Amend Amendment No. 88 by Zerwas to **CSSB 1** (page 253, prefiled amendment packet) by striking lines 6 through 7 and substituting the following:

SECTION ____.01. (a) Subsection (e), Section 533.0025, Government Code, is amended to read as follows:

(e) The commission shall determine the most cost-effective alignment of managed care service delivery areas. The commissioner may consider the number of lives impacted, the usual source of health care services for residents in an area, and other factors that impact the delivery of health care services in the area. [~~Notwithstanding Subsection (b)(1), the commission may not provide medical assistance using a health maintenance organization in Cameron County, Hidalgo County, or Maverick County.~~]

(b) Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.0027, 533.0028, and 533.0029 to read as follows:

Sec. 533.0027. PROCEDURES TO ENSURE CERTAIN RECIPIENTS ARE ENROLLED IN SAME MANAGED CARE PLAN. The commission shall ensure that all recipients who are children and who reside in the same household may, at the family's election, be enrolled in the same managed care plan.

Sec. 533.0028. EVALUATION OF CERTAIN STAR + PLUS MEDICAID MANAGED CARE PROGRAM SERVICES. The external quality review organization shall periodically conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to enrollees in the STAR + PLUS Medicaid managed care program who are eligible to receive health care benefits under both the Medicaid and Medicare programs.

Sec. 533.0029. PROMOTION AND PRINCIPLES OF PATIENT-CENTERED MEDICAL HOMES FOR RECIPIENTS. (a) For purposes of this section, a "patient-centered medical home" means a medical relationship:

(1) between a primary care physician and a child or adult patient in which the physician:

(A) provides comprehensive primary care to the patient; and

(B) facilitates partnerships between the

physician, the patient, acute care and other care providers, and, when appropriate, the patient's family; and

(2) that encompasses the following primary principles:

(A) the patient has an ongoing relationship with the physician, who is trained to be the first contact for the patient and to provide continuous and comprehensive care to the patient;

(B) the physician leads a team of individuals at the practice level who are collectively responsible for the ongoing care of the patient;

(C) the physician is responsible for providing all of the care the patient needs or for coordinating with other qualified providers to provide care to the patient throughout the patient's life, including preventive care, acute care, chronic care, and end-of-life care;

(D) the patient's care is coordinated across health care facilities and the patient's community and is facilitated by registries, information technology, and health information exchange systems to ensure that the patient receives care when and where the patient wants and needs the care and in a culturally and linguistically appropriate manner; and

(E) quality and safe care is provided.

(b) The commission shall, to the extent possible, work to ensure that managed care organizations:

(1) promote the development of patient-centered medical homes for recipients; and

(2) provide payment incentives for providers that meet the requirements of a patient-centered medical home.

(c) Section 533.003, Government Code, is amended to read as follows:

Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. In awarding contracts to managed care organizations, the commission shall:

(1) give preference to organizations that have significant participation in the organization's provider network from each health care provider in the region who has traditionally

provided care to Medicaid and charity care patients;

(2) give extra consideration to organizations that agree to assure continuity of care for at least three months beyond the period of Medicaid eligibility for recipients;

(3) consider the need to use different managed care plans to meet the needs of different populations; [~~and~~]

(4) consider the ability of organizations to process Medicaid claims electronically; and

(5) in the initial implementation of managed care in the South Texas service region, give extra consideration to an organization that either:

(A) is locally owned, managed, and operated, if one exists; or

(B) is in compliance with the requirements of Section 533.004.

(d) Section 533.005, Government Code, is amended by amending Subsection (a) and adding Subsection (a-1) 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 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;

(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;

(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;

(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; [~~and~~]

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal; and

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider;

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals

in the region where the organization provides health care services;

(20) a requirement that the managed care organization develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to:

(A) preventive care;

(B) primary care;

(C) specialty care;

(D) after-hours urgent care; and

(E) chronic care;

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that:

(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types; and

(iii) providers located throughout the region where the organization will provide health care services; and

(C) health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care; and

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information

Set (HEDIS) measures;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse.

(e) Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0066 to read as follows:

Sec. 533.0066. PROVIDER INCENTIVES. The commission shall, to the extent possible, work to ensure that managed care organizations provide payment incentives to health care providers in the organizations' networks whose performance in promoting recipients' use of preventive services exceeds minimum established standards.

(f) Section 533.0071, Government Code, is amended 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 or is covered by another liable third party insurer;

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

(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) promoting 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; and

(E) providing a single portal through which providers in any managed care organization's provider network may submit claims; and

(5) reserve the right to amend the managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process established by the commission for final determination of these disputes.

(g) Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0073 to read as follows:

Sec. 533.0073. MEDICAL DIRECTOR QUALIFICATIONS. A person who serves as a medical director for a managed care plan must be a physician licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

SECTION ____.02. If before implementing any provision of this article 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.