By: Rodriguez S.B. No. 1193

A BILL TO BE ENTITLED

AN ACT

relating to coordination of services provided by Medicaid managed care organizations and certain community centers and local mental health or mental retardation authorities.

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

SECTION 1. 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

1 out-of-network providers may not exceed limits for those usages
2 relating to total inpatient admissions, total outpatient services,
3 and emergency room admissions determined by the commission;
4 (12) if the commission finds that a managed care
5 organization has violated Subdivision (11), a requirement that the
6 managed care organization reimburse an out-of-network provider for
7 health care services at a rate that is equal to the allowable rate
8 for those services, as determined under Sections 32.028 and
9 32.0281, Human Resources Code;
10 (13) a requirement that the organization use advanced
11 practice nurses in addition to physicians as primary care providers
12 to increase the availability of primary care providers in the
13 organization's provider network;
14 (14) a requirement that the managed care organization
15 reimburse a federally qualified health center or rural health
16 clinic for health care services provided to a recipient outside of
17 regular business hours, including on a weekend day or holiday, at a
18 rate that is equal to the allowable rate for those services as
19 determined under Section 32.028, Human Resources Code, if the
20 recipient does not have a referral from the recipient's primary
21 care physician; [~~and~~]
22 (15) a requirement that the managed care organization
23 develop, implement, and maintain a system for tracking and
24 resolving all provider appeals related to claims payment, including
25 a process that will require:
26 (A) a tracking mechanism to document the status
27 and final disposition of each provider's claims payment appeal;

1 (B) the contracting with physicians who are not
2 network providers and who are of the same or related specialty as
3 the appealing physician to resolve claims disputes related to
4 denial on the basis of medical necessity that remain unresolved
5 subsequent to a provider appeal; and
6 (C) the determination of the physician resolving
7 the dispute to be binding on the managed care organization and
8 provider; and
9 (16) a requirement that the managed care organization
10 coordinate the care of each recipient who is receiving services
11 through the managed care organization and through a community
12 center created under Subchapter A, Chapter 534, Health and Safety
13 Code, or local mental health or mental retardation authority with
14 the community center or authority, as applicable.
15 SECTION 2. Subsection (d), Section 533.0352, Health and
16 Safety Code, is amended to read as follows:
17 (d) In developing the local service area plan, the local
18 mental health or mental retardation authority shall:
19 (1) solicit information regarding community needs
20 from:
21 (A) representatives of the local community;
22 (B) consumers of community-based mental health
23 and mental retardation services and members of the families of
24 those consumers;
25 (C) consumers of services of state schools for
26 persons with mental retardation, members of families of those
27 consumers, and members of state school volunteer services councils,

if a state school is located in the local service area of the local authority; and

(D) other interested persons; [~~and~~]

(2) consider:

(A) criteria for assuring accountability for, cost-effectiveness of, and relative value of service delivery options;

(B) goals to minimize the need for state hospital and community hospital care;

(C) goals to ensure a client with mental retardation is placed in the least restrictive environment appropriate to the person's care;

(D) opportunities for innovation to ensure that the local authority is communicating to all potential and incoming consumers about the availability of services of state schools for persons with mental retardation in the local service area of the local authority;

(E) goals to divert consumers of services from the criminal justice system;

(F) goals to ensure that a child with mental illness remains with the child's parent or guardian as appropriate to the child's care; and

(G) opportunities for innovation in services and service delivery; and

(3) include strategies in the plan that are designed to coordinate the care of each consumer who is receiving services through the local mental health or mental retardation authority and

1 through a Medicaid managed care organization with the managed care
2 organization.
3 SECTION 3. If before implementing any provision of this Act
4 a state agency determines that a waiver or authorization from a
5 federal agency is necessary for implementation of that provision,
6 the agency affected by the provision shall request the waiver or
7 authorization and may delay implementing that provision until the
8 waiver or authorization is granted.
9 SECTION 4. This Act takes effect September 1, 2011.