BILL ANALYSIS

Senate Research Center

C.S.S.B. 23
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Finance
4/19/2011
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

C.S.S.B. 23 makes statutory changes to implement the various cost savings and efficiencies identified by the Finance Subcommittee on Medicaid.

The cost savings and efficiencies are achieved by carving prescription drugs into Medicaid managed care; transferring children in the State Kids Insurance Program to the Children's Health Insurance Program, allowing the state to leverage federal matching funds while maintaining current services; eliminating the existing electronic finger imaging requirement for the Supplemental Nutrition Assistance Program and requiring the Health and Human Services Commission to implement cost-effective technology to prevent duplicative benefits; removing the Health Opportunity Pool as a beneficiary of proceeds from the adult entertainment fee; repealing the current prohibition against managed care in South Texas; implementing electronic visit verification technology in community care programs; preventing over-utilization of waiver services; implementing an objective client assessment process for acute nursing services; and ensuring that waiver consumers receive their personal attendant services through a Medicaid state plan program first.

C.S.S.B. 23 amends current law relating to efficiency, cost-saving, fraud prevention, and funding measures for certain health and human services and health benefits programs, including the medical assistance and child health plan programs.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (HHSC) in SECTION 2 (Section 531.02181, Government Code), SECTION 3 (Section 531.02417, Government Code), and SECTION 10 of this bill.

Rulemaking authority previously granted to HHSC is modified in SECTION 4 (Section 32.046, Human Resources Code) of this bill.

Rulemaking authority previously granted to the board of trustees of the Employees Retirement System of Texas is rescinded in SECTION 5 of this bill.

Rulemaking authority previously granted to HHSC is rescinded in SECTION 6 (Section 31.0325, Human Resources Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. SEXUAL ASSAULT PROGRAM FUND; FEE IMPOSED ON CERTAIN SEXUALLY ORIENTED BUSINESSES. (a) Amends Section 102.054, Business & Commerce Code, as follows:

> Sec. 102.054. New heading: ALLOCATION OF REVENUE FOR SEXUAL ASSAULT PROGRAMS. Requires the comptroller of public accounts (comptroller) to deposit the amount received from the fee imposed under this subchapter to the credit of the sexual assault program fund, rather than requiring the comptroller to deposit the first $25 million received from the fee imposed

under this subchapter in a state fiscal biennium to the credit of the sexual assault program fund.

(b) Requires the comptroller of public accounts to collect the fee imposed under Section 102.052 (Fee Based on Admissions; Records), Business & Commerce Code, until a court, in a final judgment upheld on appeal or no longer subject to appeal, finds Section 102.025, Business & Commerce Code, or its predecessor statute to be unconstitutional.

(c) Repealer: Section 102.055 (Allocation of Additional Revenue), Business & Commerce Code.

(d) Provides that this section prevails over any other Act of the 82nd Legislature, Regular Session, 2011, regardless of the relative dates of enactment, that purports to amend or repeal Subchapter B (Fee Imposed On Certain Sexually Oriented Businesses), Chapter 102 (Sexually Oriented Businesses), Business & Commerce Code, or any provision of Chapter 1206 (H.B. No. 1751), Acts of the 80th Legislature, Regular Session, 2007.

SECTION 2. ACCESS TO CERTAIN LONG-TERM CARE SERVICES AND SUPPORTS UNDER MEDICAID PROGRAM. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02181, as follows:

Sec. 531.02181. PROVISION AND COORDINATION OF CERTAIN ATTENDANT CARE SERVICES. (a) Requires the Health and Human Services Commission (HHSC) to ensure that recipients who are eligible to receive attendant care services under the community-based alternatives program are first provided those services, if available, under a Medicaid state plan program, including the primary home care and community attendant services programs. Authorizes HHSC to allow a recipient to receive attendant care services under the community-based alternatives program only if:

(1) the recipient requires services beyond those that are available under a Medicaid state plan program; or

(2) the services are not otherwise provided under a Medicaid state plan program.

(b) Requires the executive commissioner of HHSC (executive commissioner) to adopt rules and procedures necessary to implement this section, including:

(1) rules and procedures for the coordination of services between Medicaid state plan programs and the community-based alternatives program to ensure that recipients' needs are being met and to prevent duplication of services;

(2) rules and procedures for an automated authorization system through which case managers authorize the provision of attendant care services through the Medicaid state plan program or the community-based alternatives program, as appropriate, and register the number of hours authorized through each program; and

(3) billing procedures for attendant care services provided through the Medicaid state plan program or the community-based alternatives program, as appropriate.

(b) Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.0515, as follows:

Sec. 531.0515. RISK MANAGEMENT CRITERIA FOR CERTAIN WAIVER PROGRAMS. (a) Defines, in this section, "legally authorized representative."

(b) Requires HHSC to consider developing risk management criteria under home and community-based services waiver programs designed to allow individuals eligible to receive services under the programs to assume greater choice and responsibility over the services and supports the individuals receive.

(c) Requires HHSC to ensure that any risk management criteria developed under this section include:

(1) a requirement that if an individual to whom services and supports are to be provided has a legally authorized representative, the representative must be involved in determining which services and supports the individual will receive; and

(2) a requirement that if services or supports are declined, the decision to decline must be clearly documented.

(c) Amends Section 533.0355, Health and Safety Code, by adding Subsection (h), as follows:

(h) Requires the Department of Aging and Disability Services (DADS) to ensure that local mental retardation authorities are informing and counseling individuals and their legally authorized representatives, if applicable, about all program and service options for which the individuals are eligible in accordance with Section 533.038(d), including options such as the availability and types of ICF-MR placements for which an individual may be eligible while the individual is on a DADS interest list or other waiting list for other services.

(d) Amends Subchapter D, Chapter 161, Human Resources Code, by adding Sections 161.084 and 161.085, as follows:

Sec. 161.084. MEDICAID SERVICE OPTIONS PUBLIC EDUCATION INITIATIVE. (a) Defines in this section, "Section 1915(c) waiver program."

(b) Requires DADS, in cooperation with HHSC, to educate the public on:

(1) the availability of home and community-based services under a Medicaid state plan program, including the primary home care and community attendant services programs, and under a Section 1915(c) waiver program; and

(2) the various service delivery options available under the Medicaid program, including the consumer direction models available to recipients under Section 531.051 (Consumer Direction of Certain Services for Persons With Disabilities and Elderly Persons), Government Code.

(c) Requires DADS to coordinate the activities under this section with any other related activity.

Sec. 161.085. INTEREST LIST REPORTING. Requires DADS to post on DADS's Internet website historical data, categorized by state fiscal year, on the percentages of individuals who elect to receive services under a program for which DADS maintains an interest list once their names reach the top of the list.

(e) Requires the executive commissioner of HHSC (executive commissioner), as soon as practicable after the effective date of this Act,

to apply for and actively pursue, from the federal Centers for Medicare and Medicaid Services or any other appropriate federal agency, amendments to the community living assistance and support services waiver and the home and community-based services program waiver granted under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) to authorize the provision of personal attendant services through the programs operated under those waivers.

SECTION 3. OBJECTIVE ASSESSMENT PROCESSES FOR CERTAIN MEDICAID SERVICES. (a) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02417, 531.024171, and 531.024172, as follows:

Sec. 531.02417. MEDICAID NURSING SERVICES ASSESSMENTS. (a) Defines, in this section, "acute nursing services."

(b) Requires HHSC to develop an objective assessment process for use in assessing a Medicaid recipient's needs for acute nursing services. Requires HHSC to require that:

(1) the assessment be conducted by a state employee or contractor who is not the person who will deliver any necessary services to the recipient and is not affiliated with the person who will deliver those services; and in a timely manner so as to protect the health and safety of the recipient by avoiding unnecessary delays in service delivery; and

(2) the process include: an assessment of specified criteria and documentation of the assessment results on a standard form; an assessment of whether the recipient should be referred for additional assessments regarding the recipient's needs for therapy services, as defined by Section 531.024171, attendant care services, and durable medical equipment; and completion by the person conducting the assessment of any documents related to obtaining prior authorization for necessary nursing services.

(c) Requires HHSC to:

(1) implement the objective assessment process developed under Subsection (b) within the Medicaid fee-for-service model and the primary care case management Medicaid managed care model; and

(2) take necessary actions, including modifying contracts with managed care organizations under Chapter 533 to the extent allowed by law, to implement the process within the STAR and STAR + PLUS Medicaid managed care programs.

(d) Requires the executive commissioner to adopt rules providing for a process by which a provider of acute nursing services who disagrees with the results of the assessment conducted under Subsection (b) may request and obtain a review of those results.

Sec. 531.024171. THERAPY SERVICES ASSESSMENTS. (a) Defines in this section, "therapy services."

(b) Requires HHSC, after implementing the objective assessment process for acute nursing services as required by Section 531.02417, to consider whether implementing an objective assessment process for assessing the needs of a Medicaid recipient for therapy services that is comparable to the process required under Section 531.02417 for acute nursing services would be feasible and beneficial.

(c) Authorizes HHSC, if HHSC determines that implementing a comparable process with respect to one or more types of therapy services is feasible and would be beneficial, to implement the process within:

(1) the Medicaid fee-for-service model;

(2) the primary care case management Medicaid managed care model; and

(3) the STAR and STAR + PLUS Medicaid managed care programs.

(d) Requires that an objective assessment process implemented under this section include a process that allows a provider of therapy services to request and obtain a review of the results of an assessment conducted as provided by this section that is comparable to the process implemented under rules adopted under Section 531.02417(d).

Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM. (a) Defines in this section, "acute nursing services."

(b) Requires HHSC, if it is cost-effective and feasible, to implement an electronic visit verification system to electronically verify and document, through a telephone or computer-based system, basic information relating to the delivery of Medicaid acute nursing services, including the provider's name; the recipient's name; and the date and time the provider begins and ends each service delivery visit.

(b) Requires HHSC, not later than September 1, 2012, to implement the electronic visit verification system required by Section 531.024172, Government Code, as added by this section, if HHSC determines that implementation of that system is cost-effective and feasible.

SECTION 4. ACCESS TO MEDICALLY NECESSARY PRESCRIPTION DRUGS UNDER MEDICAID MANAGED CARE PROGRAM. (a) Amends Section 533.005(a), Government Code, as follows:

(a) Requires that a contract between a managed care organization and HHSC for the organization to provide health care services to recipients certain provisions including that it contain a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients that exclusively employs the vendor drug program formulary or a more cost-effective alternative approved by the commissioner of HHSC; complies with the preferred drug list prior authorization policies and procedures adopted by HHSC under Chapter 531 (Health and Human Services Commission) or a more cost-effective alternative approved by the commissioner of HHSC includes rebates negotiated by the managed care organization with a manufacturer or labeler as defined by Section 531.070, except that a managed care organization may not negotiate or obtain a rebate with respect to a product for which HHSC has negotiated or obtained a supplemental rebate; and complies with Section 531.089 (Certain Medication for Sex Offenders Prohibited).

(b) Amends Chapter 533, Government Code, by adding Subchapter E, as follows:

SUBCHAPTER E. MEDICAID MANAGED CARE PRESCRIPTION DRUG COVERAGE

Sec. 533.081. DEFINITIONS. Defines, in this subchapter, "step therapy protocol" or "fail first protocol."

Sec. 533.082. APPLICABILITY OF SUBCHAPTER. Provides that this subchapter applies to a managed care organization that contracts with HHSC under this chapter to provide a managed care plan under the Medicaid program, regardless of the Medicaid managed care model or arrangement through which that plan is provided.

Sec. 533.083. ESTABLISHMENT OF CERTAIN DRUG PROTOCOLS. Authorizes HHSC to allow a managed care organization to establish for purposes of the managed care plan offered by the organization a step therapy protocol or fail first protocol only under the following conditions:

(1) for a prescription drug restricted by the protocol, the organization must provide to the prescribing physician a clear and convenient process for expeditiously requesting from the organization an override of the restriction;

(2) the organization shall grant an override requested using the process required by Subdivision (1) not later than 24 hours after the request is made if the requesting physician can demonstrate that the treatment required under the protocol has previously been ineffective in treating the enrollee's condition; is expected to be ineffective based on the known relevant physical or mental characteristics of the enrollee and known characteristics of the drug regimen; or will cause or will likely cause an adverse reaction or other physical harm to the enrollee; and

(3) the treatment provided in accordance with the protocol is required to be provided for not more than 14 days if, on the expiration of that period, the prescribing physician deems the treatment under the protocol to be clinically ineffective for the enrollee.

(c) Amends Section 32.046(a), Human Resources Code, to require HHSC to adopt rules governing sanctions and penalties that apply to a provider in the vendor drug program or enrolled as a network pharmacy provider of a managed care organization or its subcontractor who submits an improper claim for reimbursement under the program.

SECTION 5. ABOLISHING STATE KIDS INSURANCE PROGRAM. (a) Amends Section 62.101, Health and Safety Code, by adding Subsection (a-1), as follows:

(a-1) Provides that a child who is the dependent of an employee of an agency of this state and who meets the requirements of Subsection (a) (relating to eligibility for health benefits coverage) may be eligible for health benefits coverage in accordance with 42 U.S.C. Section 1397jj(b)(6) and any other applicable law or regulations.

(b) Repealer: Sections 1551.159 (Coverage for Certain Dependent Children of Employees) and 1551.312 (Amount of State Contribution for Certain Dependent Children), Insurance Code.

(c) Provides that the State Kids Insurance Program operated by the Employees Retirement System of Texas (ERS) is abolished on the effective date of this Act. Prohibits the board of trustees of the system from providing dependent child coverage under the program after the first annual open enrollment period that begins under the employee group benefits program after the effective date of this Act.

(d) Requires HHSC, in cooperation with ERS, to establish a process to ensure the automatic enrollment of eligible children in the child health plan program established under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code, on or before the date those children are scheduled to stop receiving dependent child coverage under the State Kids Insurance Program, as provided by Subsection (c) of this section. Requires HHSC to modify any applicable administrative

procedures to ensure that children described by this subsection maintain continuous health benefits coverage while transitioning from enrollment in the State Kids Insurance Program to enrollment in the child health plan program.

SECTION 6. PREVENTION OF CRIMINAL OR FRAUDULENT CONDUCT BY CERTAIN FACILITIES, PROVIDERS, AND RECIPIENTS. (a) Amends Section 31.0325(a), Human Resources Code, as follows:

Sec. 31.0325. New heading: FRAUD PREVENTION PROGRAM. Deletes existing Subsection (a) designation. Requires HHSC, rather than requiring HHSC by rule, in conjunction with other appropriate agencies, to develop and implement a program to prevent welfare fraud by using cost-effective technology to:

(1) confirm the identity of adult and teen parent applicants for and adult and teen parent recipients of financial assistance under this chapter or supplemental nutrition assistance under Chapter 33; and

(2) prevent the provision of duplicate benefits to a person under the financial assistance program or under the Supplemental Nutrition Assistance Program, as applicable.

Deletes existing text requiring HHSC by rule, in conjunction with other appropriate agencies, to develop a program to prevent welfare fraud by using a type of electronic fingerprint-imaging or photo-imaging of adult and teen parent applicants for and adult and teen parent recipients of financial assistance under this chapter or food stamp benefits under Chapter 33.

Deletes existing Subsection (b) requiring HHSC, in adopting rules under this section, to provide for an exemption from the electronic imaging requirements of Subsection (a) for a person who is elderly or disabled if HHSC determines that compliance with those requirements would cause an undue burden to the person; establish criteria for an exemption under Subdivision (1); and ensure that any electronic imaging performed by HHSC is strictly confidential and is used only to prevent fraud by adult and teen parent recipients of financial assistance or food stamp benefits.

Deletes existing Subsection (c) requiring HHSC to establish the program in conjunction with an electronic benefits transfer program; use an imaging system; and provide for gradual implementation of this section by selecting specific counties or areas of the state as test sites.

Deletes existing Subsection (d) requiring HHSC, each fiscal quarter, to submit to the governor and the legislature a report on the status and progress of the programs in the test sites selected under Subsection (c)(3).

(b) Requires HHSC to make reasonable efforts to ensure the prevention of criminal or fraudulent conduct by health care facilities and providers, including facilities and providers under the Medicaid program, and recipients of benefits under programs administered by HHSC.

SECTION 7. STREAMLINING OF AND UTILIZATION MANAGEMENT IN MEDICAID LONG-TERM CARE WAIVER PROGRAMS. (a) Redesignates Section 161.077, Human Resources Code, as added by Chapter 759 (S.B. 705), Acts of the 81st Legislature, Regular Session, 2009, as Section 161.081, Human Resources Code, and amends it, as follows:

Sec. 161.081. New heading: LONG-TERM CARE MEDICAID WAIVER PROGRAMS: STREAMLINING AND UNIFORMITY. Redesignates existing Subsection 161.077 as Subsection 161.081. (a) Defines, in this section, "Section 1915(c) waiver program."

(b) Requires DADS, in consultation with HHSC, to streamline the administration of and delivery of services through Section 1915(c) waiver programs. Authorizes DADS, in implementing this subsection, subject to Subsection (c), to consider implementing the following streamlining initiatives:

(1)-(5) Makes no changes to these subdivisions;

(6) if feasible, concurrently conducting program certification and billing audit and review processes and other related audit and review processes; streamlining other billing and auditing requirements; eliminating duplicative responsibilities with respect to the coordination and oversight of individual care plans for persons receiving waiver services; and streamlining cost reports and other cost reporting processes; and

(7) any other initiatives that will increase efficiencies in the programs.

Makes a nonsubstantive change.

(c) Requires DADS to ensure that actions taken under Subsection (b), rather than this section, do not conflict with any requirements of HHSC under Section 531.0218, Government Code.

(d) Requires DADS and HHSC to jointly explore the development of uniform licensing and contracting standards that would:

(1) apply to all contracts for the delivery of Section 1915(c) waiver program services;

(2) promote competition among providers of those program services; and

(3) integrate with other department and commission efforts to streamline and unify the administration and delivery of the program services, including those required by this section or Section 531.0218, Government Code.

(b) Amends Subchapter D, Chapter 161, Human Resources Code, by adding Section 161.082, as follows:

Sec. 161.082. LONG-TERM CARE MEDICAID WAIVER PROGRAMS: UTILIZATION REVIEW. (a) Defines, in this section, "Section 1915(c) waiver program."

(b) Requires DADS to perform a utilization review of services in all Section 1915(c) waiver programs. Requires that the utilization review include reviewing program recipients' levels of care and any plans of care for those recipients that exceed service level thresholds established in the applicable waiver program guidelines.

SECTION 8. ELECTRONIC VISIT VERIFICATION SYSTEM FOR MEDICAID PROGRAM. Amends Subchapter D, Chapter 161, Human Resources Code, by adding Section 161.086, as follows:

Sec. 161.086. ELECTRONIC VISIT VERIFICATION SYSTEM. Requires DADS, if it is cost-effective, to implement an electronic visit verification system under appropriate programs administered by DADS under the Medicaid program that allows providers to

electronically verify and document basic information relating to the delivery of services, including:

(1) the provider's name;

(2) the recipient's name;

(3) the date and time the provider begins and ends the delivery of services; and

(4) the location of service delivery.

SECTION 9. REPORT ON LONG-TERM CARE SERVICES. (a) Defines, in this section, "long-term care services," "medical assistance program," and "nursing facility."

(b) Requires HHSC, in cooperation with DADS, to prepare a written report regarding individuals who receive long-term care services in nursing facilities under the medical assistance program. Requires that the report use existing data and information to identify:

(1) the reasons medical assistance recipients of long-term care services are placed in nursing facilities as opposed to being provided long-term care services in home or community-based settings;

(2) the types of medical assistance services recipients residing in nursing facilities typically receive and where and from whom those services are typically provided;

(3) the community-based services and supports available under a Medicaid state plan program, including the primary home care and community attendant services programs, or under a medical assistance waiver granted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) for which recipients residing in nursing facilities may be eligible; and

(4) ways to expedite recipients' access to community-based services and supports identified under Subdivision (3) of this subsection for which interest lists or other waiting lists exist.

(c) Requires HHSC, not later than September 1, 2012, to submit the report described by Subsection (b) of this section, together with HHSC's recommendations, to the governor, the Legislative Budget Board, the Senate Committee on Finance, the Senate Committee on Health and Human Services, the House Appropriations Committee, and the House Human Services Committee. Requires that the recommendations address options for expediting access to community-based services and supports by recipients described by Subsection (b)(3) of this section.

SECTION 10. REGULATION AND OVERSIGHT OF CERTAIN FACILITIES AND CARE PROVIDERS. (a) Defines, in this section, "executive commissioner."

(b) Authorizes the executive commissioner to adopt rules designed to:

(1) enhance the quality of services provided by certain community-based services agencies through:

(A) the adoption of minimum standards, additional training requirements, and other similar means; and

(B) the imposition of additional oversight requirements and limitations on those agencies and home and community support services agency administrators, and the prescribing of the duties and responsibilities of those administrators.

(c) Authorizes the executive commissioner to adopt rules relating to nursing institutions regarding application requirements for an initial or renewal license under Chapter 242 (Convalescent and Nursing Homes and Related Institutions), Health and Safety Code, that are designed to evaluate the applicant's compliance with applicable laws.

(d) Authorizes the executive commissioner to adopt rules designed to prevent criminal or fraudulent conduct by facilities and providers engaged in the provision of health and human services in this state, including rules providing for reviewing criminal history information.

(e) Authorizes DADS, through rules adopted by the executive commissioner, to implement strategies designed to enhance adult day-care facilities' compliance with applicable laws and regulations.

SECTION 11. ACCOUNTABILITY AND STANDARDS UNDER MEDICAID MANAGED CARE PROGRAM. (a) Amends Section 533.002, Government Code, as follows:

Sec. 533.002. PURPOSE. Requires HHSC to implement the Medicaid managed care program as part of the health care delivery system developed under former Chapter 532 as it existed on August 31, 2001, by contracting with managed care organizations in a manner that, to the extent possible:

(1)-(6) Makes no changes to these subdivisions.

(b) Amends Section 533.0025, Government Code, by amending Subsection (e) and adding Subsection (f) to read as follows:

(e) Requires the executive commissioner, in the expansion of the health maintenance organization model of Medicaid managed care into South Texas, to determine the most effective alignment of managed care service delivery areas for each model of managed care in Duval, Hidalgo, Jim Hogg, Cameron, Maverick, McMullen, Starr, Webb, Willacy, and Zapata Counties. Requires the executive commissioner in developing the service delivery areas for each managed care model, to consider the number of lives impacted, the usual source of health care services for residents of these counties, and other factors that impact the delivery of health care services in this 10-county area.

(f) Requires that the managed care organizations that operate within the 10-county South Texas service delivery area maintain a medical director within the service delivery area. Authorizes the medical director to be a managed care organization employee or under contract with the managed care organization. Requires that the duties of the medical director in the service delivery area include oversight and management of the managed care organization medical necessity determination process. Requires the managed care organization medical director to be available for peer-to-peer discussions about managed care organization medical necessity determinations and other managed care organization clinical policies. Prohibits the managed care organization medical director from being affiliated with any hospital, clinic, or other health care related institution or business that operates within the service delivery area.

Deletes existing text prohibiting HHSC, notwithstanding Subsection (b)(1) (relating to the health maintenance organization model), from providing medical assistance using a health maintenance organization in Cameron County, Hidalgo County, or Maverick County.

(c) Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.0027, 533.0028, and 533.0029, as follows:

Sec. 533.0027. PROCEDURES TO ALLOW CERTAIN CHILDREN TO CHANGE MANAGED CARE PLANS. Requires HHSC to ensure that all children who reside in the same household may, at the family's election, be enrolled in the same health plan.

Sec. 533.0028. EVALUATION OF CERTAIN MEDICAID STAR + PLUS MANAGED CARE PROGRAM SERVICES. Requires the external quality review organization to periodically conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to enrollees in the Medicaid Star + Plus 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) Defines, for purposes of this section, a "patient-centered medical home."

(b) Requires HHSC, to the extent possible, to work to ensure that managed care organizations promote the development of patient-centered medical homes for recipients; and provide payment incentives for providers that meet the requirements of a patient-centered medical home.

(d) Amends Section 533.003, Government Code, as follows:

Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. (a) Creates this subsection from existing text. Requires HHSC, in awarding contracts to managed care organizations, to:

(1)-(4) Makes no changes to these subdivisions; and

(5) give extra consideration in each service delivery area to an organization that is locally owned, managed, and operated, if one exists; and notwithstanding Section 533.004 or any other law, is not owned or operated by and does not have a contract, agreement, or other arrangement with a hospital district in the region.

(b) Provides that for purposes of this section, a managed care organization is considered to be locally owned if the organization is formed under the laws of this state and is headquartered in and operates in, and the majority of whose staff resides in, the region where the organization provides health care services.

(e) Amends Section 533.005(a), Government Code, as follows:

(a) Requires that a contract between a managed care organization and HHSC for the organization to provide health care services to recipients contain:

(1)-(3) Makes no changes to these subdivisions;

(4) subject to Subdivision (17), 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)-(14) Makes no changes to these subdivisions;

(15) subject to Subdivision (17), 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 tracking mechanism to document the status and final disposition of each

provider's claims payment appeal; 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 the determination of the physician resolving the dispute to be binding on the managed care organization and provider;

(16) a requirement that the managed care organization ensure that employees of the organization who hold management positions, including patient-care coordinators and provider and recipient support services personnel, are located in the region where the organization provides health care services;

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

(18) 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;

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

(20) a requirement that the managed care organization develop and submit to HHSC, 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 preventive care; primary care; specialty care; after-hours urgent care; and chronic care;

(21) a requirement that the managed care organization demonstrate to HHSC, before the organization begins to provide health care services to recipients, that 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; the organization's provider network includes a sufficient number of primary care providers, a sufficient variety of provider types, and providers located throughout the region where the organization will provide health care services; and health care services will be accessible to recipients through the organization's provider network to the same 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 incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures focuses on measuring outcomes; and 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.

(f) Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.0066, as follows:

Sec. 533.0066. PROVIDER INCENTIVES. Requires HHSC, to the extent possible, to 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.

(g) Amends Section 533.0071, Government Code, as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. Requires HHSC, to improve the administration of these contracts, to:

(1)-(3) Makes no changes to these subdivisions;

(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, 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; allowing managed care organizations to provide updated address information directly to the commission for correction in the state system; 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; 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 providing a single portal through which providers in any managed care organization's provider network may submit claims and prior authorization requests and obtain information; and

(5) Makes no changes to this subdivision.

SECTION 12. FEDERAL AUTHORIZATION. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 13. REPORT TO LEGISLATURE. Requires HHSC, not later than December 1, 2013, to submit a report to the legislature regarding HHSC's work to ensure that Medicaid managed care organizations promote the development of patient-centered medical homes for recipients of medical assistance as required under Section 533.0029, Government Code, as added by this Act.

SECTION 14. CONTRACTING REQUIREMENTS. Requires HHSC, in a contract between HHSC and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act, to include the provisions required by Subsection (a), Section 533.005, Government Code, as amended by this Act.

SECTION 15. Effective date: September 1, 2011.