By: Zaffirini, et al. S.B. No. 1756

A BILL TO BE ENTITLED

AN ACT

relating to the managed care delivery system known as integrated care management.

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

SECTION 1. Subchapter A, Chapter 533, Section 533.001, Government Code, is amended by adding new Subsections (6), (7) and (8) to read as follows:

Sec. 533.001. DEFINITIONS. In this chapter:

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

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

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

(4) "Managed care organization" means a person who is authorized or otherwise permitted by law to arrange for or provide a managed care plan.

(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. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(6) "Medical home", for the purposes of this subchapter, means a primary care physician or health care provide with whom the patient has a continuous, ongoing professional relationship and who manages and coordinates all aspects of a patient's health care. Children or adults with special health care needs or disabilities may select a subspecialist to act as their medical home if the specialist agrees to serve in that role.

(7) "Case Management", for purposes of this subchapter, means the method of identifying, assessing, and monitoring recipients with complex, chronic or high cost health care needs and developing a plan of care to coordinate the medical and social support services needed to achieve optimum patient outcomes in a cost-effective manner.

(8) "Care Coordination", for purposes of this subchapter, means a process to link recipients with special health care needs to medical, functional and social support services and resources in a coordinated effort to maximize the potential of the recipient to achieve optimal health care, independence, and functionality.

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

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

SECTION 2. Subchapter A, Chapter 533, 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;

(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 physicians and providers who participate in the medical assistance program; and

(8) minimizes non-direct care expenditures, except those non-direct care expenditures which assure better care

outcomes.

SECTION 3. Subchapter A, Chapter 533, Section 533.025, Government Code, is amended to read as follows:

Sec. 533.0025. DELIVERY OF SERVICES. (a) In this section, "medical assistance" has the meaning assigned by Section 32.003, Human Resources Code.

(b) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide medical assistance for health [~~acute~~] care through the most cost-effective model of Medicaid managed care as determined by the commission. In any geographic area that may be affected by a Medicaid managed care model, the commission shall seek local input and shall hold a public hearing in the affected area prior to making a determination as to any Medicaid managed care model to be implemented. If the commission determines that it is more cost-effective, the commission may provide medical assistance for health [~~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.

The commissioner may not utilize a capitated risk model for health

care services for aged, blind and disabled populations.

(c) In determining whether a model or arrangement described by Subsection (b) is more cost-effective, the 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 Article 4.11, Insurance Code [~~.~~];

(5) the impact, including fiscal impact, to the medical delivery infrastructure of municipalities, counties, hospital districts or other taxing entities that provide health care or health care service for indigent or Medicaid populations; and

(6) the long term impact to the medical assistance provider network, including participation in the network by privately practicing physicians, home and community support services providers, mental health providers, and assisted living and adult daycare providers.

(d) The commissioner shall issue a public report providing his findings, determinations, evaluations and weight given to each required provision of this section and such report shall be

provided to the Governor, Lt. Governor and the Speaker of the House of Representatives.

(e) 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 in a certain area or to certain medical assistance recipients as prescribed by this section, the commission shall provide medical assistance through a traditional fee-for-service arrangement.

(f)(1) Notwithstanding Subsection (b)(1), the commission may not provide medical assistance using a health maintenance organization in Cameron County, Hidalgo County, or Maverick County[.], and

(2) shall maintain and enhance any primary care case management program in existence on January 1, 2005.

(g) In any Medicaid managed care program established after January 1, 2005, the commission shall establish a primary care case management model as one option.

SECTION 4. Subchapter A, Chapter 533, Government Code, is amended to add a new Section 533.026, to read as follows:

Section 533.026. ESTABLISHMENT OF AN INTEGRATED CARE MANAGEMENT MODEL. (a) The commission by rule shall establish an integrated care management model throughout the state.

(b) For purposes of this section, Integrated Care Management shall be established as "Integrated Care Management I" and "Integrated Care Management II".

(c) Populations to be include within "Integrated Care Management I" include:

(1) Temporary Assistance and Needy Families and Temporary and Needy Family related populations;

(2) pregnant women; and

(3) children.

(d) Populations to be included within "Integrated Care Management II" include:

(1) recipients eligible for Supplemental Security Income payments;

(2) recipients who are determined eligible for 1915(c) community based alternatives waiver services; and

(3) recipients who are dually eligible for medical assistance and Medicare.

(e) For purposes of this section, Integrated Care Management I includes:

(1) assignment of integrated care management patients to a medical home;

(2) at least quarterly patient level reporting to physicians or appropriate health care providers of the utilization and costs of health care services, including prescription drug utilization and costs, of the integrated care management populations;

(3) health risk assessment screenings for patients upon enrollment in the integrated care management program to identify patients with chronic illnesses or diseases or who are at risk of developing such illnesses or diseases and reports of the results of assessment screenings are made to the patient's medical home.

(4) coordination by the patient's medical home of support services, including home health or durable medical equipment;

(5) a mechanism for increased levels of payment for physicians or providers who establish and maintain clinics to treat patients after normal business hours as established by commission rule;

(7) case management for patients identified with chronic conditions;

(8) a mechanism to provide for increased levels of payment to providers who adhere to physician developed, evidence based, peer reviewed, clinical guidelines and performance measures;

(9) coordination of disease management, case management, and pharmacy management;

(10) a comprehensive quality management program;

(11) a mechanism to provide increased levels of payment for integrated care providers who incorporate EPSDT services into the medical home;

(12) outreach initiatives to recruit physicians and health care providers to participate; and

(13) mechanisms to assist recipients to easily identify participating physicians and health care providers, such as a list of participating providers on the Internet.

(f) For purposes this section, Integrated Care Management II includes:

(1) the services outlined in Section (d) (1)-(13);

(2) a functional needs assessment, performed in the most cost effective manner, to determine community and social support services needed by recipients;

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

(4) promotion of the Promoting Independence Initiative to identify persons wishing to leave a nursing facility and reside in the community.

(g) In developing the long term care provisions of the integrated care management model, policy development shall continue to reside within the Department of Aging and Disability Services. (THIS IS IN RESPONSE TO CONSUMER CONCERNS ABOUT FRAGMENTATION BETWEEN HHSC AND DADS).

(h) In establishing Integrated Care Management II, the commission shall limit its implementation to nine urban service delivery areas of the state. (NOT SURE HOW TO DEFINE THE AREAS THAT WOULD HAVE BEEN INCLUDED IN STAR+PLUS HMO EXPANSION-Houston, Galveston, Nueces, Travis, Bexar, Lubbock, El Paso, Dallas, Tarrant)

(i) The commissioner shall contract for technological support and care coordination necessary to assure proper utilization of services and cost effective outcomes. The contracted tools of care management should enhance the ability of the integrated care management provider to be effective and responsive in making treatment decisions. The commissioner may amend contracts or enter into new contracts with existing

contractors to perform the services required by this subsection. In contracting, the commissioner shall take into account the effect on the physicians and health care providers who will utilize the system and make every reasonable attempt to minimize any administrative burden on the physicians and health care providers within the program.

(j) The commissioner shall establish an advisory committee to assist in the development of the integrated care management model. The commission shall consult with the advisory committee during the development of the model and before and during any rule making relating to the model. The members shall serve without compensation. The committee is not subject to Chapter 551, Government Code. The advisory committee shall establish one subcommittee to address the specific medical and community support services of children with complex or special health care needs and one subcommittee to address the medical and community support services of adults with complex or special health care needs. The advisory committee may establish other subcommittees, as necessary, to address operational and design issues relating to Integrated Care Management implementation. Any subcommittee members shall serve without compensation. Members of the advisory committee shall include:

(1) six practicing primary care physicians drawn from geographically different areas of the state, including at least two with experience practicing under a primary care management program;

(2) three specialty care physicians;

(3) one representative of a Federally Qualified Health

Center;

(4) one representative of a Rural Health Clinic;

(5) one hospital representative;

(6) two home care providers; and

(7) two consumer representatives.

(k) The commissioner shall establish a regional advisory committee to assist in the development and implementation of the model in each geographic area encompassed by the model. Members of the regional advisory committee shall be drawn from the geographic area covered by the model and shall include the same categories or representatives as specified in Subsection (f) of this section. The committee is not subject to Chapter 551, Government Code.

(l) Not later than January 5th, 2007, the commission shall submit to the Legislative Budget Board, the Lt. Governor and the Speaker of the House of Representatives a preliminary report containing the findings of the implementation of the integrated care management program and the commission's recommendations for further improvements of the model. The report shall include patient and provider satisfaction, patient access to primary and specialty care services, patient outcomes and health status improvement, cost savings and cost impact to local funding entities.

SECTION 5. Subchapter A, Chapter 533, Government Code, is amended to add a new Section 533.027, to read as follows:

Section 533.027. EFFECTIVENESS OF AN INTEGRATED CARE MANAGEMENT MODEL. (a) In determining whether integrated care management achieves cost savings, the commission shall consider the

following:

(1) savings achieved through the continuation of disease management; and

(2) increased utilization of home and community based services instead of more expensive institutional care.

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

SECTION 6. 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.