive if the provider uses a computerized physician order-entry system described by Subsection (c) and a system by which administration of pharmaceuticals is verified electronically using bar-coded or other electronically coded pharmaceutical containers and corresponding identifiers that are affixed to the patient, including identification cards or wristbands.

(e) A physician, health clinic, hospital, or other provider under the medical assistance program may receive a reimbursement rate that is three percent higher than the rate for medical assistance payments that the provider would otherwise receive if the physician, clinic, hospital, or other provider participates in quality improvement or monitoring initiatives designated by rules adopted by the executive commissioner.

(b) 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.

(c) If the Health and Human Services Commission chooses to increase reimbursement rates for any providers under Subsection (b)(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 is 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 encounter data provided by managed care organizations under Chapter 533 in a format that allows the data to be queried across recipients, regardless of whether the recipients are receiving services under the health maintenance organization model, primary care case management model, or fee-for-service system.

(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. MEDICAID MEDICAL INFORMATION TELEPHONE HOTLINE. (a) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02131 to read as follows:

Sec. 531.02131. MEDICAID MEDICAL INFORMATION TELEPHONE HOTLINE PILOT PROGRAM. (a) In this section:

(1) "Net cost-savings" means the total projected cost of Medicaid benefits for an area served under the pilot program minus the actual cost of Medicaid benefits for the area.

(2) "Physician" means an individual licensed to practice medicine in this state or another state of the United States.

(b) In order to prevent unnecessary emergency room visits

and ensure that Medicaid recipients seek medical treatment in the most medically appropriate and cost-effective setting, the commission shall develop a Medicaid medical information telephone hotline pilot program under which physicians are available by telephone to answer medical questions and provide medical information for recipients.

(c) The commission shall select the area in which to implement the pilot program. The selected area must include:

(1) at least two counties; and

(2) not more than 100,000 Medicaid recipients, with approximately 50 percent of the recipients enrolled in a managed care program in which the recipients receive services from a health maintenance organization.

(d) The commission shall request proposals from private vendors for the operation of a telephone hotline under the pilot program. The commission may not award a contract to a vendor unless the vendor agrees to contractual terms:

(1) requiring the vendor to answer medical questions and provide medical information by telephone to recipients using only physicians;

(2) providing that 50 percent of the value of the contract is contingent on achievement of net cost-savings in the area served by the vendor; and

(3) permitting the commission to terminate the contract after a reasonable period if the vendor's services do not result in net cost-savings in the area served by the vendor.

(e) The commission shall periodically determine whether the

pilot program is resulting in net cost-savings. The commission shall discontinue the pilot program if the commission determines that the pilot program is not resulting in net cost-savings after a reasonable period.

(f) Notwithstanding any other provision of this section, the commission is not required to develop the pilot program if suitable private vendors are not available to operate the telephone hotline.

(g) The executive commissioner shall adopt rules necessary for implementation of this section.

(h) The participation of a physician in a telephone hotline that is part of a pilot program established under this section does not constitute the practice of medicine in this state.

(b) Not later than January 1, 2006, the Health and Human Services Commission shall select the counties in which the pilot program will be implemented.

(c) Not later than February 1, 2006, the Health and Human Services Commission shall request proposals from private vendors for the operation of a medical information telephone hotline. The commission shall evaluate the proposals and choose one or more vendors as soon as possible after the receipt of the proposals.

(d) Not later than January 1, 2007, the Health and Human Services Commission shall report to the governor, the lieutenant governor, and the speaker of the house of representatives regarding the pilot program required by Section 531.02131, Government Code, as added by this section. The report must include:

(1) a description of the status of the pilot program,

including whether the commission was unable to contract with a suitable vendor;

(2) if the pilot program has been implemented:

(A) an evaluation of the effects of the pilot program on emergency room visits by program participants; and

(B) a description of cost savings in the area included in the pilot program; and

(3) recommendations regarding expanding or revising the pilot program.

SECTION 5. 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 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) developing and implementing a single clearinghouse for submission of Medicaid claims;

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

(3) developing an Internet portal system for prior

authorization requests;

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

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

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

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

(A) electronic communications between patients and their physicians;

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

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

(D) inpatient computerized physician 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. 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) 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 6. 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. (a) 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) making efforts to expand the provider-base for consumer-directed services by 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;

(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; and

(4) identifying, in conjunction with the Department on Aging and Disability Services, information with respect to a recipient who resides in a nursing facility that would assist the department in placing the recipient in the community and gathering that information if doing so would improve the recipient's health or quality of life outcome.

(b) The commission shall ensure that stakeholders are educated on issues faced by caregivers providing long-term care for recipients.

Sec. 531.084. MEDICAID LONG-TERM CARE COST CONTAINMENT STRATEGIES. 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 incurred medical expenses for dental services controlled in long-term care facilities;

(2) implement a fee schedule for allowable 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 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 on 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 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.

SECTION 7. MEDICAID MANAGED CARE. (a) Section 533.005(a), Government Code, is amended to read as follows:

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

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

(2) capitation 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 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; and

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

(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) 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 pre-authorization 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) This section does not apply to a managed care organization operated by a political subdivision of this state.

(b) 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. The record must be prepared not later than the 30th day after the date the commission orders the imposition of a sanction against the organization.

(c) 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.

(d) The commission shall post and maintain the records required by this section on the commission's Internet website 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 monthly.

(e) 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.

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

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

(c) The Health and Human Services Commission and the Texas Department of Insurance shall jointly develop policies for the joint regulation of the exclusive provider organization model used in the children's health insurance program and in the primary care case management model. The policies must be developed to regulate exclusive provider organizations in a manner similar to the manner in which health maintenance organizations are regulated. In addition, the commission shall evaluate the possibility that the state is currently at risk of financial exposure to risks

associated with the exclusive provider organization model used in the children's health insurance program and in the primary care case management model and shall determine whether additional regulation by the Texas Department of Insurance is necessary.

(d) The Health and Human Services Commission shall re-evaluate 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.

(e) 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.

(f) 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 provide immunizations to Medicaid clients;

(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 meaningful 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.

(g) 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.

(h) 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 8. ENHANCED UTILIZATION MANAGEMENT SYSTEMS. (a) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Sections 32.0551, 32.0552, and 32.0553 to read as follows:

Sec. 32.0551. ENHANCED UTILIZATION MANAGEMENT SYSTEMS. (a) The department shall develop the enhanced utilization management systems required by Sections 32.0552 and 32.0553 to more effectively coordinate medical and case management services provided to recipients who do not receive services through a managed care organization to:

(1) eliminate duplication of and barriers to receiving services; and

(2) ensure the most appropriate use of services.

(b) The department shall require each managed care organization with which the department contracts under Chapter 533, Government Code, to:

(1) develop and implement enhanced utilization

management systems that are equivalent to those required under Sections 32.0552 and 32.0553; or

(2) if the managed care organization already operates enhanced utilization management systems equivalent to those required under Sections 32.0552 and 32.0553, maintain those systems.

Sec. 32.0552. ACUTE CARE ENHANCED UTILIZATION MANAGEMENT SYSTEM. (a) The department shall develop an acute care enhanced utilization management system to improve the medical outcomes for recipients receiving acute care services who do not receive those services through a managed care organization and to maximize the cost-effectiveness of the Medicaid acute care system.

(b) The department shall develop the acute care enhanced utilization management system in a manner that prioritizes recipient populations that are identified through data analysis as needing additional assistance and with respect to which the department has evidence indicating that providing focused interventions or case management may be successful in:

(1) improving the health outcomes of recipients included in those populations; and

(2) controlling costs.

(c) In developing the system, the department must appropriately acknowledge variations among the different kinds of applicable service delivery modalities while concurrently providing a consistent platform to leverage development efforts. The care coordination system for each applicable service delivery modality must be designed to ensure that care is managed for

high-cost recipients, regardless of the recipients' diagnoses.

(d) The acute care enhanced utilization management system must include:

(1) a mechanism to identify those recipients who reach a specified level of expense to the program and identify specific, medically appropriate interventions for those recipients;

(2) care coordination, case management, disease management, support services, utilization management, and other services in a single, complete system;

(3) predictive modeling applications that use health risk assessments and claims data to identify recipients with utilization patterns or complex health conditions that are likely to generate disproportionately large health care costs in the future;

(4) targeted case management programs to serve recipients who have complex conditions that are not addressed through existing treatment protocols and standardized care plans; and

(5) incentives for providers who are especially effective at managing complex or costly cases and a provider-profiling tool to monitor, measure, and report performance results at individual provider and health plan levels.

(e) The department shall consider including in the incentives for providers required under Subsection (d)(5) financial incentives in the form of increased case management fees or enhancements to the fee schedule that could be funded through cost savings achieved by the acute care enhanced utilization

management system.

(f) The department may collaborate with managed care organizations under Chapter 533, Government Code, to avoid duplication of effort and to integrate the acute care enhanced utilization management system with the disease management, care coordination, and utilization management systems used by managed care organizations under that chapter.

Sec. 32.0553. LONG-TERM CARE ENHANCED UTILIZATION MANAGEMENT SYSTEM. The department shall develop a long-term care enhanced utilization management system to provide intensive case management and care coordination for recipients receiving long-term care services who do not receive those services through a managed care organization.

(b) In developing the acute care and long-term care enhanced utilization management systems required by Sections 32.0552 and 32.0553, Human Resources Code, as added by this section, 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 conduct a study regarding the cost-effectiveness of including within Medicaid disease management programs in existence on the effective date of this section end-stage renal disease, home health services for children with chronic conditions that are not included in the existing disease management programs, the use of schools and school nurses to manage chronic conditions of children, and the inclusion of other diseases, conditions, and strategies. In studying the cost-effectiveness of including other diseases, conditions, and strategies, the commission shall review existing research and examine the experiences of other states, insurance companies, and managed care organizations.

(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. 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. TEXAS HEALTH STEPS PROGRAM. (a) Section 32.056, Human Resources Code, is amended to read as follows:

Sec. 32.056. COMPLIANCE WITH TEXAS HEALTH STEPS. (a) The executive commissioner of the Health and Human Services Commission

by rule shall develop procedures to ensure that recipients of medical assistance who are eligible for Texas Health Steps comply with the regimen of care prescribed by the Texas Health Steps program.

(b) The department, in conjunction with the Department of State Health Services, shall develop mechanisms to increase compliance with the checkup and immunization schedules of the Texas Health Steps program.

(b) Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0561 to read as follows:

Sec. 32.0561. TEXAS HEALTH STEPS PROGRAM MULTIAGENCY ENHANCEMENTS. (a) The Health and Human Services Commission, in conjunction with the health and human services agencies, as defined by Section 531.001, Government Code, shall develop a quality assurance system for the Texas Health Steps program.

(b) The Health and Human Services Commission and the Department of State Health Services shall encourage enhanced coordination and communication between providers of checkups under the Texas Health Steps program and primary care providers under the Medicaid program with regard to children involved in both programs.

(c) The Health and Human Services Commission shall facilitate the integration of Texas Health Steps program services and Medicaid primary care physicians for children involved in both programs.

(c) The Health and Human Services Commission and the Department of State Health Services shall continue to coordinate efforts to obtain approval from the Centers for Medicare and

Medicaid Services to include prenatal and family planning exams as components of Texas Health Steps program medical exams.

SECTION 10. 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 physicians or nonemergency 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 11. 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 12. 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 13. EFFECTIVE DATE. This Act takes effect September 1, 2005.