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S.B. No. 23

A BILL TO BE ENTITLED

AN ACT

1
2 relating to efficiency, cost-saving, fraud prevention, and funding
3 measures for certain health and human services and health benefits
4 programs, including the medical assistance and child health plan
5 programs.

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

7 SECTION 1. SEXUAL ASSAULT PROGRAM FUND; FEE IMPOSED ON
8 CERTAIN SEXUALLY ORIENTED BUSINESSES. (a) Section 102.054,
9 Business & Commerce Code, is amended to read as follows:

10 Sec. 102.054. ALLOCATION OF [~~CERTAIN~~] REVENUE FOR SEXUAL
11 ASSAULT PROGRAMS. The comptroller shall deposit the amount [~~first~~
12 ~~\$25 million~~] received from the fee imposed under this subchapter
13 [~~in a state fiscal biennium~~] to the credit of the sexual assault
14 program fund.

15 (b) The comptroller of public accounts shall collect the fee
16 imposed under Section 102.052, Business & Commerce Code, until a
17 court, in a final judgment upheld on appeal or no longer subject to
18 appeal, finds Section 102.052, Business & Commerce Code, or its
19 predecessor statute, to be unconstitutional.

20 (c) Section 102.055, Business & Commerce Code, is repealed.

21 (d) This section prevails over any other Act of the 82nd
22 Legislature, Regular Session, 2011, regardless of the relative
23 dates of enactment, that purports to amend or repeal Subchapter B,
24 Chapter 102, Business & Commerce Code, or any provision of Chapter

1 1206 (H.B. No. 1751), Acts of the 80th Legislature, Regular
2 Session, 2007.

3 SECTION 2. ACCESS TO CERTAIN LONG-TERM CARE SERVICES AND
4 SUPPORTS UNDER MEDICAID PROGRAM. (a) Subchapter B, Chapter 531,
5 Government Code, is amended by adding Section 531.02181 to read as
6 follows:

7 Sec. 531.02181. PROVISION AND COORDINATION OF CERTAIN
8 ATTENDANT CARE SERVICES. (a) The commission shall ensure that
9 recipients who are eligible to receive attendant care services
10 under the community-based alternatives program are first provided
11 those services, if available, under a Medicaid state plan program,
12 including the primary home care and community attendant services
13 programs. The commission may allow a recipient to receive
14 attendant care services under the community-based alternatives
15 program only if:

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

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

20 (b) The executive commissioner shall adopt rules and
21 procedures necessary to implement this section, including:

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

26 (2) rules and procedures for an automated
27 authorization system through which case managers authorize the

1 provision of attendant care services through the Medicaid state
2 plan program or the community-based alternatives program, as
3 appropriate, and register the number of hours authorized through
4 each program; and

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

8 (b) Subchapter B, Chapter 531, Government Code, is amended
9 by adding Section 531.0515 to read as follows:

10 Sec. 531.0515. RISK MANAGEMENT CRITERIA FOR CERTAIN WAIVER
11 PROGRAMS. (a) In this section, "legally authorized
12 representative" has the meaning assigned by Section 531.051.

13 (b) The commission shall consider developing risk
14 management criteria under home and community-based services waiver
15 programs designed to allow individuals eligible to receive services
16 under the programs to assume greater choice and responsibility over
17 the services and supports the individuals receive.

18 (c) The commission shall ensure that any risk management
19 criteria developed under this section include:

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

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

26 (c) Section 533.0355, Health and Safety Code, is amended by
27 adding Subsection (h) to read as follows:

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

10 (d) Subchapter D, Chapter 161, Human Resources Code, is
11 amended by adding Sections 161.084 and 161.085 to read as follows:

12 Sec. 161.084. MEDICAID SERVICE OPTIONS PUBLIC EDUCATION
13 INITIATIVE. (a) In this section, "Section 1915(c) waiver program"
14 has the meaning assigned by Section 531.001, Government Code.

15 (b) The department, in cooperation with the commission,
16 shall educate the public on:

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

21 (2) the various service delivery options available
22 under the Medicaid program, including the consumer direction models
23 available to recipients under Section 531.051, Government Code.

24 (c) The department may coordinate the activities under this
25 section with any other related activity.

26 Sec. 161.085. INTEREST LIST REPORTING. The department
27 shall post on the department's Internet website historical data,

1 categorized by state fiscal year, on the percentages of individuals
2 who elect to receive services under a program for which the
3 department maintains an interest list once their names reach the
4 top of the list.

5 (e) As soon as practicable after the effective date of this
6 Act, the executive commissioner of the Health and Human Services
7 Commission shall apply for and actively pursue, from the federal
8 Centers for Medicare and Medicaid Services or any other appropriate
9 federal agency, amendments to the community living assistance and
10 support services waiver and the home and community-based services
11 program waiver granted under Section 1915(c) of the federal Social
12 Security Act (42 U.S.C. Section 1396n(c)) to authorize the
13 provision of personal attendant services through the programs
14 operated under those waivers.

15 SECTION 3. OBJECTIVE ASSESSMENT PROCESSES FOR CERTAIN
16 MEDICAID SERVICES. (a) Subchapter B, Chapter 531, Government
17 Code, is amended by adding Sections 531.02417, 531.024171, and
18 531.024172 to read as follows:

19 Sec. 531.02417. MEDICAID NURSING SERVICES ASSESSMENTS.

20 (a) In this section, "acute nursing services" means home health
21 skilled nursing services, home health aide services, and private
22 duty nursing services.

23 (b) The commission shall develop an objective assessment
24 process for use in assessing a Medicaid recipient's needs for acute
25 nursing services. The commission shall require that:

26 (1) the assessment be conducted:

27 (A) by a state employee or contractor who is not

1 the person who will deliver any necessary services to the recipient
2 and is not affiliated with the person who will deliver those
3 services; and

4 (B) in a timely manner so as to protect the health
5 and safety of the recipient by avoiding unnecessary delays in
6 service delivery; and

7 (2) the process include:

8 (A) an assessment of specified criteria and
9 documentation of the assessment results on a standard form;

10 (B) an assessment of whether the recipient should
11 be referred for additional assessments regarding the recipient's
12 needs for therapy services, as defined by Section 531.024171,
13 attendant care services, and durable medical equipment; and

14 (C) completion by the person conducting the
15 assessment of any documents related to obtaining prior
16 authorization for necessary nursing services.

17 (c) The commission shall:

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

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

26 (d) The executive commissioner shall adopt rules providing
27 for a process by which a provider of acute nursing services who

1 disagrees with the results of the assessment conducted under
2 Subsection (b) may request and obtain a review of those results.

3 Sec. 531.024171. THERAPY SERVICES ASSESSMENTS. (a) In
4 this section, "therapy services" includes occupational, physical,
5 and speech therapy services.

6 (b) After implementing the objective assessment process for
7 acute nursing services as required by Section 531.02417, the
8 commission shall consider whether implementing an objective
9 assessment process for assessing the needs of a Medicaid recipient
10 for therapy services that is comparable to the process required
11 under Section 531.02417 for acute nursing services would be
12 feasible and beneficial.

13 (c) If the commission determines that implementing a
14 comparable process with respect to one or more types of therapy
15 services is feasible and would be beneficial, the commission may
16 implement the process within:

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

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

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

22 (d) An objective assessment process implemented under this
23 section must include a process that allows a provider of therapy
24 services to request and obtain a review of the results of an
25 assessment conducted as provided by this section that is comparable
26 to the process implemented under rules adopted under Section
27 531.02417(d).

1 Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM.

2 (a) In this section, "acute nursing services" has the meaning
3 assigned by Section 531.02417.

4 (b) If it is cost-effective and feasible, the commission
5 shall implement an electronic visit verification system to
6 electronically verify and document, through a telephone or
7 computer-based system, basic information relating to the delivery
8 of Medicaid acute nursing services, including:

9 (1) the provider's name;

10 (2) the recipient's name; and

11 (3) the date and time the provider begins and ends each
12 service delivery visit.

13 (b) Not later than September 1, 2012, the Health and Human
14 Services Commission shall implement the electronic visit
15 verification system required by Section 531.024172, Government
16 Code, as added by this section, if the commission determines that
17 implementation of that system is cost-effective and feasible.

18 SECTION 4. ACCESS TO MEDICALLY NECESSARY PRESCRIPTION DRUGS
19 UNDER MEDICAID MANAGED CARE PROGRAM. (a) Subsection (a), Section
20 533.005, Government Code, is amended to read as follows:

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

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

1 (2) capitation rates that ensure the cost-effective
2 provision of quality health care;

3 (3) a requirement that the managed care organization
4 provide ready access to a person who assists recipients in
5 resolving issues relating to enrollment, plan administration,
6 education and training, access to services, and grievance
7 procedures;

8 (4) a requirement that the managed care organization
9 provide ready access to a person who assists providers in resolving
10 issues relating to payment, plan administration, education and
11 training, and grievance procedures;

12 (5) a requirement that the managed care organization
13 provide information and referral about the availability of
14 educational, social, and other community services that could
15 benefit a recipient;

16 (6) procedures for recipient outreach and education;

17 (7) a requirement that the managed care organization
18 make payment to a physician or provider for health care services
19 rendered to a recipient under a managed care plan not later than the
20 45th day after the date a claim for payment is received with
21 documentation reasonably necessary for the managed care
22 organization to process the claim, or within a period, not to exceed
23 60 days, specified by a written agreement between the physician or
24 provider and the managed care organization;

25 (8) a requirement that the commission, on the date of a
26 recipient's enrollment in a managed care plan issued by the managed
27 care organization, inform the organization of the recipient's

1 Medicaid certification date;

2 (9) a requirement that the managed care organization
3 comply with Section 533.006 as a condition of contract retention
4 and renewal;

5 (10) a requirement that the managed care organization
6 provide the information required by Section 533.012 and otherwise
7 comply and cooperate with the commission's office of inspector
8 general;

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

14 (12) if the commission finds that a managed care
15 organization has violated Subdivision (11), a requirement that the
16 managed care organization reimburse an out-of-network provider for
17 health care services at a rate that is equal to the allowable rate
18 for those services, as determined under Sections 32.028 and
19 32.0281, Human Resources Code;

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

24 (14) a requirement that the managed care organization
25 reimburse a federally qualified health center or rural health
26 clinic for health care services provided to a recipient outside of
27 regular business hours, including on a weekend day or holiday, at a

1 rate that is equal to the allowable rate for those services as
2 determined under Section 32.028, Human Resources Code, if the
3 recipient does not have a referral from the recipient's primary
4 care physician; ~~and~~

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

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

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

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

19 (16) a requirement that the managed care organization
20 develop, implement, and maintain an outpatient pharmacy benefit
21 plan for its enrolled recipients that:

22 (A) exclusively employs the vendor drug program
23 formulary or a more cost-effective alternative approved by the
24 commissioner;

25 (B) complies with the preferred drug list prior
26 authorization policies and procedures adopted by the commission
27 under Chapter 531 or a more cost-effective alternative approved by

1 the commissioner;

2 (C) includes rebates negotiated by the managed
3 care organization with a manufacturer or labeler as defined by
4 Section 531.070, except that a managed care organization may not
5 negotiate or obtain a rebate with respect to a product for which the
6 commission has negotiated or obtained a supplemental rebate; and

7 (D) complies with Section 531.089.

8 (b) Chapter 533, Government Code, is amended by adding
9 Subchapter E to read as follows:

10 SUBCHAPTER E. MEDICAID MANAGED CARE PRESCRIPTION DRUG COVERAGE

11 Sec. 533.081. DEFINITIONS. In this subchapter, "step
12 therapy protocol" or "fail first protocol" means a prescription
13 drug protocol under which coverage will not be provided under a
14 managed care plan for a particular drug until requirements of the
15 plan's coverage policy are met.

16 Sec. 533.082. APPLICABILITY OF SUBCHAPTER. This subchapter
17 applies to a managed care organization that contracts with the
18 commission under this chapter to provide a managed care plan under
19 the Medicaid program, regardless of the Medicaid managed care model
20 or arrangement through which that plan is provided.

21 Sec. 533.083. ESTABLISHMENT OF CERTAIN DRUG PROTOCOLS. The
22 commission may allow a managed care organization to establish for
23 purposes of the managed care plan offered by the organization a step
24 therapy protocol or fail first protocol only under the following
25 conditions:

26 (1) for a prescription drug restricted by the
27 protocol, the organization must provide to the prescribing

1 physician a clear and convenient process for expeditiously
2 requesting from the organization an override of the restriction;

3 (2) the organization shall grant an override requested
4 using the process required by Subdivision (1) not later than 24
5 hours after the request is made if the requesting physician can
6 demonstrate that the treatment required under the protocol:

7 (A) has previously been ineffective in treating
8 the enrollee's condition;

9 (B) is expected to be ineffective based on the
10 known relevant physical or mental characteristics of the enrollee
11 and known characteristics of the drug regimen; or

12 (C) will cause or will likely cause an adverse
13 reaction or other physical harm to the enrollee; and

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

19 (c) Subsection (a), Section 32.046, Human Resources Code,
20 is amended to read as follows:

21 (a) The department shall adopt rules governing sanctions
22 and penalties that apply to a provider in the vendor drug program or
23 enrolled as a network pharmacy provider of a managed care
24 organization or its subcontractor who submits an improper claim for
25 reimbursement under the program.

26 SECTION 5. ABOLISHING STATE KIDS INSURANCE PROGRAM.

27 (a) Section 62.101, Health and Safety Code, is amended by adding

1 Subsection (a-1) to read as follows:

2 (a-1) A child who is the dependent of an employee of an
3 agency of this state and who meets the requirements of Subsection
4 (a) may be eligible for health benefits coverage in accordance with
5 42 U.S.C. Section 1397jj(b)(6) and any other applicable law or
6 regulations.

7 (b) Sections 1551.159 and 1551.312, Insurance Code, are
8 repealed.

9 (c) The State Kids Insurance Program operated by the
10 Employees Retirement System of Texas is abolished on the effective
11 date of this Act. The board of trustees of the system may not
12 provide dependent child coverage under the program after the first
13 annual open enrollment period that begins under the employee group
14 benefits program after the effective date of this Act.

15 (d) The Health and Human Services Commission, in
16 cooperation with the Employees Retirement System of Texas, shall
17 establish a process to ensure the automatic enrollment of eligible
18 children in the child health plan program established under Chapter
19 62, Health and Safety Code, on or before the date those children are
20 scheduled to stop receiving dependent child coverage under the
21 State Kids Insurance Program, as provided by Subsection (c) of this
22 section. The commission shall modify any applicable administrative
23 procedures to ensure that children described by this subsection
24 maintain continuous health benefits coverage while transitioning
25 from enrollment in the State Kids Insurance Program to enrollment
26 in the child health plan program.

27 SECTION 6. PREVENTION OF CRIMINAL OR FRAUDULENT CONDUCT BY

1 CERTAIN FACILITIES, PROVIDERS, AND RECIPIENTS. (a) Section
2 31.0325, Human Resources Code, is amended to read as follows:

3 Sec. 31.0325. FRAUD PREVENTION [~~ELECTRONIC IMAGING~~]
4 PROGRAM. [~~(a)~~] In conjunction with other appropriate agencies,
5 the department [~~by rule~~] shall develop and implement a program to
6 prevent welfare fraud by using cost-effective technology to:

7 (1) confirm the identity [~~a type of electronic~~
8 ~~fingerprint imaging or photo imaging~~] of adult and teen parent
9 applicants for and adult and teen parent recipients of financial
10 assistance under this chapter or supplemental nutrition assistance
11 [~~food stamp benefits~~] under Chapter 33; and

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

15 [~~(b) In adopting rules under this section, the department~~
16 ~~shall:~~

17 [~~(1) provide for an exemption from the electronic~~
18 ~~imaging requirements of Subsection (a) for a person who is elderly~~
19 ~~or disabled if the department determines that compliance with those~~
20 ~~requirements would cause an undue burden to the person;~~

21 [~~(2) establish criteria for an exemption under~~
22 ~~Subdivision (1); and~~

23 [~~(3) ensure that any electronic imaging performed by~~
24 ~~the department is strictly confidential and is used only to prevent~~
25 ~~fraud by adult and teen parent recipients of financial assistance~~
26 ~~or food stamp benefits.~~

27 [~~(c) The department shall:~~

1 ~~[(1) establish the program in conjunction with an~~
2 ~~electronic benefits transfer program;~~

3 ~~[(2) use an imaging system; and~~

4 ~~[(3) provide for gradual implementation of this~~
5 ~~section by selecting specific counties or areas of the state as test~~
6 ~~sites.~~

7 ~~[(d) Each fiscal quarter, the department shall submit to the~~
8 ~~governor and the legislature a report on the status and progress of~~
9 ~~the programs in the test sites selected under Subsection (c)(3).]~~

10 (b) The Health and Human Services Commission shall make
11 reasonable efforts to ensure the prevention of criminal or
12 fraudulent conduct by health care facilities and providers,
13 including facilities and providers under the Medicaid program, and
14 recipients of benefits under programs administered by the
15 commission.

16 SECTION 7. STREAMLINING OF AND UTILIZATION MANAGEMENT IN
17 MEDICAID LONG-TERM CARE WAIVER PROGRAMS. (a) Section 161.077,
18 Human Resources Code, as added by Chapter 759 (S.B. 705), Acts of
19 the 81st Legislature, Regular Session, 2009, is redesignated as
20 Section 161.081, Human Resources Code, and amended to read as
21 follows:

22 Sec. 161.081 [~~161.077~~]. LONG-TERM CARE MEDICAID WAIVER
23 PROGRAMS: STREAMLINING AND UNIFORMITY. (a) In this section,
24 "Section 1915(c) waiver program" has the meaning assigned by
25 Section 531.001, Government Code.

26 (b) The department, in consultation with the commission,
27 shall streamline the administration of and delivery of services

1 through Section 1915(c) waiver programs. In implementing this
2 subsection, the department, subject to Subsection (c), may consider
3 implementing the following streamlining initiatives:

4 (1) reducing the number of forms used in administering
5 the programs;

6 (2) revising program provider manuals and training
7 curricula;

8 (3) consolidating service authorization systems;

9 (4) eliminating any physician signature requirements
10 the department considers unnecessary;

11 (5) standardizing individual service plan processes
12 across the programs; ~~and~~

13 (6) if feasible:

14 (A) concurrently conducting program
15 certification and billing audit and review processes and other
16 related audit and review processes;

17 (B) streamlining other billing and auditing
18 requirements;

19 (C) eliminating duplicative responsibilities
20 with respect to the coordination and oversight of individual care
21 plans for persons receiving waiver services; and

22 (D) streamlining cost reports and other cost
23 reporting processes; and

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

26 (c) The department shall ensure that actions taken under
27 Subsection (b) ~~[this section]~~ do not conflict with any requirements

1 of the commission under Section 531.0218, Government Code.

2 (d) The department and the commission shall jointly explore
3 the development of uniform licensing and contracting standards that
4 would:

5 (1) apply to all contracts for the delivery of Section
6 1915(c) waiver program services;

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

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

13 (b) Subchapter D, Chapter 161, Human Resources Code, is
14 amended by adding Section 161.082 to read as follows:

15 Sec. 161.082. LONG-TERM CARE MEDICAID WAIVER PROGRAMS:
16 UTILIZATION REVIEW. (a) In this section, "Section 1915(c) waiver
17 program" has the meaning assigned by Section 531.001, Government
18 Code.

19 (b) The department shall perform a utilization review of
20 services in all Section 1915(c) waiver programs. The utilization
21 review must include reviewing program recipients' levels of care
22 and any plans of care for those recipients that exceed service level
23 thresholds established in the applicable waiver program
24 guidelines.

25 SECTION 8. ELECTRONIC VISIT VERIFICATION SYSTEM FOR
26 MEDICAID PROGRAM. Subchapter D, Chapter 161, Human Resources Code,
27 is amended by adding Section 161.086 to read as follows:

1 Sec. 161.086. ELECTRONIC VISIT VERIFICATION SYSTEM. If it
2 is cost-effective, the department shall implement an electronic
3 visit verification system under appropriate programs administered
4 by the department under the Medicaid program that allows providers
5 to electronically verify and document basic information relating to
6 the delivery of services, including:

7 (1) the provider's name;

8 (2) the recipient's name;

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

11 (4) the location of service delivery.

12 SECTION 9. REPORT ON LONG-TERM CARE SERVICES. (a) In this
13 section:

14 (1) "Long-term care services" has the meaning assigned
15 by Section 22.0011, Human Resources Code.

16 (2) "Medical assistance program" means the medical
17 assistance program administered under Chapter 32, Human Resources
18 Code.

19 (3) "Nursing facility" means a convalescent or nursing
20 home or related institution licensed under Chapter 242, Health and
21 Safety Code.

22 (b) The Health and Human Services Commission, in
23 cooperation with the Department of Aging and Disability Services,
24 shall prepare a written report regarding individuals who receive
25 long-term care services in nursing facilities under the medical
26 assistance program. The report shall use existing data and
27 information to identify:

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

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

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

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

19 (c) Not later than September 1, 2012, the Health and Human
20 Services Commission shall submit the report described by Subsection
21 (b) of this section, together with the commission's
22 recommendations, to the governor, the Legislative Budget Board, the
23 Senate Committee on Finance, the Senate Committee on Health and
24 Human Services, the House Appropriations Committee, and the House
25 Human Services Committee. The recommendations must address options
26 for expediting access to community-based services and supports by
27 recipients described by Subdivision (3), Subsection (b) of this

1 section.

2 SECTION 10. REGULATION AND OVERSIGHT OF CERTAIN FACILITIES
3 AND CARE PROVIDERS. (a) In this section, "executive commissioner"
4 means the executive commissioner of the Health and Human Services
5 Commission.

6 (b) The executive commissioner may adopt rules designed to:

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

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

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

16 (c) The executive commissioner may adopt rules relating to
17 nursing institutions regarding application requirements for an
18 initial or renewal license under Chapter 242, Health and Safety
19 Code, that are designed to evaluate the applicant's compliance with
20 applicable laws.

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

26 (e) The Department of Aging and Disability Services,
27 through rules adopted by the executive commissioner, may implement

1 strategies designed to enhance adult day-care facilities'
2 compliance with applicable laws and regulations.

3 SECTION 11. ASSISTED LIVING FACILITY LICENSING EXEMPTIONS.
4 Section 247.004, Health and Safety Code, is amended to read as
5 follows:

6 Sec. 247.004. EXEMPTIONS. This chapter does not apply to:

7 (1) a boarding home facility as defined by Section
8 254.001;

9 (2) an establishment conducted by or for the adherents
10 of the Church of Christ, Scientist, for the purpose of providing
11 facilities for the care or treatment of the sick who depend
12 exclusively on prayer or spiritual means for healing without the
13 use of any drug or material remedy if the establishment complies
14 with local safety, sanitary, and quarantine ordinances and
15 regulations;

16 (3) a facility conducted by or for the adherents of a
17 qualified religious society classified as a tax-exempt
18 organization under an Internal Revenue Service group exemption
19 ruling for the purpose of providing personal care services without
20 charge solely for the society's professed members or ministers in
21 retirement, if the facility complies with local safety, sanitation,
22 and quarantine ordinances and regulations; or

23 (4) a facility that provides personal care services
24 only to persons enrolled in a program that:

25 (A) is funded in whole or in part by the
26 department and that is monitored by the department or its
27 designated local mental retardation authority in accordance with

1 standards set by the department; or

2 (B) is funded in whole or in part by the
3 Department of State Health Services and that is monitored by the
4 Department of State Health Services or its designated local mental
5 health authority in accordance with standards set by the Department
6 of State Health Services.

7 SECTION 12. ACCOUNTABILITY AND STANDARDS UNDER MEDICAID
8 MANAGED CARE PROGRAM. (a) Section 533.002, Government Code, is
9 amended to read as follows:

10 Sec. 533.002. PURPOSE. The commission shall implement the
11 Medicaid managed care program as part of the health care delivery
12 system developed under former Chapter 532 as it existed on August
13 31, 2001, by contracting with managed care organizations in a
14 manner that, to the extent possible:

15 (1) improves the health of Texans by:

16 (A) emphasizing prevention;

17 (B) promoting continuity of care; and

18 (C) providing a medical home for recipients;

19 (2) ensures that each recipient receives high quality,
20 comprehensive health care services in the recipient's local
21 community;

22 (3) encourages the training of and access to primary
23 care physicians and providers;

24 (4) maximizes cooperation with existing public health
25 entities, including local departments of health;

26 (5) provides incentives to managed care organizations
27 to improve the quality of health care services for recipients by

1 providing value-added services; and

2 (6) reduces administrative and other nonfinancial
3 barriers for recipients in obtaining health care services.

4 (b) Section 533.0025, Government Code, is amended by
5 amending Subsection (e) and adding Subsection (f) to read as
6 follows:

7 (e) In the expansion of the health maintenance organization
8 model of Medicaid managed care into South Texas, the executive
9 commissioner shall determine the most effective alignment of
10 managed care service delivery areas for each model of managed care
11 in Duval, Hidalgo, Jim Hogg, Cameron, Maverick, McMullen, Starr,
12 Webb, Willacy, and Zapata Counties. In developing the service
13 delivery areas for each managed care model, the executive
14 commissioner shall consider the number of lives impacted, the usual
15 source of health care services for residents of these counties, and
16 other factors that impact the delivery of health care services in
17 this 10-county area [~~Notwithstanding Subsection (b)(1), the~~
18 ~~commission may not provide medical assistance using a health~~
19 ~~maintenance organization in Cameron County, Hidalgo County, or~~
20 ~~Maverick County]~~.

21 (f) Managed care organizations that operate within the
22 10-county South Texas service delivery area must maintain a medical
23 director within the service delivery area. The medical director
24 may be a managed care organization employee or under contract with
25 the managed care organization. The duties of the medical director
26 in the service delivery area must include oversight and management
27 of the managed care organization medical necessity determination

1 process. The managed care organization medical director must be
2 available for peer-to-peer discussions about managed care
3 organization medical necessity determinations and other managed
4 care organization clinical policies. The managed care organization
5 medical director may not be affiliated with any hospital, clinic,
6 or other health care related institution or business that operates
7 within the service delivery area.

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

11 Sec. 533.0027. PROCEDURES TO ALLOW CERTAIN CHILDREN TO
12 CHANGE MANAGED CARE PLANS. The commission shall ensure that all
13 children who reside in the same household may, at the family's
14 election, be enrolled in the same health plan.

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

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

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

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

3 (B) facilitates partnerships between the
4 physician, the patient, acute care and other care providers, and,
5 when appropriate, the patient's family; and

6 (2) that encompasses the following primary
7 principles:

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

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

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

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

26 (E) quality and safe care is provided.

27 (b) The commission shall, to the extent possible, work to

1 ensure that managed care organizations:

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

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

6 (d) Section 533.003, Government Code, is amended to read as
7 follows:

8 Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS.

9 (a) In awarding contracts to managed care organizations, the
10 commission shall:

11 (1) give preference to organizations that have
12 significant participation in the organization's provider network
13 from each health care provider in the region who has traditionally
14 provided care to Medicaid and charity care patients;

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

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

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

22 (5) give extra consideration in each service delivery
23 area to an organization that:

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

26 (B) notwithstanding Section 533.004 or any other
27 law, is not owned or operated by and does not have a contract,

1 agreement, or other arrangement with a hospital district in the
2 region.

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

8 (e) Subsection (a), Section 533.005, Government Code, is
9 amended to read as follows:

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

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

17 (2) capitation rates that ensure the cost-effective
18 provision of quality health care;

19 (3) a requirement that the managed care organization
20 provide ready access to a person who assists recipients in
21 resolving issues relating to enrollment, plan administration,
22 education and training, access to services, and grievance
23 procedures;

24 (4) subject to Subdivision (17), a requirement that
25 the managed care organization provide ready access to a person who
26 assists providers in resolving issues relating to payment, plan
27 administration, education and training, and grievance procedures;

1 (5) a requirement that the managed care organization
2 provide information and referral about the availability of
3 educational, social, and other community services that could
4 benefit a recipient;

5 (6) procedures for recipient outreach and education;

6 (7) a requirement that the managed care organization
7 make payment to a physician or provider for health care services
8 rendered to a recipient under a managed care plan not later than the
9 45th day after the date a claim for payment is received with
10 documentation reasonably necessary for the managed care
11 organization to process the claim, or within a period, not to exceed
12 60 days, specified by a written agreement between the physician or
13 provider and the managed care organization;

14 (8) a requirement that the commission, on the date of a
15 recipient's enrollment in a managed care plan issued by the managed
16 care organization, inform the organization of the recipient's
17 Medicaid certification date;

18 (9) a requirement that the managed care organization
19 comply with Section 533.006 as a condition of contract retention
20 and renewal;

21 (10) a requirement that the managed care organization
22 provide the information required by Section 533.012 and otherwise
23 comply and cooperate with the commission's office of inspector
24 general;

25 (11) a requirement that the managed care
26 organization's usages of out-of-network providers or groups of
27 out-of-network providers may not exceed limits for those usages

1 relating to total inpatient admissions, total outpatient services,
2 and emergency room admissions determined by the commission;

3 (12) if the commission finds that a managed care
4 organization has violated Subdivision (11), a requirement that the
5 managed care organization reimburse an out-of-network provider for
6 health care services at a rate that is equal to the allowable rate
7 for those services, as determined under Sections 32.028 and
8 32.0281, Human Resources Code;

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

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

21 (15) subject to Subdivision (17), a requirement that
22 the managed care organization develop, implement, and maintain a
23 system for tracking and resolving all provider appeals related to
24 claims payment, including a process that will require:

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

27 (B) the contracting with physicians who are not

1 network providers and who are of the same or related specialty as
2 the appealing physician to resolve claims disputes related to
3 denial on the basis of medical necessity that remain unresolved
4 subsequent to a provider appeal; and

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

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

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

16 (18) a requirement that the managed care organization
17 develop and establish a process for responding to provider appeals
18 in the region where the organization provides health care services;

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

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

27 (A) preventive care;

1 (B) primary care;

2 (C) specialty care;

3 (D) after-hours urgent care; and

4 (E) chronic care;

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

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

11 (B) the organization's provider network
12 includes:

13 (i) a sufficient number of primary care
14 providers;

15 (ii) a sufficient variety of provider
16 types; and

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

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

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

1 network that:

2 (A) incorporates the National Committee for
3 Quality Assurance's Healthcare Effectiveness Data and Information
4 Set (HEDIS) measures;

5 (B) focuses on measuring outcomes; and

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

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

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

18 (g) Section 533.0071, Government Code, is amended to read as
19 follows:

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

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

27 (2) evaluate options for Medicaid payment recovery

1 from managed care organizations if the enrollee dies or is
2 incarcerated or if an enrollee is enrolled in more than one state
3 program or is covered by another liable third party insurer;

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

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

14 (A) where possible, decreasing the duplication
15 of administrative reporting requirements for the managed care
16 organizations, such as requirements for the submission of encounter
17 data, quality reports, historically underutilized business
18 reports, and claims payment summary reports;

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

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

26 (D) reviewing the appropriateness of primary
27 care case management requirements in the admission and clinical

1 criteria process, such as requirements relating to including a
2 separate cover sheet for all communications, submitting
3 handwritten communications instead of electronic or typed review
4 processes, and admitting patients listed on separate
5 notifications; and

6 (E) providing a single portal through which
7 providers in any managed care organization's provider network may
8 submit claims and prior authorization requests and obtain
9 information; and

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

15 SECTION 13. FEDERAL AUTHORIZATION. Subject to the
16 requirements of Subsection (e), Section 2 of this Act, if before
17 implementing any provision of this Act a state agency determines
18 that a waiver or authorization from a federal agency is necessary
19 for implementation of that provision, the agency affected by the
20 provision shall request the waiver or authorization and may delay
21 implementing that provision until the waiver or authorization is
22 granted.

23 SECTION 14. REPORT TO LEGISLATURE. Not later than December
24 1, 2013, the Health and Human Services Commission shall submit a
25 report to the legislature regarding the commission's work to ensure
26 that Medicaid managed care organizations promote the development of
27 patient-centered medical homes for recipients of medical

1 assistance as required under Section 533.0029, Government Code, as
2 added by this Act.

3 SECTION 15. CONTRACTING REQUIREMENTS. The Health and Human
4 Services Commission shall, in a contract between the commission and
5 a managed care organization under Chapter 533, Government Code,
6 that is entered into or renewed on or after the effective date of
7 this Act, include the provisions required by Subsection (a),
8 Section 533.005, Government Code, as amended by this Act.

9 SECTION 16. EFFECTIVE DATE. This Act takes effect
10 September 1, 2011.