By: Schwertner, et al. (Kolkhorst) S.B. No. 348

A BILL TO BE ENTITLED

AN ACT

relating to a utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program.

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

SECTION 1. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00281 to read as follows:

Sec. 533.00281. UTILIZATION REVIEW FOR STAR + PLUS MEDICAID MANAGED CARE ORGANIZATIONS. (a) The commission's office of contract management shall establish an annual utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program. The commission shall determine the topics to be examined in the review process, except that the review process must include a thorough investigation of each managed care organization's procedures for determining whether a recipient should be enrolled in the STAR + PLUS home and community-based services and supports (HCBS) program, including the conduct of functional assessments for that purpose and records relating to those assessments.

(b) The office of contract management shall use the utilization review process to review each fiscal year:

(1) every managed care organization participating in the STAR + PLUS Medicaid managed care program; or

(2) only the managed care organizations that, using a

risk-based assessment process, the office determines have a higher likelihood of inappropriate client placement in the STAR + PLUS home and community-based services and supports (HCBS) program.

(c) Notwithstanding Subsection (b), during the state fiscal biennium ending August 31, 2015, the office of contract management shall use the utilization review process to review every managed care organization participating in the STAR + PLUS Medicaid managed care program. This subsection expires September 1, 2016.

(d) In conjunction with the commission's office of contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over the Medicaid program not later than December 1 of each year. The report must:

(1) summarize the results of the utilization reviews conducted under this section during the preceding fiscal year;

(2) provide analysis of errors committed by each reviewed managed care organization; and

(3) extrapolate those findings and make recommendations for improving the efficiency of the program.

(e) If a utilization review conducted under this section results in a determination to recoup money from a managed care organization, a service provider who contracts with the managed care organization may not be held liable for the good faith provision of services based on an authorization from the managed care organization.

SECTION 2. The Health and Human Services Commission shall provide the first report required by Subsection (d), Section

533.00281, Government Code, as added by this Act, not later than December 1, 2014.

SECTION 3. 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 4. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2013.