1-1 By: Rodriguez S.B. No. 1193
1-2 (In the Senate - Filed March 4, 2011; March 16, 2011, read
1-3 first time and referred to Committee on Health and Human Services;
1-4 May 17, 2011, reported adversely, with favorable Committee
1-5 Substitute by the following vote: Yeas 9, Nays 0; May 17, 2011,
1-6 sent to printer.)

1-7 COMMITTEE SUBSTITUTE FOR S.B. No. 1193 By: Nichols

1-8 A BILL TO BE ENTITLED
1-9 AN ACT

1-10 relating to coordination of services provided by Medicaid managed
1-11 care organizations and certain community centers and local mental
1-12 health or mental retardation authorities.
1-13 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:
1-14 SECTION 1. Subsection (a), Section 533.005, Government
1-15 Code, is amended to read as follows:
1-16 (a) A contract between a managed care organization and the
1-17 commission for the organization to provide health care services to
1-18 recipients must contain:
1-19 (1) procedures to ensure accountability to the state
1-20 for the provision of health care services, including procedures for
1-21 financial reporting, quality assurance, utilization review, and
1-22 assurance of contract and subcontract compliance;
1-23 (2) capitation rates that ensure the cost-effective
1-24 provision of quality health care;
1-25 (3) a requirement that the managed care organization
1-26 provide ready access to a person who assists recipients in
1-27 resolving issues relating to enrollment, plan administration,
1-28 education and training, access to services, and grievance
1-29 procedures;
1-30 (4) a requirement that the managed care organization
1-31 provide ready access to a person who assists providers in resolving
1-32 issues relating to payment, plan administration, education and
1-33 training, and grievance procedures;
1-34 (5) a requirement that the managed care organization
1-35 provide information and referral about the availability of
1-36 educational, social, and other community services that could
1-37 benefit a recipient;
1-38 (6) procedures for recipient outreach and education;
1-39 (7) a requirement that the managed care organization
1-40 make payment to a physician or provider for health care services
1-41 rendered to a recipient under a managed care plan not later than the
1-42 45th day after the date a claim for payment is received with
1-43 documentation reasonably necessary for the managed care
1-44 organization to process the claim, or within a period, not to exceed
1-45 60 days, specified by a written agreement between the physician or
1-46 provider and the managed care organization;
1-47 (8) a requirement that the commission, on the date of a
1-48 recipient's enrollment in a managed care plan issued by the managed
1-49 care organization, inform the organization of the recipient's
1-50 Medicaid certification date;
1-51 (9) a requirement that the managed care organization
1-52 comply with Section 533.006 as a condition of contract retention
1-53 and renewal;
1-54 (10) a requirement that the managed care organization
1-55 provide the information required by Section 533.012 and otherwise
1-56 comply and cooperate with the commission's office of inspector
1-57 general;
1-58 (11) a requirement that the managed care
1-59 organization's usages of out-of-network providers or groups of
1-60 out-of-network providers may not exceed limits for those usages
1-61 relating to total inpatient admissions, total outpatient services,
1-62 and emergency room admissions determined by the commission;
1-63 (12) if the commission finds that a managed care

2-1 organization has violated Subdivision (11), a requirement that the
2-2 managed care organization reimburse an out-of-network provider for
2-3 health care services at a rate that is equal to the allowable rate
2-4 for those services, as determined under Sections 32.028 and
2-5 32.0281, Human Resources Code;
2-6 (13) a requirement that the organization use advanced
2-7 practice nurses in addition to physicians as primary care providers
2-8 to increase the availability of primary care providers in the
2-9 organization's provider network;
2-10 (14) a requirement that the managed care organization
2-11 reimburse a federally qualified health center or rural health
2-12 clinic for health care services provided to a recipient outside of
2-13 regular business hours, including on a weekend day or holiday, at a
2-14 rate that is equal to the allowable rate for those services as
2-15 determined under Section 32.028, Human Resources Code, if the
2-16 recipient does not have a referral from the recipient's primary
2-17 care physician; [~~and~~]
2-18 (15) a requirement that the managed care organization
2-19 develop, implement, and maintain a system for tracking and
2-20 resolving all provider appeals related to claims payment, including
2-21 a process that will require:
2-22 (A) a tracking mechanism to document the status
2-23 and final disposition of each provider's claims payment appeal;
2-24 (B) the contracting with physicians who are not
2-25 network providers and who are of the same or related specialty as
2-26 the appealing physician to resolve claims disputes related to
2-27 denial on the basis of medical necessity that remain unresolved
2-28 subsequent to a provider appeal; and
2-29 (C) the determination of the physician resolving
2-30 the dispute to be binding on the managed care organization and
2-31 provider; and
2-32 (16) a requirement that the managed care organization
2-33 coordinate the care of each recipient who is receiving services
2-34 through the managed care organization and through a community
2-35 center created under Subchapter A, Chapter 534, Health and Safety
2-36 Code, or local mental health or mental retardation authority with
2-37 the community center or authority, as applicable.
2-38 SECTION 2. Subsection (d), Section 533.0352, Health and
2-39 Safety Code, is amended to read as follows:
2-40 (d) In developing the local service area plan, the local
2-41 mental health or mental retardation authority shall:
2-42 (1) solicit information regarding community needs
2-43 from:
2-44 (A) representatives of the local community;
2-45 (B) consumers of community-based mental health
2-46 and mental retardation services and members of the families of
2-47 those consumers;
2-48 (C) consumers of services of state schools for
2-49 persons with mental retardation, members of families of those
2-50 consumers, and members of state school volunteer services councils,
2-51 if a state school is located in the local service area of the local
2-52 authority; and
2-53 (D) other interested persons; [~~and~~]
2-54 (2) consider:
2-55 (A) criteria for assuring accountability for,
2-56 cost-effectiveness of, and relative value of service delivery
2-57 options;
2-58 (B) goals to minimize the need for state hospital
2-59 and community hospital care;
2-60 (C) goals to ensure a client with mental
2-61 retardation is placed in the least restrictive environment
2-62 appropriate to the person's care;
2-63 (D) opportunities for innovation to ensure that
2-64 the local authority is communicating to all potential and incoming
2-65 consumers about the availability of services of state schools for
2-66 persons with mental retardation in the local service area of the
2-67 local authority;
2-68 (E) goals to divert consumers of services from
2-69 the criminal justice system;

3-1 (F) goals to ensure that a child with mental
3-2 illness remains with the child's parent or guardian as appropriate
3-3 to the child's care; and
3-4 (G) opportunities for innovation in services and
3-5 service delivery; and
3-6 (3) include strategies in the plan that are designed
3-7 to coordinate the care of each consumer who is receiving services
3-8 through the local mental health or mental retardation authority and
3-9 through a Medicaid managed care organization with the managed care
3-10 organization.
3-11 SECTION 3. If before implementing any provision of this Act
3-12 a state agency determines that a waiver or authorization from a
3-13 federal agency is necessary for implementation of that provision,
3-14 the agency affected by the provision shall request the waiver or
3-15 authorization and may delay implementing that provision until the
3-16 waiver or authorization is granted.
3-17 SECTION 4. This Act takes effect September 1, 2011.

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