By: Nelson S.B. No. 23

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COMMITTEE SUBSTITUTE FOR S.B. No. 23 By: Nelson

A BILL TO BE ENTITLED
AN ACT

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.

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

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

Sec. 102.054. ALLOCATION OF [~~CERTAIN~~] REVENUE FOR SEXUAL ASSAULT PROGRAMS. The comptroller shall deposit the amount [~~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) The comptroller of public accounts shall collect the fee imposed under Section 102.052, Business & Commerce Code, until a court, in a final judgment upheld on appeal or no longer subject to appeal, finds Section 102.052, Business & Commerce Code, or its predecessor statute, to be unconstitutional.

(c) Section 102.055, Business & Commerce Code, is repealed.

(d) 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, Chapter 102, 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) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02181 to read as follows:

Sec. 531.02181. PROVISION AND COORDINATION OF CERTAIN ATTENDANT CARE SERVICES. (a) The commission shall 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. The commission may 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) The executive commissioner shall 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) Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0515 to read as follows:

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

(b) The commission shall 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) The commission shall 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) Section 533.0355, Health and Safety Code, is amended by adding Subsection (h) to read as follows:

(h) The Department of Aging and Disability Services shall 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 department interest list or other waiting list for other services.

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

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

(b) The department, in cooperation with the commission, shall 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, Government Code.

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

Sec. 161.085. INTEREST LIST REPORTING. The department shall post on the department'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 the department maintains an interest list once their names reach the top of the list.

(e) As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall 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) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02417, 531.024171, and 531.024172 to read as follows:

Sec. 531.02417. MEDICAID NURSING SERVICES ASSESSMENTS.

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

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

(1) the assessment be conducted:

(A) 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

(B) 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:

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

(B) 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

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

(c) The commission shall:

(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) The executive commissioner shall 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) In this section, "therapy services" includes occupational, physical, and speech therapy services.

(b) After implementing the objective assessment process for acute nursing services as required by Section 531.02417, the commission shall 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) If the commission determines that implementing a comparable process with respect to one or more types of therapy services is feasible and would be beneficial, the commission may 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) An objective assessment process implemented under this section must 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) In this section, "acute nursing services" has the meaning assigned by Section 531.02417.

(b) If it is cost-effective and feasible, the commission shall 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:

(1) the provider's name;

(2) the recipient's name; and

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

(b) Not later than September 1, 2012, the Health and Human Services Commission shall implement the electronic visit verification system required by Section 531.024172, Government Code, as added by this section, if the commission 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) Subsection (a), Section 533.005, Government Code, is amended to read as follows:

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

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

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

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

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

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

(6) procedures for recipient outreach and education;

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

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

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

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

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

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

(13) a requirement that the organization use advanced practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the

organization's provider network;

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

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

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

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

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

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

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

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

(C) 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 the commission has negotiated or obtained a supplemental rebate; and

(D) complies with Section 531.089.

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

SUBCHAPTER E. MEDICAID MANAGED CARE PRESCRIPTION DRUG COVERAGE

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

Sec. 533.082. APPLICABILITY OF SUBCHAPTER. This subchapter applies to a managed care organization that contracts with the commission 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. The commission may 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:

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

(B) 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

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

(a) The department shall 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) Section 62.101, Health and Safety Code, is amended by adding Subsection (a-1) to read as follows:

(a-1) A child who is the dependent of an employee of an agency of this state and who meets the requirements of Subsection (a) 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) Sections 1551.159 and 1551.312, Insurance Code, are repealed.

(c) The State Kids Insurance Program operated by the Employees Retirement System of Texas is abolished on the effective date of this Act. The board of trustees of the system may not provide 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) The Health and Human Services Commission, in cooperation with the Employees Retirement System of Texas, shall establish a process to ensure the automatic enrollment of eligible children in the child health plan program established under Chapter 62, 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. The commission shall 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) Section 31.0325, Human Resources Code, is amended to read as follows:

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

(1) confirm the identity [~~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 supplemental nutrition assistance [~~food stamp benefits~~] 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.

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

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

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

[~~(3) ensure that any electronic imaging performed by the department is strictly confidential and is used only to prevent fraud by adult and teen parent recipients of financial assistance~~

~~or food stamp benefits.~~

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

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

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

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

[~~(d) Each fiscal quarter, the department shall 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) The Health and Human Services Commission shall 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 the commission.

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

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

(b) The department, in consultation with the commission, shall streamline the administration of and delivery of services through Section 1915(c) waiver programs. In implementing this subsection, the department, subject to Subsection (c), may consider implementing the following streamlining initiatives:

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

(2) revising program provider manuals and training curricula;

(3) consolidating service authorization systems;

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

(5) standardizing individual service plan processes across the programs; [~~and~~]

(6) if feasible:

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

(B) streamlining other billing and auditing requirements;

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

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

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

(c) The department shall ensure that actions taken under Subsection (b) [~~this section~~] do not conflict with any requirements of the commission under Section 531.0218, Government Code.

(d) The department and the commission shall 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) Subchapter D, Chapter 161, Human Resources Code, is

amended by adding Section 161.082 to read as follows:

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

(b) The department shall perform a utilization review of services in all Section 1915(c) waiver programs. The utilization review must 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. Subchapter D, Chapter 161, Human Resources Code, is amended by adding Section 161.086 to read as follows:

Sec. 161.086. ELECTRONIC VISIT VERIFICATION SYSTEM. If it is cost-effective, the department shall implement an electronic visit verification system under appropriate programs administered by the department 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) In this section:

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

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

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

(b) The Health and Human Services Commission, in cooperation with the Department of Aging and Disability Services, shall prepare a written report regarding individuals who receive long-term care services in nursing facilities under the medical assistance program. The report shall 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) Not later than September 1, 2012, the Health and Human Services Commission shall submit the report described by Subsection (b) of this section, together with the commission'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. The recommendations must address options for expediting access to community-based services and supports by recipients described by Subdivision (3), Subsection (b) of this section.

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

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

(d) The executive commissioner may 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) The Department of Aging and Disability Services, through rules adopted by the executive commissioner, may 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) Section 533.002, Government Code, is amended to read as follows:

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

(1) improves the health of Texans by:

(A) emphasizing prevention;

(B) promoting continuity of care; and

(C) providing a medical home for recipients;

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

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

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

(5) provides incentives to managed care organizations to improve the quality of health care services for recipients by providing value-added services; and

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

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

(e) <u>In the expansion of the health maintenance organization model of Medicaid managed care into South Texas, the executive commissioner shall 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. In developing the service delivery areas for each managed care model, the executive commissioner shall 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</u> [~~Notwithstanding Subsection (b)(1), the commission may not provide medical assistance using a health maintenance organization in Cameron County, Hidalgo County, or Maverick County~~].

(f) Managed care organizations that operate within the 10-county South Texas service delivery area must maintain a medical director within the service delivery area. The medical director may be a managed care organization employee or under contract with the managed care organization. The duties of the medical director in the service delivery area must include oversight and management of the managed care organization medical necessity determination process. The managed care organization medical director must be available for peer-to-peer discussions about managed care organization medical necessity determinations and other managed care organization clinical policies. The managed care organization medical director may not be affiliated with any hospital, clinic, or other health care related institution or business that operates within the service delivery area.

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

Sec. 533.0027. PROCEDURES TO ALLOW CERTAIN CHILDREN TO CHANGE MANAGED CARE PLANS. The commission shall 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. The external quality review organization shall periodically conduct studies and surveys to assess the quality of care and satisfaction with health care services provided to enrollees in the 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) For purposes of this section, a "patient-centered medical home" means a medical relationship:

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

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

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

(2) that encompasses the following primary principles:

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

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

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

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

(E) quality and safe care is provided.

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

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

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

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

Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS.

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

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

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

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

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

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

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

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

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

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

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

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

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

(6) procedures for recipient outreach and education;

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

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

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

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

general;

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

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

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

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

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

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

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

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

(A) preventive care;

(B) primary care;

(C) specialty care;

(D) after-hours urgent care; and

(E) chronic care;

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

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

(B) the organization's provider network

includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types; and

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

(C) health care services will be accessible to recipients through the organization's provider network to 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:

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

(B) focuses on measuring outcomes; and

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

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

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

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

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

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

(2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program or is covered by another liable third party insurer;

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

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

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

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

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

(D) reviewing the appropriateness of primary

care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications; and

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

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

SECTION 12. FEDERAL AUTHORIZATION. Subject to the requirements of Subsection (e), Section 2 of this Act, if before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 13. REPORT TO LEGISLATURE. Not later than December 1, 2013, the Health and Human Services Commission shall submit a report to the legislature regarding the commission'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. The Health and Human Services Commission shall, in a contract between the commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act, include the provisions required by Subsection (a), Section 533.005, Government Code, as amended by this Act.

SECTION 15. EFFECTIVE DATE. This Act takes effect September 1, 2011.

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