PRELIMINARY DRAFT

TEXAS LEGISLATIVE COUNCIL
Government Code
Chapter 540
10/17/22

CHAPTER 540. MEDICAID MANAGED CARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 540.0001. DEFINITIONS. In this chapter:

(1) Notwithstanding Section _____ [[[Section 531.001(2)]]], "commission" means the Health and Human Services Commission or an agency operating part of the Medicaid managed care program, as appropriate.

(2) "Health care service region" or "region" means a Medicaid managed care service area the commission delineates.

(3) "Managed care organization" means a person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan.

(4) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care service. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(5) "Potentially preventable event" has the meaning assigned by Section _____ [[[Section 536.001]]].

(6) "Recipient" means a Medicaid recipient. (Gov. Code, Secs. 533.001(1), (4), (5), (6), (7), 533.00251(a)(4), 533.00253(a)(3), 533.00256(a)(1) (part), 533.00511(a).)

Source Law

Sec. 533.001. DEFINITIONS. In this chapter:

(1) "Commission" means the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program, as appropriate.

(4) "Managed care organization" means a person who is authorized or otherwise permitted by law to arrange for or provide a managed care plan.

(5) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care services. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(6) "Recipient" means a recipient of Medicaid.

(7) "Health care service region" or "region" means a Medicaid managed care service area as delineated by the commission.

Sec. 533.00251. DELIVERY OF CERTAIN BENEFITS, INCLUDING NURSING FACILITY BENEFITS, THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this section and Sections 533.002515 and 533.00252:

(4) "Potentially preventable event" has the meaning assigned by Section 536.001.

Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM. (a) In this section:

(3) "Potentially preventable event" has the meaning assigned by Section 536.001.

[Sec. 533.00256]

(a) . . . [the commission shall:

(1) establish a clinical improvement program to . . . reduce] potentially preventable events, as defined by Section 536.001; and

. . .

Sec. 533.00511. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MANAGED CARE ORGANIZATIONS. (a) In this section, "potentially preventable event" has the meaning assigned by Section 536.001.

Revisor's Note

(1) Section 533.001(1), Government Code, defines "[c]ommission" for purposes of Chapter 533, Government Code, as meaning the Health and Human Services Commission and certain other state agencies. That definition applies to the law revised in this chapter, which is substantially derived from Chapter 533. Section 531.001(2), Government Code, which is revised as Section ____ of this subtitle, defines

"[c]ommission" for purposes of Subtitle I, Title 4, Government Code, to mean only the Health and Human Services Commission. The law revised in this chapter is derived from Subtitle I, and the definition provided by Section 531.001(2) would apply to this chapter in the absence of the definition provided by Section 533.001(1) that more specifically applies to the law revised in this chapter that is derived from Chapter 533. The provisions of this chapter that are not derived from Chapter 533 do not use the term "commission." The revised law defines "commission" to have the more expansive meaning assigned by Section 533.001(1) for purposes of the law revised in this chapter and, for clarity and the convenience of the reader, adds that this definition is "[n]otwithstanding Section _____ [[[Section 531.001(2)]]]."

(2) Sections 533.001(2) and (3), Government Code, define "[e]xecutive commissioner" and "[h]ealth and human services agencies" for purposes of Chapter 533, Government Code. The law revised in this chapter is substantially derived from Chapter 533, and the cited definitions apply to the terms as used in this chapter that are derived from Chapter 533. However, the revised law omits the definitions because the definitions duplicate the definitions for those terms in Section 531.001, Government Code, which is revised in this subtitle as Section _____ and applies to this subtitle, including to the law revised in this chapter. The omitted law reads:

> (2) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.
>
> (3) "Health and human services agencies" has the meaning assigned by Section 531.001.

(3) Sections 533.001(4) and (6), Government Code, define "[m]anaged care organization" and "[r]ecipient" for purposes of Chapter 533, Government Code. The law revised in this chapter is substantially derived from Chapter 533. This chapter also includes the revision of Section 531.0211, Government Code. That section is revised in this chapter as Section 540.0054, and the defined terms are made applicable to that revised law. Because it is clear from the context that the defined terms have the same meaning in Section 531.0211, applying the defined terms to the revision of that section in this chapter does not result in a substantive change.

SUBCHAPTER B. ADMINISTRATION OF MEDICAID MANAGED CARE PROGRAM

Revised Law

Sec. 540.0051. PURPOSE AND IMPLEMENTATION. The commission shall implement the Medicaid managed care program 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 each recipient receives high quality, comprehensive health care services in the recipient's local community;

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

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

(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. (Gov. Code, Sec. 533.002.)

Source Law

> Sec. 533.002. PURPOSE. The commission shall implement the Medicaid managed care program 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.

Revised Law

Sec. 540.0052. RECIPIENT DIRECTORY. The commission shall, in accordance with a single source of truth design:

(1) maintain an accurate electronic directory of contact information for each recipient enrolled in a Medicaid managed care plan offered by a managed care organization, including, to the extent feasible, each recipient's:

(A) home, work, and mobile telephone numbers;

(B) e-mail address; and

(C) home and work addresses; and

(2) ensure that each Medicaid managed care organization and enrollment broker participating in the Medicaid managed care program update the electronic directory in real time. (Gov. Code, Sec. 533.00751.)

Source Law

> Sec. 533.00751. RECIPIENT DIRECTORY. The commission shall in accordance with a single source of truth design:
>
> (1) maintain an accurate electronic directory of contact information for each recipient enrolled in a managed care plan offered by a Medicaid

managed care organization under this chapter, including, to the extent feasible, each recipient's:

(A) home, work, and mobile telephone numbers;

(B) e-mail address; and

(C) home and work addresses; and

(2) ensure that each Medicaid managed care organization and enrollment broker participating in the Medicaid managed care program update the electronic directory required under Subdivision (1) in real time.

Revisor's Note

Section 533.00751(1), Government Code, refers to "a managed care plan" offered by a Medicaid managed care organization. Throughout this chapter, the revised law substitutes "Medicaid managed care plan" for "managed care plan" for clarity and consistency when the context is clear that the source law is referring to a managed care plan offered under the Medicaid managed care program.

Revised Law

Sec. 540.0053. STATEWIDE EFFORT TO PROMOTE MEDICAID ELIGIBILITY MAINTENANCE. (a) The commission shall develop and implement a statewide effort to assist recipients who satisfy Medicaid eligibility requirements and who receive Medicaid services through a Medicaid managed care organization with:

(1) maintaining eligibility; and

(2) avoiding lapses in Medicaid coverage.

(b) As part of the commission's effort under Subsection (a), the commission shall:

(1) require each Medicaid managed care organization to assist the organization's recipients with maintaining eligibility;

(2) if the commission determines it is cost-effective, develop specific strategies for assisting recipients who receive Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq. with maintaining eligibility; and

(3) ensure information relevant to a recipient's eligibility status is provided to the recipient's Medicaid managed care organization. (Gov. Code, Sec. 533.0077.)

Source Law

Sec. 533.0077. STATEWIDE EFFORT TO PROMOTE MAINTENANCE OF ELIGIBILITY. (a) The commission shall develop and implement a statewide effort to assist recipients who satisfy Medicaid eligibility requirements and who receive Medicaid services through a managed care organization with maintaining eligibility and avoiding lapses in coverage under Medicaid.

(b) As part of its effort under Subsection (a), the commission shall:

(1) require each managed care organization providing health care services to recipients to assist those recipients with maintaining eligibility;

(2) if the commission determines it is cost-effective, develop specific strategies for assisting recipients who receive Supplemental Security Income (SSI) benefits under 42 U.S.C. Section 1381 et seq. with maintaining eligibility; and

(3) ensure information that is relevant to a recipient's eligibility status is provided to the managed care organization through which the recipient receives Medicaid services.

Revisor's Note

Section 533.0077(a), Government Code, refers to Medicaid recipients who receive "Medicaid services through a managed care organization," and Section 533.0077(b)(1), Government Code, refers to a "managed care organization providing health care services to recipients." A managed care organization that provides those services to recipients is a Medicaid managed care organization, which is defined by Section _____ [[[Section 531.001]]] as a managed care organization that contracts with the Health and Human Services Commission under Chapter 533, Government Code, the relevant portions of which are revised in this chapter, to provide health care services to Medicaid recipients. That definition applies subtitle-wide, including to the law revised in this chapter. For consistency of terminology, the revised law substitutes "Medicaid managed care organization" for "managed care organization." Similar changes are made throughout the revised law in this chapter where the context of the law from which the revised law is

derived indicates that the reference is specifically to a Medicaid managed care organization rather than to a managed care organization generally.

Revised Law

Sec. 540.0054. PROVIDER AND RECIPIENT EDUCATION PROGRAMS. (a) In adopting rules to implement a Medicaid managed care program, the executive commissioner shall establish guidelines for, and require Medicaid managed care organizations to provide, education programs for providers and recipients using a variety of techniques and media.

(b) A provider education program must include information on:

(1) Medicaid policies, procedures, eligibility standards, and benefits;

(2) recipients' specific problems and needs; and

(3) recipients' rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by Section _____ [[[Section 531.0212]]].

(c) A recipient education program must present information in a manner that is easy to understand. A program must include information on:

(1) a recipient's rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by Section _____ [[[Section 531.0212]]];

(2) how to access health care services;

(3) how to access complaint procedures and the recipient's right to bypass the Medicaid managed care organization's internal complaint system and use the notice and appeal procedures otherwise required by Medicaid;

(4) Medicaid policies, procedures, eligibility standards, and benefits;

(5) the Medicaid managed care organization's policies and procedures; and

(6) the importance of prevention, early intervention,

and appropriate use of services. (Gov. Code, Sec. 531.0211.)

Source Law

Sec. 531.0211. MANAGED CARE MEDICAID PROGRAM: RULES; EDUCATION PROGRAMS. (a) In adopting rules to implement a managed care Medicaid program, the executive commissioner shall establish guidelines for, and require managed care organizations to provide, education programs for providers and clients using a variety of techniques and mediums.

(b) A provider education program must include information on:

(1) Medicaid policies, procedures, eligibility standards, and benefits;

(2) the specific problems and needs of Medicaid clients; and

(3) the rights and responsibilities of Medicaid clients under the bill of rights and the bill of responsibilities prescribed by Section 531.0212.

(c) A client education program must present information in a manner that is easy to understand. A program must include information on:

(1) a client's rights and responsibilities under the bill of rights and the bill of responsibilities prescribed by Section 531.0212;

(2) how to access health care services;

(3) how to access complaint procedures and the client's right to bypass the managed care organization's internal complaint system and use the notice and appeal procedures otherwise required by Medicaid;

(4) Medicaid policies, procedures, eligibility standards, and benefits;

(5) the policies and procedures of the managed care organization; and

(6) the importance of prevention, early intervention, and appropriate use of services.

Revisor's Note

(1) Section 531.0211(a), Government Code, refers to a "managed care Medicaid program." The revised law substitutes the term "Medicaid managed care program" for "managed care Medicaid program" because the terms are synonymous and "Medicaid managed care program" is more commonly used.

(2) Section 531.0211, Government Code, refers to a Medicaid client. The revised law substitutes "recipient" for references to a Medicaid client for clarity and consistency in the terminology used within the chapter and because "recipient," as defined by Section 540.0001 of this chapter, is applicable to the revised law and is more commonly used.

Revised Law

Sec. 540.0055. MARKETING GUIDELINES. (a) The commission shall establish marketing guidelines for Medicaid managed care organizations, including guidelines that prohibit:

(1) door-to-door marketing to a recipient by a Medicaid managed care organization or the organization's agent;

(2) using marketing materials with inaccurate or misleading information;

(3) making a misrepresentation to a recipient or provider;

(4) offering a recipient a material or financial incentive to choose a Medicaid managed care plan, other than a nominal gift or free health screening the commission approves that the Medicaid managed care organization offers to all recipients regardless of whether the recipients enroll in the plan;

(5) using a marketing agent who is paid solely by commission; and

(6) face-to-face marketing at a public assistance office by a Medicaid managed care organization or the organization's agent.

(b) This section does not prohibit:

(1) distributing approved marketing materials at a public assistance office; or

(2) providing information directly to a recipient under marketing guidelines the commission establishes. (Gov. Code, Secs. 533.008(a), (b).)

Source Law

Sec. 533.008. MARKETING GUIDELINES. (a) The commission shall establish marketing guidelines for managed care organizations that contract with the commission to provide health care services to recipients, including guidelines that prohibit:

(1) door-to-door marketing to recipients by managed care organizations or agents of those organizations;

(2) the use of marketing materials with inaccurate or misleading information;

(3) misrepresentations to recipients or providers;

(4) offering recipients material or

financial incentives to choose a managed care plan other than nominal gifts or free health screenings approved by the commission that the managed care organization offers to all recipients regardless of whether the recipients enroll in the managed care plan;

(5) the use of marketing agents who are paid solely by commission; and

(6) face-to-face marketing at public assistance offices by managed care organizations or agents of those organizations.

(b) This section does not prohibit:

(1) the distribution of approved marketing materials at public assistance offices; or

(2) the provision of information directly to recipients under marketing guidelines established by the commission.

Revised Law

Sec. 540.0056. GUIDELINES FOR COMMUNICATIONS WITH RECIPIENTS. The executive commissioner shall adopt and publish guidelines for Medicaid managed care organizations regarding how an organization may communicate by text message or e-mail with a recipient enrolled in the organization's Medicaid managed care plan using the contact information provided in the recipient's application for Medicaid benefits under Section 32.025(g)(2), Human Resources Code, including updated information provided to the organization in accordance with Section 32.025(h), Human Resources Code. (Gov. Code, Sec. 533.008(c).)

Source Law

(c) The executive commissioner shall adopt and publish guidelines for Medicaid managed care organizations regarding how organizations may communicate by text message or e-mail with recipients enrolled in the organization's managed care plan using the contact information provided in a recipient's application for Medicaid benefits under Section 32.025(g)(2), Human Resources Code, including updated information provided to the organization in accordance with Section 32.025(h), Human Resources Code.

Revised Law

Sec. 540.0057. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. (a) To the extent possible, the commission shall coordinate all external oversight activities to minimize duplicating oversight of Medicaid managed care plans and disrupting operations under those plans.

(b) The executive commissioner, after consulting with the commission's office of inspector general, shall by rule define the

commission's and office's roles in, jurisdiction over, and frequency of audits of Medicaid managed care organizations that are conducted by the commission and the office.

(c) In accordance with Sections ____ [[[Sections 531.102(q) and (w)]]], the commission shall share with the commission's office of inspector general, at the office's request, the results of any informal audit or on-site visit that could inform the office's risk assessment when determining:

(1) whether to conduct an audit of a Medicaid managed care organization; or

(2) the scope of the audit. (Gov. Code, Sec. 533.015.)

Source Law

> Sec. 533.015. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. (a) To the extent possible, the commission shall coordinate all external oversight activities to minimize duplication of oversight of managed care plans under Medicaid and disruption of operations under those plans.
>
> (b) The executive commissioner, after consulting with the commission's office of inspector general, shall by rule define the commission's and office's roles in and jurisdiction over, and frequency of, audits of managed care organizations participating in Medicaid that are conducted by the commission and the commission's office of inspector general.
>
> (c) [as added Acts 84th Leg., R.S., Ch. 837] In accordance with Section 531.102(q), the commission shall share with the commission's office of inspector general, at the request of the office, the results of any informal audit or onsite visit that could inform that office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.
>
> (c) [as added Acts 84th Leg., R.S., Ch. 945] In accordance with Section 531.102(w), the commission shall share with the commission's office of inspector general, at the request of the office, the results of any informal audit or on-site visit that could inform that office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

Revised Law

Sec. 540.0058. INFORMATION FOR FRAUD CONTROL. (a) Each Medicaid managed care organization shall submit at no cost to the commission and, on request, the office of the attorney general:

(1) a description of any financial or other business relationship between the organization and any subcontractor providing health care services under the contract between the

organization and the commission;

(2) a copy of each type of contract between the organization and a subcontractor relating to the delivery of or payment for health care services;

(3) a description of the fraud control program any subcontractor that delivers health care services uses; and

(4) a description and breakdown of all money paid to or by the organization, including a health maintenance organization, primary care case management provider, pharmacy benefit manager, and exclusive provider organization, necessary for the commission to determine the actual cost of administering the Medicaid managed care plan.

(b) The information under this section must be:

(1) submitted in the form the commission or the office of the attorney general, as applicable, requires; and

(2) updated as the commission or the office of the attorney general, as applicable, requires.

(c) The commission's office of inspector general or the office of the attorney general, as applicable, shall review the information a Medicaid managed care organization submits under this section as appropriate in investigating fraud in the Medicaid managed care program.

(d) Information a Medicaid managed care organization submits to the commission or the office of the attorney general under Subsection (a)(1) is confidential and not subject to disclosure under Chapter 552. (Gov. Code, Sec. 533.012.)

Source Law

Sec. 533.012. INFORMATION FOR FRAUD CONTROL. (a) Each managed care organization contracting with the commission under this chapter shall submit the following, at no cost, to the commission and, on request, the office of the attorney general:

(1) a description of any financial or other business relationship between the organization and any subcontractor providing health care services under the contract;

(2) a copy of each type of contract between the organization and a subcontractor relating to the delivery of or payment for health care services;

(3) a description of the fraud control

program used by any subcontractor that delivers health care services; and

(4) a description and breakdown of all funds paid to or by the managed care organization, including a health maintenance organization, primary care case management provider, pharmacy benefit manager, and exclusive provider organization, necessary for the commission to determine the actual cost of administering the managed care plan.

(b) The information submitted under this section must be submitted in the form required by the commission or the office of the attorney general, as applicable, and be updated as required by the commission or the office of the attorney general, as applicable.

(c) The commission's office of inspector general or the office of the attorney general, as applicable, shall review the information submitted under this section as appropriate in the investigation of fraud in the Medicaid managed care program.

(e) Information submitted to the commission or the office of the attorney general, as applicable, under Subsection (a)(1) is confidential and not subject to disclosure under Chapter 552, Government Code.

Revisor's Note

Section 533.012(a)(4), Government Code, refers to "funds" paid to or by a Medicaid managed care organization. The revised law substitutes "money" for "funds" because, in context, the meaning is the same and "money" is the more commonly used term.

Revised Law

Sec. 540.0059. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) In consultation with appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, the commission shall:

(1) establish a clinical improvement program to identify goals designed to:

(A) improve quality of care and care management; and

(B) reduce potentially preventable events; and

(2) require Medicaid managed care organizations to develop and implement collaborative program improvement strategies to address the goals.

(b) Goals established under this section may be set by

geographic region and program type. (Gov. Code, Secs. 533.00256(a) (part), (b).)

Source Law

> Sec. 533.00256. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) In consultation with appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, the commission shall:
>
> (1) establish a clinical improvement program to identify goals designed to improve quality of care and care management and to reduce potentially preventable events . . . ; and
>
> (2) require managed care organizations to develop and implement collaborative program improvement strategies to address the goals.
>
> (b) Goals established under this section may be set by geographic region and program type.

Revised Law

Sec. 540.0060. COMPLAINT SYSTEM GUIDELINES. (a) The Texas Department of Insurance, in conjunction with the commission, shall establish complaint system guidelines for Medicaid managed care organizations.

(b) The guidelines must require that information regarding a Medicaid managed care organization's complaint process be made available to a recipient in an appropriate communication format when the recipient enrolls in the Medicaid managed care program. (Gov. Code, Secs. 533.020(a) (part), (b).)

Source Law

> Sec. 533.020. MANAGED CARE ORGANIZATIONS: FISCAL SOLVENCY AND COMPLAINT SYSTEM GUIDELINES. (a) The Texas Department of Insurance, in conjunction with the commission, shall establish . . . complaint system guidelines for managed care organizations that serve recipients.
>
> (b) The guidelines must require that information regarding a managed care organization's complaint process be made available to a recipient in an appropriate communication format when the recipient enrolls in the Medicaid managed care program.

SUBCHAPTER C. FISCAL PROVISIONS

Revised Law

Sec. 540.0101. FISCAL SOLVENCY STANDARDS. The Texas Department of Insurance, in conjunction with the commission, shall establish fiscal solvency standards for Medicaid managed care organizations. (Gov. Code, Sec. 533.020(a) (part).)

Source Law

> Sec. 533.020. MANAGED CARE ORGANIZATIONS: FISCAL SOLVENCY AND COMPLAINT SYSTEM GUIDELINES. (a) The Texas Department of Insurance, in conjunction with the commission, shall establish fiscal solvency standards and . . . for managed care organizations that serve recipients.

Revised Law

Sec. 540.0102. PROFIT SHARING. (a) The executive commissioner shall adopt rules regarding the sharing of profits earned by a Medicaid managed care organization through a Medicaid managed care plan.

(b) Except as provided by Subsection (c), any amount this state receives under this section shall be deposited in the general revenue fund.

(c) If cost-effective, the commission may use amounts this state receives under this section to provide incentives to specific Medicaid managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service use. (Gov. Code, Sec. 533.014.)

Source Law

> Sec. 533.014. PROFIT SHARING. (a) The executive commissioner shall adopt rules regarding the sharing of profits earned by a managed care organization through a managed care plan providing health care services under a contract with the commission under this chapter.
>
> (b) Except as provided by Subsection (c), any amount received by the state under this section shall be deposited in the general revenue fund.
>
> (c) If cost-effective, the commission may use amounts received by the state under this section to provide incentives to specific managed care organizations to promote quality of care, encourage payment reform, reward local service delivery reform, increase efficiency, and reduce inappropriate or preventable service utilization.

Revised Law

Sec. 540.0103. TREATMENT OF STATE TAXES IN CALCULATING EXPERIENCE REBATE OR PROFIT SHARING. The commission shall ensure that any experience rebate or profit sharing for Medicaid managed care organizations is calculated by treating premium, maintenance, and other taxes under the Insurance Code and any other taxes payable

to this state as allowable expenses to determine the amount of the experience rebate or profit sharing. (Gov. Code, Sec. 533.0132.)

Source Law

> Sec. 533.0132. STATE TAXES. The commission shall ensure that any experience rebate or profit sharing for managed care organizations is calculated by treating premium, maintenance, and other taxes under the Insurance Code and any other taxes payable to this state as allowable expenses for purposes of determining the amount of the experience rebate or profit sharing.

SUBCHAPTER D. STRATEGY FOR MANAGING AUDIT RESOURCES

Revised Law

Sec. 540.0151. DEFINITIONS. In this subchapter:

(1) "Accounts receivable tracking system" means the system the commission uses to track experience rebates and other payments collected from managed care organizations.

(2) "Agreed-upon procedures engagement" means an evaluation of a managed care organization's financial statistical reports or other data conducted by an independent auditing firm the commission engages as agreed in the managed care organization's contract with the commission.

(3) "Experience rebate" means the amount a managed care organization is required to pay this state according to the graduated rebate method described in the organization's contract with the commission.

(4) "External quality review organization" means an organization that performs an external quality review of a managed care organization in accordance with 42 C.F.R. Section 438.350. (Gov. Code, Sec. 533.051.)

Source Law

> Sec. 533.051. DEFINITIONS. In this subchapter:
> (1) "Accounts receivable tracking system" means the system the commission uses to track experience rebates and other payments collected from managed care organizations.
> (2) "Agreed-upon procedures engagement" means an evaluation of a managed care organization's financial statistical reports or other data conducted by an independent auditing firm engaged by the commission as agreed in the managed care organization's contract with the commission.
> (3) "Experience rebate" means the amount a

managed care organization is required to pay the state according to the graduated rebate method described in the managed care organization's contract with the commission.

(4) "External quality review organization" means an organization that performs an external quality review of a managed care organization in accordance with 42 C.F.R. Section 438.350.

Revised Law

Sec. 540.0152. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. This subchapter does not apply to and may not be construed as affecting the conduct of audits by the commission's office of inspector general under the authority provided by _____ [[[Subchapter C, Chapter 531]]], including an audit of a managed care organization the office conducts after coordinating the office's audit and oversight activities with the commission as required by Section _____ [[[Section 531.102(q)]]]. (Gov. Code, Sec. 533.052.)

Source Law

Sec. 533.052. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. This subchapter does not apply to and may not be construed as affecting the conduct of audits by the commission's office of inspector general under the authority provided by Subchapter C, Chapter 531, including an audit of a managed care organization conducted by the office after coordinating the office's audit and oversight activities with the commission as required by Section 531.102(q), as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015.

Revisor's Note

Section 533.052, Government Code, refers to Section 531.102(q), Government Code, "as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015," because another Section 531.102(q), Government Code, was added by Chapter 945 (S.B. 207), Acts of the 84th Legislature, Regular Session, 2015. The revised law omits the quoted language as unnecessary because Section 531.102(q), as added by Chapter 945 (S.B. 207), was redesignated as Section 531.102(x), Government Code, by Chapter 324 (S.B. 1488), Acts of the 85th Legislature, Regular Session, 2017.

Revised Law

Sec. 540.0153. OVERALL STRATEGY FOR MANAGING AUDIT RESOURCES. The commission shall develop and implement an overall strategy for planning, managing, and coordinating audit resources that the commission uses to verify the accuracy and reliability of program and financial information managed care organizations report. (Gov. Code, Sec. 533.053.)

Source Law

> Sec. 533.053. OVERALL STRATEGY FOR MANAGING AUDIT RESOURCES. The commission shall develop and implement an overall strategy for planning, managing, and coordinating audit resources that the commission uses to verify the accuracy and reliability of program and financial information reported by managed care organizations.

Revised Law

Sec. 540.0154. PERFORMANCE AUDIT SELECTION PROCESS AND FOLLOW-UP. (a) To improve the commission's processes for performance audits of managed care organizations, the commission shall:

(1) document the process by which the commission selects organizations to audit;

(2) include previous audit coverage as a risk factor in selecting organizations to audit; and

(3) prioritize the highest risk organizations to audit.

(b) To verify that managed care organizations correct negative performance audit findings, the commission shall:

(1) establish a process to:

(A) document how the commission follows up on those findings; and

(B) verify that organizations implement performance audit recommendations; and

(2) establish and implement policies and procedures to:

(A) determine under what circumstances the commission must issue a corrective action plan to an organization

based on a performance audit; and

(B) follow up on the organization's implementation of the plan. (Gov. Code, Sec. 533.054.)

Source Law

Sec. 533.054. PERFORMANCE AUDIT SELECTION PROCESS AND FOLLOW-UP. (a) To improve the commission's processes for performance audits of managed care organizations, the commission shall:

(1) document the process by which the commission selects managed care organizations to audit;

(2) include previous audit coverage as a risk factor in selecting managed care organizations to audit; and

(3) prioritize the highest risk managed care organizations to audit.

(b) To verify that managed care organizations correct negative performance audit findings, the commission shall:

(1) establish a process to:

(A) document how the commission follows up on negative performance audit findings; and

(B) verify that managed care organizations implement performance audit recommendations; and

(2) establish and implement policies and procedures to:

(A) determine under what circumstances the commission must issue a corrective action plan to a managed care organization based on a performance audit; and

(B) follow up on the managed care organization's implementation of the corrective action plan.

Revised Law

Sec. 540.0155. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS. To enhance the commission's use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, the commission shall:

(1) ensure that financial risks identified in agreed-upon procedures engagements are adequately and consistently addressed; and

(2) establish policies and procedures to determine under what circumstances the commission must issue a corrective action plan based on an agreed-upon procedures engagement. (Gov. Code, Sec. 533.055.)

Source Law

> Sec. 533.055. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS. To enhance the commission's use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, the commission shall:
>
> (1) ensure that financial risks identified in agreed-upon procedures engagements are adequately and consistently addressed; and
>
> (2) establish policies and procedures to determine under what circumstances the commission must issue a corrective action plan based on an agreed-upon procedures engagement.

Revised Law

Sec. 540.0156. AUDITS OF PHARMACY BENEFIT MANAGERS. To obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, the commission shall:

(1) periodically audit each pharmacy benefit manager that contracts with a managed care organization; and

(2) develop, document, and implement a monitoring process to ensure that managed care organizations correct and resolve negative findings reported in performance audits or agreed-upon procedures engagements of pharmacy benefit managers. (Gov. Code, Sec. 533.056.)

Source Law

> Sec. 533.056. AUDITS OF PHARMACY BENEFIT MANAGERS. To obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, the commission shall:
>
> (1) periodically audit each pharmacy benefit manager that contracts with a managed care organization; and
>
> (2) develop, document, and implement a monitoring process to ensure that managed care organizations correct and resolve negative findings reported in performance audits or agreed-upon procedures engagements of pharmacy benefit managers.

Revised Law

Sec. 540.0157. COLLECTING COSTS FOR AUDIT-RELATED SERVICES. The commission shall develop, document, and implement billing processes in the commission's Medicaid and CHIP services department to ensure that managed care organizations reimburse the commission for audit-related services as required by contract.

(Gov. Code, Sec. 533.057.)

Source Law

> Sec. 533.057. COLLECTION OF COSTS FOR AUDIT-RELATED SERVICES. The commission shall develop, document, and implement billing processes in the Medicaid and CHIP services department of the commission to ensure that managed care organizations reimburse the commission for audit-related services as required by contract.

Revised Law

Sec. 540.0158. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING. To strengthen the commission's process for collecting shared profits from managed care organizations, the commission shall develop, document, and implement monitoring processes in the commission's Medicaid and CHIP services department to ensure that the commission:

(1) identifies experience rebates deposited in the commission's suspense account and timely transfers those rebates to the appropriate accounts; and

(2) timely follows up on and resolves disputes over experience rebates managed care organizations claim. (Gov. Code, Sec. 533.058.)

Source Law

> Sec. 533.058. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING. To strengthen the commission's process for collecting shared profits from managed care organizations, the commission shall develop, document, and implement monitoring processes in the Medicaid and CHIP services department of the commission to ensure that the commission:
>
> (1) identifies experience rebates deposited in the commission's suspense account and timely transfers those rebates to the appropriate accounts; and
>
> (2) timely follows up on and resolves disputes over experience rebates claimed by managed care organizations.

Revised Law

Sec. 540.0159. USING INFORMATION FROM EXTERNAL QUALITY REVIEWS. (a) To enhance the commission's monitoring of managed care organizations, the commission shall use the information provided by the external quality review organization, including:

(1) detailed data from results of surveys of:

(A) recipients and, if applicable, child health plan program enrollees;

(B) caregivers of those recipients and enrollees; and

(C) Medicaid and, as applicable, child health plan program providers; and

(2) the validation results of matching paid claims data with medical records.

(b) The commission shall document how the commission uses the information described by Subsection (a) to monitor managed care organizations. (Gov. Code, Sec. 533.059.)

Source Law

> Sec. 533.059. USE OF INFORMATION FROM EXTERNAL QUALITY REVIEWS. (a) To enhance the commission's monitoring of managed care organizations, the commission shall use the information provided by the external quality review organization, including:
>
> (1) detailed data from results of surveys of Medicaid recipients and, if applicable, child health plan program enrollees, caregivers of those recipients and enrollees, and Medicaid and, as applicable, child health plan program providers; and
>
> (2) the validation results of matching paid claims data with medical records.
>
> (b) The commission shall document how the commission uses the information described by Subsection (a) to monitor managed care organizations.

Revisor's Note

> Section 533.059(a)(1), Government Code, refers to "Medicaid recipients." The revised law omits "Medicaid" in that context because the term is included within the definition of "recipient" in Section 533.001, Government Code, revised in this chapter as Section 540.0001.

Revised Law

Sec. 540.0160. SECURITY OF AND PROCESSING CONTROLS OVER INFORMATION TECHNOLOGY SYSTEMS. The commission shall:

(1) strengthen user access controls for the commission's accounts receivable tracking system and network folders that the commission uses to manage the collection of experience rebates;

(2) document daily reconciliations of deposits recorded in the accounts receivable tracking system to the transactions processed in:

(A) the commission's cost accounting system for all health and human services agencies; and

(B) the uniform statewide accounting system; and

(3) develop, document, and implement a process to ensure that the commission formally documents:

(A) all programming changes made to the accounts receivable tracking system; and

(B) the authorization and testing of the changes described by Paragraph (A). (Gov. Code, Sec. 533.060.)

Source Law

> Sec. 533.060. SECURITY AND PROCESSING CONTROLS OVER INFORMATION TECHNOLOGY SYSTEMS. The commission shall:
>
> (1) strengthen user access controls for the commission's accounts receivable tracking system and network folders that the commission uses to manage the collection of experience rebates;
>
> (2) document daily reconciliations of deposits recorded in the accounts receivable tracking system to the transactions processed in:
>
> (A) the commission's cost accounting system for all health and human services agencies; and
>
> (B) the uniform statewide accounting system; and
>
> (3) develop, document, and implement a process to ensure that the commission formally documents:
>
> (A) all programming changes made to the accounts receivable tracking system; and
>
> (B) the authorization and testing of the changes described by Paragraph (A).

SUBCHAPTER E. CONTRACT ADMINISTRATION

Revised Law

Sec. 540.0201. CONTRACT ADMINISTRATION IMPROVEMENT EFFORTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve contract administration, 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 a managed care organization if an enrolled recipient:

(A) dies;

(B) is incarcerated;

(C) is enrolled in more than one state program; or

(D) is covered by another liable third party insurer;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in recovering capitation payments, payments from other liable third parties, and other payments made to a managed care organization with respect to an enrolled recipient who leaves the managed care program;

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

(A) where possible, decreasing duplicate administrative reporting and process requirements for managed care organizations and providers, such as requirements for submitting:

(i) encounter data;

(ii) quality reports;

(iii) historically underutilized business reports; and

(iv) claims payment summary reports;

(B) allowing a managed care organization 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:

(i) the preauthorization process;

(ii) lengths of hospital stays;

(iii) filing deadlines;

(iv) levels of care; and

(v) case management services;

(D) reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to:

(i) including a separate cover sheet for all communications;

(ii) submitting handwritten communications instead of electronic or typed review processes; and

(iii) admitting patients listed on separate notices; and

(E) providing a portal through which a provider in any managed care organization's provider network may submit acute care services and long-term services and supports claims; and

(5) reserve the right to amend a managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process the commission establishes for final determination of these disputes. (Gov. Code, Sec. 533.0071.)

Source Law

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 and process requirements for the managed care organizations and providers, 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;

(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 portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims; 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.

Revised Law

Sec. 540.0202. PUBLIC NOTICE OF REQUEST FOR CONTRACT APPLICATIONS. Not later than the 30th day before the date the commission plans to issue a request for applications to enter into a contract with the commission to provide health care services to recipients in a region, the commission shall publish notice of and make available for public review the request for applications and all related nonproprietary documents, including the proposed contract. (Gov. Code, Sec. 533.011.)

Source Law

Sec. 533.011. PUBLIC NOTICE. Not later than the 30th day before the commission plans to issue a request for applications to enter into a contract with the commission to provide health care services to recipients in a region, the commission shall publish notice of and make available for public review the request for applications and all related nonproprietary documents, including the proposed contract.

Revised Law

Sec. 540.0203. CERTIFICATION BY COMMISSION. (a) Before

the commission may award a contract under this chapter to a managed care organization, the commission shall evaluate and certify that the organization is reasonably able to fulfill the contract terms, including all federal and state law requirements. Notwithstanding any other law, the commission may not award a contract under this chapter to an organization that does not receive the required certification.

(b) A managed care organization may appeal the commission's denial of certification. (Gov. Code, Sec. 533.0035.)

Source Law

Sec. 533.0035. CERTIFICATION BY COMMISSION. (a) Before the commission may award a contract under this chapter to a managed care organization, the commission shall evaluate and certify that the organization is reasonably able to fulfill the terms of the contract, including all requirements of applicable federal and state law.

(b) Notwithstanding any other law, the commission may not award a contract under this chapter to a managed care organization that does not receive the certification required under this section.

(c) A managed care organization may appeal a denial of certification by the commission under this section.

Revisor's Note

Sections 533.0035(a) and (b), Government Code, require the Health and Human Services Commission to evaluate and certify a managed care organization before awarding to the organization a contract under "this chapter," meaning Chapter 533, Government Code. The relevant provisions of Chapter 533 relating to awarding contracts to those organizations are revised in this chapter. The revised law is drafted accordingly.

Revised Law

Sec. 540.0204. CONTRACT CONSIDERATIONS RELATING TO MANAGED CARE ORGANIZATIONS. In awarding contracts to managed care organizations, the commission shall:

(1) give preference to an organization that has 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 an organization that agrees to assure continuity of care for at least three months beyond a recipient's Medicaid eligibility period;

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

(4) consider the ability of an organization to process Medicaid claims electronically. (Gov. Code, Sec. 533.003(a) (part).)

Source Law

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

Revisor's Note

Section 533.003(a)(5), Government Code, requires the Health and Human Services Commission to give extra consideration to certain managed care organizations when awarding contracts to provide health care services during the commission's initial implementation of managed care in the South Texas service region. According to the commission, the commission has implemented managed care in that region. Accordingly, the revised law omits the provision as executed. The omitted law reads:

> [Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. (a) In awarding contracts to managed care organizations, the commission shall:]

. . .

(5) in the initial implementation of managed care in the South Texas service region, give extra consideration to an organization that either:

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

(B) is in compliance with the requirements of Section 533.004.

Revised Law

Sec. 540.0205. CONTRACT CONSIDERATIONS RELATING TO PHARMACY BENEFIT MANAGERS. In considering approval of a subcontract between a managed care organization and a pharmacy benefit manager to provide Medicaid prescription drug benefits, the commission shall review and consider whether in the preceding three years the pharmacy benefit manager has been:

(1) convicted of:

(A) an offense involving a material misrepresentation or an act of fraud; or

(B) another violation of state or federal criminal law;

(2) adjudicated to have committed a breach of contract; or

(3) assessed a penalty or fine of $500,000 or more in a state or federal administrative proceeding. (Gov. Code, Sec. 533.003(b).)

Source Law

(b) The commission, in considering approval of a subcontract between a managed care organization and a pharmacy benefit manager for the provision of prescription drug benefits under Medicaid, shall review and consider whether the pharmacy benefit manager has been in the preceding three years:

(1) convicted of an offense involving a material misrepresentation or an act of fraud or of another violation of state or federal criminal law;

(2) adjudicated to have committed a breach of contract; or

(3) assessed a penalty or fine in the amount of $500,000 or more in a state or federal administrative proceeding.

Revised Law

Sec. 540.0206. MANDATORY CONTRACTS. (a) Subject to the certification required under Section 540.0203 and the

considerations required under Section 540.0204, in providing health care services through Medicaid managed care to recipients in a health care service region, the commission shall contract with a managed care organization in that region that holds a certificate of authority issued under Chapter 843, Insurance Code, to provide health care in that region and that is:

(1) wholly owned and operated by a hospital district in that region;

(2) created by a nonprofit corporation that:

(A) has a contract, agreement, or other arrangement with a hospital district in that region or with a municipality in that region that owns a hospital licensed under Chapter 241, Health and Safety Code, and has an obligation to provide health care to indigent patients; and

(B) under the contract, agreement, or other arrangement, assumes the obligation to provide health care to indigent patients and leases, manages, or operates a hospital facility the hospital district or municipality owns; or

(3) created by a nonprofit corporation that has a contract, agreement, or other arrangement with a hospital district in that region under which the nonprofit corporation acts as an agent of the district and assumes the district's obligation to arrange for services under the Medicaid expansion for children as authorized by Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular Session, 1995.

(b) A managed care organization described by Subsection (a) is subject to all terms to which other managed care organizations are subject, including all contractual, regulatory, and statutory provisions relating to participation in the Medicaid managed care program.

(c) The commission shall make the awarding and renewal of a mandatory contract under this section to a managed care organization affiliated with a hospital district or municipality contingent on the district or municipality entering into a matching

funds agreement to expand Medicaid for children as authorized by Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular Session, 1995. The commission shall make compliance with the matching funds agreement a condition of the continuation of the contract with the organization to provide health care services to recipients.

(d) In providing health care services through Medicaid managed care to recipients in a health care service region, with the exception of the Harris service area for the STAR Medicaid managed care program, as the commission defined as of September 1, 1999, the commission shall also contract with a managed care organization in that region that holds a certificate of authority as a health maintenance organization issued under Chapter 843, Insurance Code, and that:

(1) is certified under Section 162.001, Occupations Code;

(2) is created by The University of Texas Medical Branch at Galveston; and

(3) has obtained a certificate of authority as a health maintenance organization to serve one or more counties in that region from the Texas Department of Insurance before September 2, 1999. (Gov. Code, Secs. 533.004(a), (b), (c), (e).)

Source Law

Sec. 533.004. MANDATORY CONTRACTS. (a) Subject to the considerations required under Section 533.003 and the certification required under Section 533.0035, in providing health care services through Medicaid managed care to recipients in a health care service region, the commission shall contract with a managed care organization in that region that is licensed under Chapter 843, Insurance Code, to provide health care in that region and that is:

(1) wholly owned and operated by a hospital district in that region;

(2) created by a nonprofit corporation that:

(A) has a contract, agreement, or other arrangement with a hospital district in that region or with a municipality in that region that owns a hospital licensed under Chapter 241, Health and Safety Code, and has an obligation to provide health care to indigent patients; and

(B) under the contract, agreement, or

other arrangement, assumes the obligation to provide health care to indigent patients and leases, manages, or operates a hospital facility owned by the hospital district or municipality; or

(3) created by a nonprofit corporation that has a contract, agreement, or other arrangement with a hospital district in that region under which the nonprofit corporation acts as an agent of the district and assumes the district's obligation to arrange for services under the Medicaid expansion for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995.

(b) A managed care organization described by Subsection (a) is subject to all terms and conditions to which other managed care organizations are subject, including all contractual, regulatory, and statutory provisions relating to participation in the Medicaid managed care program.

(c) The commission shall make the awarding and renewal of a mandatory contract under this section to a managed care organization affiliated with a hospital district or municipality contingent on the district or municipality entering into a matching funds agreement to expand Medicaid for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995. The commission shall make compliance with the matching funds agreement a condition of the continuation of the contract with the managed care organization to provide health care services to recipients.

(e) In providing health care services through Medicaid managed care to recipients in a health care service region, with the exception of the Harris service area for the STAR Medicaid managed care program, as defined by the commission as of September 1, 1999, the commission shall also contract with a managed care organization in that region that holds a certificate of authority as a health maintenance organization under Chapter 843, Insurance Code, and that:

(1) is certified under Section 162.001, Occupations Code;

(2) is created by The University of Texas Medical Branch at Galveston; and

(3) has obtained a certificate of authority as a health maintenance organization to serve one or more counties in that region from the Texas Department of Insurance before September 2, 1999.

Revisor's Note

(1) Section 533.004(a), Government Code, refers to the Health and Human Services Commission contracting with a managed care organization, "[s]ubject to the considerations required under Section 533.003," Government Code. Section 533.003 is revised in this chapter as Sections 540.0204 and 540.0205. The relevant provisions relating to contract considerations for managed care

organizations are revised as Section 540.0204 of this chapter, and the revised law is drafted accordingly.

(2) Section 533.004(a), Government Code, refers to a managed care organization that "is licensed" under Chapter 843, Insurance Code. The revised law substitutes "holds a certificate of authority" for the quoted language because Section 843.071, Insurance Code, requires a health maintenance organization to hold a certificate of authority, not a license, to engage in business in this state.

(3) Section 533.004(b), Government Code, refers to certain "terms and conditions" to which a managed care organization is subject. The revised law omits "conditions" from the quoted phrase because, in that context, the meaning of "conditions" is included in the meaning of "terms."

(4) Section 533.004(d), Government Code, provides that the requirements of Section 533.004(c), Government Code, which is revised in this chapter as Section 540.0206(c), do not apply if the Health and Human Services Commission does not expand Medicaid for children as authorized by Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular Session, 1995, or a federal waiver for the expansion is not authorized. According to the commission, the commission expanded Medicaid for children as authorized by the Act and obtained a federal waiver. Accordingly, the revised law omits the provision as executed. The omitted law reads:

> (d) Subsection (c) does not apply if:
>
> (1) the commission does not expand Medicaid for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995; or
>
> (2) a waiver from a federal agency necessary for the expansion is not granted.

Revised Law

Sec. 540.0207. CONTRACTUAL OBLIGATIONS REVIEW. The commission shall review each Medicaid managed care organization to determine whether the organization is prepared to meet the organization's contractual obligations. (Gov. Code, Sec. 533.007(a).)

Source Law

> Sec. 533.007. CONTRACT COMPLIANCE. (a) The commission shall review each managed care organization that contracts with the commission to provide health care services to recipients through a managed care plan issued by the organization to determine whether the organization is prepared to meet its contractual obligations.

Revised Law

Sec. 540.0208. CONTRACT IMPLEMENTATION PLAN. (a) Each Medicaid managed care organization that contracts to provide health care services to recipients in a health care service region shall submit an implementation plan not later than the 90th day before the date the organization plans to begin providing those services in that region through managed care. The implementation plan must include:

(1) specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training; and

(2) specific time frames for demonstrating preparedness for implementation before the date the organization plans to begin providing those services in that region through managed care.

(b) The commission shall respond to an implementation plan not later than the 10th day after the date a Medicaid managed care organization submits the plan if the plan does not adequately meet preparedness guidelines.

(c) Each Medicaid managed care organization that contracts to provide health care services to recipients in a health care service region shall submit status reports on the implementation

plan:

(1) not later than the 60th day and the 30th day before the date the organization plans to begin providing those services in that region through managed care; and

(2) every 30th day after that date until the 180th day after that date. (Gov. Code, Secs. 533.007(b), (c), (d).)

Source Law

> (b) Each managed care organization that contracts with the commission to provide health care services to recipients in a health care service region shall submit an implementation plan not later than the 90th day before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care. The implementation plan must include:
>
> (1) specific staffing patterns by function for all operations, including enrollment, information systems, member services, quality improvement, claims management, case management, and provider and recipient training; and
>
> (2) specific time frames for demonstrating preparedness for implementation before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care.
>
> (c) The commission shall respond to an implementation plan not later than the 10th day after the date a managed care organization submits the plan if the plan does not adequately meet preparedness guidelines.
>
> (d) Each managed care organization that contracts with the commission to provide health care services to recipients in a region shall submit status reports on the implementation plan not later than the 60th day and the 30th day before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care and every 30th day after that date until the 180th day after that date.

Revised Law

Sec. 540.0209. COMPLIANCE AND READINESS REVIEW. (a) The commission shall conduct a compliance and readiness review of each Medicaid managed care organization:

(1) not later than the 15th day before the date the process of enrolling recipients in a managed care plan the organization issues is to begin in a region; and

(2) not later than the 15th day before the date the organization plans to begin providing health care services to recipients in that region through managed care.

(b) The compliance and readiness review must include an on-site inspection and tests of service authorization and claims payment systems, including:

(1) the Medicaid managed care organization's ability to process claims electronically;

(2) the Medicaid managed care organization's complaint processing systems; and

(3) any other process or system the contract between the Medicaid managed care organization and the commission requires.

(c) The commission may delay recipient enrollment in a managed care plan a Medicaid managed care organization issues if the compliance and readiness review reveals that the organization is not prepared to meet the organization's contractual obligations. The commission shall notify the organization of a decision to delay enrollment in a plan the organization issues. (Gov. Code, Secs. 533.007(e), (f).)

Source Law

> (e) The commission shall conduct a compliance and readiness review of each managed care organization that contracts with the commission not later than the 15th day before the date on which the process of enrolling recipients in a managed care plan issued by the managed care organization is to begin in a region and again not later than the 15th day before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care. The review must include an on-site inspection and tests of service authorization and claims payment systems, including the ability of the managed care organization to process claims electronically, complaint processing systems, and any other process or system required by the contract.
>
> (f) The commission may delay enrollment of recipients in a managed care plan issued by a managed care organization if the review reveals that the managed care organization is not prepared to meet its contractual obligations. The commission shall notify a managed care organization of a decision to delay enrollment in a plan issued by that organization.

Revised Law

Sec. 540.0210. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) The commission shall prepare and maintain a record of each enforcement action the commission initiates that results in a sanction, including a penalty, being

imposed against a managed care organization for failure to comply with the terms of a contract to provide health care services to recipients through a Medicaid managed care plan the organization issues.

(b) The record must include:

(1) the managed care organization's name and address;

(2) a description of the contractual obligation the organization failed to meet;

(3) the date of determination of noncompliance;

(4) the date the sanction was imposed;

(5) the maximum sanction that may be imposed under the contract for the violation; and

(6) the actual sanction imposed against the organization.

(c) The commission shall:

(1) post and maintain on the commission's Internet website the records required by this section:

(A) in English and Spanish; and

(B) in a format that is readily accessible to and understandable by the public; and

(2) update the list of records on the website at least quarterly.

(d) The commission may not post information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(e) A record prepared under this section may not include information that is excepted from disclosure under Chapter 552.

(f) The executive commissioner shall adopt rules as necessary to implement this section. (Gov. Code, Sec. 533.0072.)

Source Law

Sec. 533.0072. INTERNET POSTING OF SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS. (a) The commission shall prepare and maintain a record of each enforcement action initiated by the commission that results in a sanction, including a penalty, being imposed against a managed care organization for failure to comply with the terms of a contract to

provide health care services to recipients through a managed care plan issued by the organization.

(b) The record must include:

(1) the name and address of the organization;

(2) a description of the contractual obligation the organization failed to meet;

(3) the date of determination of noncompliance;

(4) the date the sanction was imposed;

(5) the maximum sanction that may be imposed under the contract for the violation; and

(6) the actual sanction imposed against the organization.

(c) The commission shall post and maintain the records required by this section on the commission's Internet website in English and Spanish. The records must be posted in a format that is readily accessible to and understandable by a member of the public. The commission shall update the list of records on the website at least quarterly.

(d) The commission may not post information under this section that relates to a sanction while the sanction is the subject of an administrative appeal or judicial review.

(e) A record prepared under this section may not include information that is excepted from disclosure under Chapter 552.

(f) The executive commissioner shall adopt rules as necessary to implement this section.

Revised Law

Sec. 540.0211. PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS. (a) The commission shall establish outcome-based performance measures and incentives to include in each contract between the commission and a health maintenance organization to provide health care services to recipients that is procured and managed under a value-based purchasing model. The performance measures and incentives must:

(1) be designed to facilitate and increase recipient access to appropriate health care services; and

(2) to the extent possible, align with other state and regional quality care improvement initiatives.

(b) Subject to Subsection (c), the commission shall include the performance measures and incentives in each contract described by Subsection (a) in addition to all other contract provisions required by this chapter and Chapter _____ [[[Sections 533.00257, 533.002571, 533.00258, 533.002581]]].

(c) The commission may use a graduated approach to including the performance measures and incentives in contracts described by

Subsection (a) to ensure incremental and continued improvements over time.

(d) Subject to Subsection (e), the commission shall assess the feasibility and cost-effectiveness of including provisions in a contract described by Subsection (a) that require the health maintenance organization to provide to the providers in the organization's provider network pay-for-performance opportunities that support quality improvements in recipient care. Pay-for-performance opportunities may include incentives for providers to:

(1) provide care after normal business hours;

(2) participate in the early and periodic screening, diagnosis, and treatment program; and

(3) participate in other activities that improve recipient access to care.

(e) The commission shall, to the extent possible, base an assessment of feasibility and cost-effectiveness under Subsection (d) on publicly available, scientifically valid, evidence-based criteria appropriate for assessing the Medicaid population.

(f) In assessing feasibility and cost-effectiveness under Subsection (d), the commission may consult with participating Medicaid providers, including providers with expertise in quality improvement and performance measurement.

(g) If the commission determines that the provisions described by Subsection (d) are feasible and may be cost-effective, the commission shall develop and implement a pilot program in at least one health care service region under which the commission will include the provisions in contracts with health maintenance organizations offering Medicaid managed care plans in the region.

(h) The commission shall post the financial statistical report on the commission's Internet website in a comprehensive and understandable format. (Gov. Code, Sec. 533.0051.)

Source Law

Sec. 533.0051. PERFORMANCE MEASURES AND

INCENTIVES FOR VALUE-BASED CONTRACTS. (a) The commission shall establish outcome-based performance measures and incentives to include in each contract between a health maintenance organization and the commission for the provision of health care services to recipients that is procured and managed under a value-based purchasing model. The performance measures and incentives must:

(1) be designed to facilitate and increase recipients' access to appropriate health care services; and

(2) to the extent possible, align with other state and regional quality care improvement initiatives.

(b) Subject to Subsection (c), the commission shall include the performance measures and incentives established under Subsection (a) in each contract described by that subsection in addition to all other contract provisions required by this chapter.

(c) The commission may use a graduated approach to including the performance measures and incentives established under Subsection (a) in contracts described by that subsection to ensure incremental and continued improvements over time.

(d) Subject to Subsection (f), the commission shall assess the feasibility and cost-effectiveness of including provisions in a contract described by Subsection (a) that require the health maintenance organization to provide to the providers in the organization's provider network pay-for-performance opportunities that support quality improvements in the care of recipients. Pay-for-performance opportunities may include incentives for providers to provide care after normal business hours and to participate in the early and periodic screening, diagnosis, and treatment program and other activities that improve recipients' access to care. If the commission determines that the provisions are feasible and may be cost-effective, the commission shall develop and implement a pilot program in at least one health care service region under which the commission will include the provisions in contracts with health maintenance organizations offering managed care plans in the region.

(e) The commission shall post the financial statistical report on the commission's web page in a comprehensive and understandable format.

(f) The commission shall, to the extent possible, base an assessment of feasibility and cost-effectiveness under Subsection (d) on publicly available, scientifically valid, evidence-based criteria appropriate for assessing the Medicaid population.

(g) In performing the commission's duties under Subsection (d) with respect to assessing feasibility and cost-effectiveness, the commission may consult with participating Medicaid providers, including those with expertise in quality improvement and performance measurement.

Revisor's Note

Section 533.0051(e), Government Code, refers to the Health and Human Services Commission's "web page." The revised law substitutes the term "Internet

website" for "web page" because the terms are synonymous and "Internet website" is more commonly used.

Revised Law

Sec. 540.0212. MONITORING COMPLIANCE WITH BEHAVIORAL HEALTH INTEGRATION. (a) In this section, "behavioral health services" has the meaning assigned by Section 540.0703.

(b) In monitoring contracts the commission enters into with Medicaid managed care organizations under this chapter, the commission shall:

(1) ensure the organizations fully integrate behavioral health services into a recipient's primary care coordination;

(2) use performance audits and other oversight tools to improve monitoring of the provision and coordination of behavioral health services; and

(3) establish performance measures that may be used to determine the effectiveness of the behavioral health services integration.

(c) In monitoring a Medicaid managed care organization's compliance with behavioral health services integration requirements under this section, the commission shall give particular attention to an organization that provides behavioral health services through a contract with a third party. (Gov. Code, Sec. 533.002551.)

Source Law

Sec. 533.002551. MONITORING OF COMPLIANCE WITH BEHAVIORAL HEALTH INTEGRATION. (a) In this section, "behavioral health services" has the meaning assigned by Section 533.00255.

(b) In monitoring contracts the commission enters into with managed care organizations under this chapter, the commission shall:

(1) ensure managed care organizations fully integrate behavioral health services into a recipient's primary care coordination;

(2) use performance audits and other oversight tools to improve monitoring of the provision and coordination of behavioral health services; and

(3) establish performance measures that may be used to determine the effectiveness of the

integration of behavioral health services.

(c) In monitoring a managed care organization's compliance with behavioral health services integration requirements under this section, the commission shall give particular attention to a managed care organization that provides behavioral health services through a contract with a third party.

SUBCHAPTER F. REQUIRED CONTRACT PROVISIONS

Revised Law

Sec. 540.0251. APPLICABILITY. This subchapter applies to a contract between a Medicaid managed care organization and the commission to provide health care services to recipients. (Gov. Code, Sec. 533.005(a) (part).)

Source Law

Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

Revised Law

Sec. 540.0252. ACCOUNTABILITY TO STATE. A contract to which this subchapter applies must contain procedures to ensure accountability to this state for providing health care services, including procedures for:

(1) financial reporting;

(2) quality assurance;

(3) utilization review; and

(4) assurance of contract and subcontract compliance.

(Gov. Code, Sec. 533.005(a)(1).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (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;

. . .

Revised Law

Sec. 540.0253. CAPITATION RATES. A contract to which this subchapter applies must contain capitation rates that:

(1) include acuity and risk adjustment methodologies

that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the Medicaid managed care plan; and

(2) ensure the cost-effective provision of quality health care. (Gov. Code, Sec. 533.005(a)(2).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(2) capitation rates that:

(A) include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the plan; and

(B) ensure the cost-effective provision of quality health care;

. . .

Revisor's Note

Section 533.005(a)(2)(A), Government Code, refers to capitation rates for services and supports provided under a Medicaid managed care organization's "plan." Because an organization that contracts with the Health and Human Services Commission under Chapter 533, Government Code, to provide health care services to Medicaid recipients provides those services through a Medicaid managed care plan, and because it is clear from the context that is the plan to which the source law refers, the revised law substitutes "Medicaid managed care plan" for "plan" for the convenience of the reader.

Revised Law

Sec. 540.0254. COST INFORMATION. A contract to which this subchapter applies must require the contracting Medicaid managed care organization and any entity with which the organization contracts to perform services under a Medicaid managed care plan to disclose at no cost to the commission and, on request, the office of the attorney general all agreements affecting the net cost of goods

or services provided under the plan, including:

(1) discounts;

(2) incentives;

(3) rebates;

(4) fees;

(5) free goods; and

(6) bundling arrangements. (Gov. Code, Sec. 533.005(a)(24).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan;

. . .

Revised Law

Sec. 540.0255. FRAUD CONTROL. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to:

(1) provide the information required by Section 540.0058; and

(2) otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general. (Gov. Code, Sec. 533.005(a)(10).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(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 and the office of the attorney general;

. . .

Revised Law

Sec. 540.0256. RECIPIENT OUTREACH AND EDUCATION. A contract to which this subchapter applies must:

(1) require the contracting Medicaid managed care organization to provide:

(A) information about the availability of and referral to educational, social, and other community services that could benefit a recipient; and

(B) special programs and materials for recipients with limited English proficiency or low literacy skills; and

(2) contain procedures for recipient outreach and education. (Gov. Code, Secs. 533.005(a)(5), (6), (18).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(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;

. . .

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

. . .

Revised Law

Sec. 540.0257. NOTICE OF MEDICAID CERTIFICATION DATE. A contract to which this subchapter applies must require the commission to inform the contracting Medicaid managed care organization, on the date of a recipient's enrollment in a Medicaid managed care plan the organization issues, of the recipient's Medicaid certification date. (Gov. Code, Sec. 533.005(a)(8).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(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;

. . .

Revised Law

Sec. 540.0258. PRIMARY CARE PROVIDER ASSIGNMENT. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to make initial and subsequent primary care provider assignments and changes. (Gov. Code, Sec. 533.005(a)(26).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

Revised Law

Sec. 540.0259. COMPLIANCE WITH PROVIDER NETWORK REQUIREMENTS. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to comply with Sections 540.0651(a)(1) and (2) and (b) as a condition of contract retention and renewal. (Gov. Code, Sec. 533.005(a)(9).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

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

. . .

Revised Law

Sec. 540.0260. COMPLIANCE WITH PROVIDER ACCESS STANDARDS; REPORT. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to:

(1) develop and submit to the commission, before the organization begins providing health care services to recipients, a comprehensive plan that describes how the organization's provider

network complies with the provider access standards the commission establishes under Section 540.0652;

(2) as a condition of contract retention and renewal:

(A) continue to comply with the provider access standards; and

(B) make substantial efforts, as the commission determines, to mitigate or remedy any noncompliance with the provider access standards;

(3) pay liquidated damages for each failure, as the commission determines, to comply with the provider access standards in amounts that are reasonably related to the noncompliance; and

(4) regularly, as the commission determines, submit to the commission and make available to the public a report containing:

(A) data on the organization's provider network sufficiency with regard to providing the care and services described by Section 540.0652(a); and

(B) specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated. (Gov. Code, Sec. 533.005(a)(20).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(20) a requirement that the managed care organization:

(A) 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 complies with the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a) and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated;

. . .

Revised Law

Sec. 540.0261. PROVIDER NETWORK SUFFICIENCY. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to demonstrate to the commission, before the organization begins providing health care services to recipients, that, subject to the provider access standards the commission establishes under Section 540.0652:

(1) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a Medicaid managed care plan the organization offers;

(2) the organization's provider network includes:

(A) a sufficient number of primary care providers;

(B) a sufficient variety of provider types;

(C) a sufficient number of long-term services and supports providers and specialty pediatric care providers of home

and community-based services; and

(D) providers located throughout the region in which the organization will provide health care services; and

(3) health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service model or primary care case management Medicaid managed care model. (Gov. Code, Sec. 533.005(a)(21).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that, subject to the provider access standards established under Section 533.0061:

(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;

(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and

(iv) 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 a comparable 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;

. . .

Revised Law

Sec. 540.0262. QUALITY MONITORING PROGRAM FOR HEALTH CARE SERVICES. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(1) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(2) focuses on measuring outcomes; and

(3) includes collecting and analyzing clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance use. (Gov. Code, Sec. 533.005(a)(22).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(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 or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(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;

. . .

Revisor's Note

Section 533.005(a)(22)(C), Government Code, refers to the treatment of "substance abuse." The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), published by the American Psychiatric Association to assist in classifying mental disorders, combines the categories of substance abuse and substance dependence into a single disorder referred to as "substance use disorder." Therefore,

the revised law substitutes "substance use" for "substance abuse" to reflect modern terminology regarding the disorder.

Revised Law

Sec. 540.0263. OUT-OF-NETWORK PROVIDER USAGE AND REIMBURSEMENT. (a) A contract to which this subchapter applies must require that:

(1) the contracting Medicaid managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits the commission determines for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions; and

(2) the 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, if the commission finds that the organization violated Subdivision (1).

(b) In accordance with Subsection (a)(2), a Medicaid managed care organization must reimburse an out-of-network provider of poststabilization services for providing the services at the allowable rate for those services until the organization arranges for the recipient's timely transfer, as the recipient's attending physician determines, to a provider in the organization's provider network. The organization may not refuse to reimburse an out-of-network provider for emergency or poststabilization services provided as a result of the organization's failure to arrange for and authorize a recipient's timely transfer. (Gov. Code, Secs. 533.005(a)(11), (12), (b).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(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;

. . .

(b) In accordance with Subsection (a)(12), all post-stabilization services provided by an out-of-network provider must be reimbursed by the managed care organization at the allowable rate for those services until the managed care organization arranges for the timely transfer of the recipient, as determined by the recipient's attending physician, to a provider in the network. A managed care organization may not refuse to reimburse an out-of-network provider for emergency or post-stabilization services provided as a result of the managed care organization's failure to arrange for and authorize a timely transfer of a recipient.

Revised Law

Sec. 540.0264. PROVIDER REIMBURSEMENT RATE REDUCTION. (a) A contract to which this subchapter applies must require that the contracting Medicaid managed care organization not implement a significant, nonnegotiated, across-the-board provider reimbursement rate reduction unless:

(1) subject to Subsection (b), the organization has the commission's prior approval to implement the reduction; or

(2) the rate reduction is based on changes to the Medicaid fee schedule or cost containment initiatives the commission implements.

(b) A provider reimbursement rate reduction a Medicaid managed care organization proposes is considered to have received the commission's prior approval unless the commission issues a written statement of disapproval not later than the 45th day after the date the commission receives notice of the proposed rate reduction from the organization. (Gov. Code, Secs. 533.005(a)(25), (a-3).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reductions; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; and

. . .

(a-3) For purposes of Subsection (a)(25)(A), a provider reimbursement rate reduction is considered to have received the commission's prior approval unless the commission issues a written statement of disapproval not later than the 45th day after the date the commission receives notice of the proposed rate reduction from the managed care organization.

Revised Law

Sec. 540.0265. PROMPT PAYMENT OF CLAIMS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to pay a physician or provider for health care services provided to a recipient under a Medicaid managed care plan on any claim for payment the organization receives with documentation reasonably necessary for the organization to process the claim:

(1) not later than:

(A) the 10th day after the date the organization receives the claim if the claim relates to services a nursing facility, intermediate care facility, or group home provided;

(B) the 30th day after the date the organization receives the claim if the claim relates to the provision of long-term services and supports not subject to Paragraph (A); and

(C) the 45th day after the date the organization receives the claim if the claim is not subject to Paragraph (A) or (B); or

(2) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the organization.

(b) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to demonstrate to the commission that the organization pays claims described by

Subsection (a)(1)(B) on average not later than the 21st day after the date the organization receives the claim. (Gov. Code, Secs. 533.005(a)(7), (7-a).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(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 on any claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

. . .

Revised Law

Sec. 540.0266. REIMBURSEMENT FOR CERTAIN SERVICES PROVIDED OUTSIDE REGULAR BUSINESS HOURS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to 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 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.

(b) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be

outside of regular business hours for purposes of Subsection (a). (Gov. Code, Secs. 533.005(a)(14), (c).)

Source Law

> [Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]
>
> . . .
>
> (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;
>
> . . .
>
> (c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (a)(14).

Revised Law

Sec. 540.0267. PROVIDER APPEALS PROCESS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop, implement, and maintain a system for tracking and resolving provider appeals related to claims payment. The system must include a process that requires:

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

(2) 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 that:

(A) relate to denial on the basis of medical necessity; and

(B) remain unresolved after a provider appeal;

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

(4) the organization to allow a provider to initiate an appeal of a claim that has not been paid before the time prescribed by Section 540.0265(a)(1)(B).

(b) A contract to which this subchapter applies must require

the contracting Medicaid managed care organization to develop and establish a process for responding to provider appeals in the region in which the organization provides health care services. (Gov. Code, Secs. 533.005(a)(15), (19).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(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;

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

(D) the managed care organization to allow a provider with a claim that has not been paid before the time prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that claim;

. . .

(19) 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;

. . .

Revised Law

Sec. 540.0268. ASSISTANCE RESOLVING RECIPIENT AND PROVIDER ISSUES. A contract to which this subchapter applies must require the contracting Medicaid managed care organization to provide ready access to a person who assists:

(1) a recipient in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures; and

(2) a provider in resolving issues relating to payment, plan administration, education and training, and grievance procedures. (Gov. Code, Secs. 533.005(a)(3), (4).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(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;

. . .

Revised Law

Sec. 540.0269. USE OF ADVANCED PRACTICE REGISTERED NURSES AND PHYSICIAN ASSISTANTS. (a) A contract to which this subchapter applies must require the contracting Medicaid managed care organization, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, to:

(1) use advanced practice registered nurses and physician assistants as primary care providers in addition to physicians to increase the availability of primary care providers in the organization's provider network; and

(2) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(A) selection and assignment as primary care providers;

(B) inclusion as primary care providers in the organization's provider network; and

(C) inclusion as primary care providers in any provider network directory the organization maintains.

(b) For purposes of this section, an advanced practice registered nurse may be included as a primary care provider in a Medicaid managed care organization's provider network regardless of whether the physician supervising the advanced practice registered nurse is in the provider network. This subsection may

not be construed as authorizing a Medicaid managed care organization to supervise or control the practice of medicine as prohibited by Subtitle B, Title 3, Occupations Code. (Gov. Code, Secs. 533.005(a)(13), (d).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

. . .

(d) For purposes of Subsection (a)(13), an advanced practice registered nurse may be included as a primary care provider in a managed care organization's provider network regardless of whether the physician supervising the advanced practice registered nurse is in the provider network. This subsection may not be construed as authorizing a managed care organization to supervise or control the practice of medicine as prohibited by Subtitle B, Title 3, Occupations Code.

Revised Law

Sec. 540.0270. MEDICAL DIRECTOR AVAILABILITY. A contract to which this subchapter applies must require that a medical director who is authorized to make medical necessity determinations be available to the region in which the contracting Medicaid managed care organization provides health care services. (Gov. Code, Sec. 533.005(a)(16).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

. . .

Revised Law

Sec. 540.0271. PERSONNEL REQUIRED IN CERTAIN SERVICE REGIONS. A contract to which this subchapter applies must require a contracting Medicaid managed care organization that provides a Medicaid managed care plan in the South Texas service region to ensure the following personnel are located in that region:

(1) a medical director;

(2) patient care coordinators; and

(3) provider and recipient support services personnel. (Gov. Code, Sec. 533.005(a)(17).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

. . .

Revised Law

Sec. 540.0272. CERTAIN SERVICES PERMITTED IN LIEU OF OTHER MENTAL HEALTH OR SUBSTANCE USE DISORDER SERVICES; ANNUAL REPORT. A contract to which this subchapter applies must contain language permitting the contracting Medicaid managed care organization to offer medically appropriate, cost-effective, evidence-based services from a list approved by the former state Medicaid managed care advisory committee and included in the contract in lieu of mental health or substance use disorder services specified in the state Medicaid plan. A recipient is not required to use a service from the list included in the contract in lieu of another mental health or substance use disorder service specified in the state Medicaid plan. The commission shall:

(1) prepare and submit to the legislature an annual report on the number of times during the preceding year a service from the list included in the contract is used; and

(2) consider the actual cost and use of any services from the list included in the contract that are offered by a Medicaid managed care organization when setting the capitation rates for that organization under the contract. (Gov. Code, Sec. 533.005(h).)

Source Law

> (h) In addition to the requirements specified by Subsection (a), a contract described by that subsection must contain language permitting a managed care organization to offer medically appropriate, cost-effective, evidence-based services from a list approved by the state Medicaid managed care advisory committee and included in the contract in lieu of mental health or substance use disorder services specified in the state Medicaid plan. A recipient is not required to use a service from the list included in the contract in lieu of another mental health or substance use disorder service specified in the state Medicaid plan. The commission shall:
>
> (1) prepare and submit an annual report to the legislature on the number of times during the preceding year a service from the list included in the contract is used; and
>
> (2) take into consideration the actual cost and use of any services from the list included in the contract that are offered by a managed care organization when setting the capitation rates for that organization under the contract.

Revisor's Note

(1) Section 533.005(h), Government Code, specifies certain language that must be included in a contract under Section 533.005(a), Government Code, that is "[i]n addition to the requirements specified by Subsection (a)" of Section 533.005. The revised law omits the quoted language as unnecessary because the requirements specified by Section 533.005(a), which is revised throughout this subchapter, apply by their own terms and do not require a separate statement to that effect.

(2) Section 533.005(h), Government Code, references a list of services approved by the state

Medicaid managed care advisory committee. That advisory committee will be abolished December 31, 2024, in accordance with 1 T.A.C. Section 351.805(i). Because the effective date of the revised law is later than the date the advisory committee is to be abolished, the revised law refers to the "former" state Medicaid managed care advisory committee.

Revised Law

Sec. 540.0273. OUTPATIENT PHARMACY BENEFIT PLAN. (a) Subject to Subsection (b), a contract to which this subchapter applies must require the contracting Medicaid managed care organization to develop, implement, and maintain an outpatient pharmacy benefit plan for the organization's enrolled recipients that:

(1) except as provided by Section 540.0280(2), exclusively employs the vendor drug program formulary and preserves this state's ability to reduce Medicaid fraud, waste, and abuse;

(2) adheres to the applicable preferred drug list the commission adopts under Section ____ [[[Section 531.072]]];

(3) except as provided by Section 540.0280(1), includes the prior authorization procedures and requirements prescribed by or implemented under Sections ____ [[[Sections 531.073(b), (c), and (g)]]] for the vendor drug program;

(4) does not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, as defined by Section _____ [[[Section 531.073]]], or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse; and

(5) does not require prior authorization for a nonpreferred antipsychotic drug prescribed to an adult recipient if the requirements of Section _____ [[[Section 531.073(a-3)]]] are met.

(b) The requirements imposed by Subsections (a)(1)-(3) do not apply, and may not be enforced, on and after August 31, 2023.

(Gov. Code, Secs. 533.005(a)(23)(A), (B), (C), (C-1), (C-2), (a-1).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:]

. . .

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that, except as provided by Paragraph (L)(ii), exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under Medicaid;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that, except as provided by Paragraph (L)(i), includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(C-1) that does not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, as defined by Section 531.073, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse;

(C-2) that does not require prior authorization for a nonpreferred antipsychotic drug prescribed to an adult recipient if the requirements of Section 531.073(a-3) are met;

. . .

(a-1) The requirements imposed by Subsections (a)(23)(A), (B), and (C) do not apply, and may not be enforced, on and after August 31, 2023.

Revised Law

Sec. 540.0274. PHARMACY BENEFIT PLAN: REBATES AND RECEIPT OF CONFIDENTIAL INFORMATION PROHIBITED. A Medicaid managed care organization, for purposes of the organization's outpatient pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, may not:

(1) negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; or

(2) receive drug rebate or pricing information that is confidential under Section ____ [[[Section 531.071]]]. (Gov. Code, Sec. 533.005(a)(23)(D).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS.

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

. . .

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

. . .

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

. . .

Revised Law

Sec. 540.0275. PHARMACY BENEFIT PLAN: CERTAIN PHARMACY BENEFITS FOR SEX OFFENDERS PROHIBITED. A Medicaid managed care organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies must comply with the prohibition under Section ____ [[[Section 531.089]]]. (Gov. Code, Sec. 533.005(a)(23)(E).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

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

. . .

(E) that complies with the prohibition under Section 531.089;

. . .

Revised Law

Sec. 540.0276. PHARMACY BENEFIT PLAN: RECIPIENT SELECTION OF PHARMACEUTICAL SERVICES PROVIDER. A Medicaid managed care organization, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice to provide pharmaceutical services under the plan by imposing different copayments. (Gov. Code, Sec. 533.005(a)(23)(F).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

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

. . .

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

. . .

Revised Law

Sec. 540.0277. PHARMACY BENEFIT PLAN: PHARMACY BENEFIT PROVIDERS. (a) A Medicaid managed care organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies must allow the organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(1) the organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for administering the pharmacy benefit plan; and

(2) the organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs that:

(A) are consistent with rules the executive commissioner adopts; and

(B) include notice to network pharmacy providers from the organization.

(b) A Medicaid managed care organization, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies:

(1) may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to

comply with the financial terms, as well as other reasonable administrative and professional terms, of the contract;

(2) may include mail-order pharmacies in the organization's networks, but may not require enrolled recipients to use those pharmacies; and

(3) may not charge an enrolled recipient who opts to use a mail-order pharmacy a fee, including a postage or handling fee. (Gov. Code, Secs. 533.005(a)(23)(G), (H), (I).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

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

. . .

(G) that allows the managed care organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

. . .

Revisor's Note

(1) Section 533.005(a)(23)(G)(i), Government Code, refers to a Medicaid managed care organization's

pharmacy benefit "program." The revised law substitutes the term "plan" for "program" for consistency of terminology throughout this subchapter.

(2) Section 533.005(a)(23)(H), Government Code, refers to a pharmacy or pharmacist's agreement to comply with "terms and conditions" of a contract between a Medicaid managed care organization or pharmacy benefit manager and the pharmacy or pharmacist. The revised law omits "conditions" from the quoted phrase for the reason stated in Revisor's Note (3) to Section 540.0206.

Revised Law

Sec. 540.0278. PHARMACY BENEFIT PLAN: PROMPT PAYMENT OF PHARMACY BENEFIT CLAIMS. A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must pay claims in accordance with Section 843.339, Insurance Code. (Gov. Code, Sec. 533.005(a)(23)(J).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

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

. . .

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code;

. . .

Revised Law

Sec. 540.0279. PHARMACY BENEFIT PLAN: MAXIMUM ALLOWABLE COST PRICE AND LIST FOR PHARMACY BENEFITS. (a) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section

540.0273 in a contract to which this subchapter applies, must:

(1) ensure that, to place a drug on a maximum allowable cost list:

(A) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(B) the drug is generally available for purchase by pharmacies in this state from national or regional wholesalers and is not obsolete;

(2) review and update maximum allowable cost price information at least once every seven days to reflect any maximum allowable cost pricing modification;

(3) in formulating a drug's maximum allowable cost price, use only the price of the drug and drugs listed as therapeutically equivalent in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book;

(4) establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace; and

(5) notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail.

(b) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must:

(1) provide a procedure for a network pharmacy provider to challenge a drug's listed maximum allowable cost price;

(2) respond to a challenge not later than the 15th day

after the date the provider makes the challenge;

(3) if the challenge is successful, adjust the drug price effective on the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as the Medicaid managed care organization or pharmacy benefit manager, as appropriate, determines;

(4) if the challenge is denied, provide the reason for the denial; and

(5) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period.

(c) A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies, must provide:

(1) to a network pharmacy provider, at the time the organization or pharmacy benefit manager enters into or renews a contract with the provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider; and

(2) a process for each network pharmacy provider to readily access the maximum allowable cost list specific to that provider.

(d) Except as provided by Subsection (c)(2), a maximum allowable cost list specific to a provider that a Medicaid managed care organization or pharmacy benefit manager maintains is confidential. (Gov. Code, Secs. 533.005(a)(23)(K), (a-2).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) to place a drug on a maximum allowable cost list, must ensure that:

(a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(b) the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(ii) must provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(iii) must review and update maximum allowable cost price information at least once every seven days to reflect any modification of maximum allowable cost pricing;

(iv) must, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book;

(v) must establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(vi) must:

(a) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

(b) respond to a challenge not later than the 15th day after the date the challenge is made;

(c) if the challenge is successful, make an adjustment in the drug price effective on the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager, as appropriate;

(d) if the challenge is denied, provide the reason for the denial; and

(e) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period;

(vii) must notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail; and

(viii) must provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to

that provider; and

. . .

(a-2) Except as provided by Subsection (a)(23)(K)(viii), a maximum allowable cost list specific to a provider and maintained by a managed care organization or pharmacy benefit manager is confidential.

Revised Law

Sec. 540.0280. PHARMACY BENEFIT PLAN: PHARMACY BENEFITS FOR CHILD ENROLLED IN STAR KIDS MANAGED CARE PROGRAM. A Medicaid managed care organization or pharmacy benefit manager, as applicable, under the organization's pharmacy benefit plan required by Section 540.0273 in a contract to which this subchapter applies:

(1) may not require a prior authorization, other than a clinical prior authorization or a prior authorization the commission imposes to minimize the opportunity for fraud, waste, or abuse, for or impose any other barriers to a drug that is prescribed to a child enrolled in the STAR Kids managed care program for a particular disease or treatment and that is on the vendor drug program formulary or require additional prior authorization for a drug included in the preferred drug list the commission adopts under Section _____ [[[Section 531.072]]];

(2) must provide continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the organization's formulary;

(3) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug the child's physician recommends for the child's treatment before the organization will cover the recommended drug; and

(4) must pay liquidated damages to the commission for each failure, as the commission determines, to comply with this section in an amount that is a reasonable forecast of the damages caused by the noncompliance. (Gov. Code, Sec. 533.005(a)(23)(L).)

Source Law

[Sec. 533.005. REQUIRED CONTRACT PROVISIONS. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

. . .

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:]

. . .

(L) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) may not require a prior authorization, other than a clinical prior authorization or a prior authorization imposed by the commission to minimize the opportunity for waste, fraud, or abuse, for or impose any other barriers to a drug that is prescribed to a child enrolled in the STAR Kids managed care program for a particular disease or treatment and that is on the vendor drug program formulary or require additional prior authorization for a drug included in the preferred drug list adopted under Section 531.072;

(ii) must provide for continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the managed care organization's formulary;

(iii) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug that the child's physician recommends for the child's treatment before the managed care organization provides coverage for the recommended drug; and

(iv) must pay liquidated damages to the commission for each failure, as determined by the commission, to comply with this paragraph in an amount that is a reasonable forecast of the damages caused by the noncompliance;

. . .

SUBCHAPTER G. PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCEDURES

Revised Law

Sec. 540.0301. INAPPLICABILITY OF CERTAIN OTHER LAW TO MEDICAID MANAGED CARE UTILIZATION REVIEWS. Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization. (Gov. Code, Sec. 533.00282(a).)

Source Law

Sec. 533.00282. UTILIZATION REVIEW AND PRIOR

AUTHORIZATION PROCEDURES. (a) Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization.

Revised Law

Sec. 540.0302. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT. (a) This section applies only to a prior authorization request submitted with respect to a recipient who is hospitalized at the time of the request.

(b) In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must require that, notwithstanding any other law, the organization review and issue a determination on a prior authorization request to which this section applies according to the following time frames:

(1) within one business day after the organization receives the request, except as provided by Subdivisions (2) and (3);

(2) within 72 hours after the organization receives the request if a provider of acute care inpatient services submits the request and the request is for services or equipment necessary to discharge the recipient from an inpatient facility; or

(3) within one hour after the organization receives the request if the request is related to poststabilization care or a life-threatening condition. (Gov. Code, Sec. 533.002821.)

Source Law

Sec. 533.002821. PRIOR AUTHORIZATION PROCEDURES FOR HOSPITALIZED RECIPIENT. In addition to the requirements of Section 533.005, a contract between a managed care organization and the commission described by that section must require that, notwithstanding any other law, the organization review and issue determinations on prior authorization requests with respect to a recipient who is hospitalized at the time of the request according to the following time frames:

(1) within one business day after receiving the request, except as provided by Subdivisions (2) and (3);

(2) within 72 hours after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the recipient from an inpatient facility; or

(3) within one hour after receiving the request if the request is related to poststabilization care or a life-threatening condition.

Revisor's Note

Section 533.002821, Government Code, refers to the "requirements of Section 533.005," Government Code, meaning the required provisions in a contract between a Medicaid managed care organization and the Health and Human Services Commission for the organization to provide health care services to Medicaid recipients. The required contract provisions of Section 533.005 are revised in this chapter as Subchapter F. Accordingly, the revised law throughout this subchapter substitutes a reference to the "requirements of Subchapter F" for the quoted phrase.

Revised Law

Sec. 540.0303. PRIOR AUTHORIZATION PROCEDURES FOR NONHOSPITALIZED RECIPIENT. (a) This section applies only to a prior authorization request submitted with respect to a recipient who is not hospitalized at the time of the request.

(b) In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must require that the organization review and issue a determination on a prior authorization request to which this section applies according to the following time frames:

(1) within three business days after the organization receives the request; or

(2) within the time frame and following the process the commission establishes if the organization receives a prior authorization request that does not include sufficient or adequate documentation.

(c) The commission shall establish a process for use by a Medicaid managed care organization that receives a prior authorization request to which this section applies that does not

include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(1). (Gov. Code, Secs. 533.00282(b) (part), (c).)

Source Law

> (b) In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must require that:
>
> . . .
>
> (2) the organization review and issue determinations on prior authorization requests with respect to a recipient who is not hospitalized at the time of the request according to the following time frames:
>
> (A) within three business days after receiving the request; or
>
> (B) within the time frame and following the process established by the commission if the organization receives a request for prior authorization that does not include sufficient or adequate documentation.
>
> (c) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a process for use by a Medicaid managed care organization that receives a prior authorization request, with respect to a recipient who is not hospitalized at the time of the request, that does not include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(2)(A) within which a Medicaid managed care organization must issue a determination on a prior authorization request.

Revisor's Note

Section 533.00282(c), Government Code, requires the Health and Human Services Commission to consult with the state Medicaid managed care advisory committee. As stated in Revisor's Note (2) to Section 540.0272 of this chapter, that advisory committee will be abolished December 31, 2024. Because the effective date of the revised law is later than the date the advisory committee is to be abolished, the revised law omits the requirement to consult with the advisory committee.

Revised Law

Sec. 540.0304. ANNUAL REVIEW OF PRIOR AUTHORIZATION

REQUIREMENTS. (a) Each Medicaid managed care organization, in consultation with the organization's provider advisory group required by contract, shall develop and implement a process for conducting an annual review of the organization's prior authorization requirements. The annual review process does not apply to a prior authorization requirement prescribed by or implemented under Section _____ [[[Section 531.073]]] for the vendor drug program.

(b) In conducting an annual review, a Medicaid managed care organization must:

(1) solicit, receive, and consider input from providers in the organization's provider network; and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that, as appropriate, distinguish between categories of recipients for whom prior authorization requests are submitted, including age categories.

(c) A Medicaid managed care organization may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Section _____ [[[Section 531.073]]] for the vendor drug program, unless the organization reviewed the requirement during the most recent annual review.

(d) The commission shall periodically review each Medicaid managed care organization to ensure the organization's compliance with this section. (Gov. Code, Sec. 533.00283.)

Source Law

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed care organization, in consultation with the organization's provider advisory group required by contract, shall develop and implement a process to conduct an annual review of the organization's prior authorization requirements, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program. In conducting a review, the organization must:

(1) solicit, receive, and consider input from providers in the organization's provider network;

and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted.

(b) A Medicaid managed care organization may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program, unless the organization has reviewed the requirement during the most recent annual review required under this section.

(c) The commission shall periodically review each Medicaid managed care organization to ensure the organization's compliance with this section.

Revised Law

Sec. 540.0305. PHYSICIAN CONSULTATION BEFORE ADVERSE PRIOR AUTHORIZATION DETERMINATION. In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must require that, before issuing an adverse determination on a prior authorization request, the organization provide the physician requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who:

(1) practices in the same or a similar specialty, but not necessarily the same subspecialty; and

(2) has experience in treating the same category of population as the recipient on whose behalf the physician submitted the request. (Gov. Code, Sec. 533.00282(b) (part).)

Source Law

(b) In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must require that:

(1) before issuing an adverse determination on a prior authorization request, the organization provide the physician requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and

. . .

Revised Law

Sec. 540.0306. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) The

commission shall establish a uniform process and timeline for a Medicaid managed care organization to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. In addition to the requirements of Subchapter F, a contract between a Medicaid managed care organization and the commission to which that subchapter applies must include a requirement that the organization implement the process and timeline.

(b) The process and timeline must:

(1) allow a provider to submit any documentation identified as insufficient or inadequate in the notice provided under Section _____ [[[Section 531.024162]]];

(2) allow the provider requesting the prior authorization to discuss the request with another provider who:

(A) practices in the same or a similar specialty, but not necessarily the same subspecialty; and

(B) has experience in treating the same category of population as the recipient on whose behalf the provider submitted the request; and

(3) require the Medicaid managed care organization to amend the determination on the prior authorization request as necessary, considering the additional documentation.

(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the Medicaid managed care organization only if the determination is not amended under Subsection (b)(3) to approve the request.

(d) The process and timeline for reconsidering an adverse determination on a prior authorization request under this section do not affect:

(1) any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; or

(2) any rights of a recipient to appeal a determination on a prior authorization request. (Gov. Code, Sec.

533.00284.)

Source Law

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a uniform process and timeline for Medicaid managed care organizations to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must include a requirement that the organization implement the process and timeline.

(b) The process and timeline must:

(1) allow a provider to submit any documentation that was identified as insufficient or inadequate in the notice provided under Section 531.024162;

(2) allow the provider requesting the prior authorization to discuss the request with another provider who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and

(3) require the Medicaid managed care organization to amend the determination on the prior authorization request as necessary, considering the additional documentation.

(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the Medicaid managed care organization only if the determination is not amended under Subsection (b)(3) to approve the request.

(d) The process and timeline for reconsidering an adverse determination on a prior authorization request under this section do not affect:

(1) any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; or

(2) any rights of a recipient to appeal a determination on a prior authorization request.

Revisor's Note

Section 533.00284(a), Government Code, requires the Health and Human Services Commission to consult with the state Medicaid managed care advisory committee. The revised law omits the requirement to consult with the advisory committee for the reason stated in the revisor's note to Section 540.0303 of this chapter.

Revised Law

Sec. 540.0307. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION

DECISION; ACCESS TO CARE. The combined amount of time provided for the time frames prescribed by the utilization review and prior authorization procedures described by Sections 540.0301, 540.0303, and 540.0305 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 540.0306 may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care. (Gov. Code, Sec. 533.002841.)

Source Law

> Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. The time frames prescribed by the utilization review and prior authorization procedures described by Section 533.00282 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 533.00284 together may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care.

SUBCHAPTER H. PREMIUM PAYMENT RATES

Revised Law

Sec. 540.0351. PREMIUM PAYMENT RATE DETERMINATION. (a) In determining premium payment rates paid to a managed care organization under a managed care plan, the commission shall consider:

(1) the regional variation in health care service costs;

(2) the range and type of health care services that premium payment rates are to cover;

(3) the number of managed care plans in a region;

(4) the current and projected number of recipients in each region, including the current and projected number for each category of recipient;

(5) the managed care plan's ability to meet operating costs under the proposed premium payment rates;

(6) the requirements of the Balanced Budget Act of 1997 (Pub. L. No. 105-33) and implementing regulations that require adequacy of premium payments to Medicaid managed care organizations;

(7) the adequacy of the management fee paid for assisting enrollees of Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) who are voluntarily enrolled in the managed care plan;

(8) the impact of reducing premium payment rates for the category of pregnant recipients; and

(9) the managed care plan's ability under the proposed premium payment rates to pay inpatient and outpatient hospital provider payment rates that are comparable to the inpatient and outpatient hospital provider payment rates the commission pays under a primary care case management model or a partially capitated model.

(b) The premium payment rates paid to a managed care organization that holds a certificate of authority issued under Chapter 843, Insurance Code, must be established by a competitive bid process but may not exceed the maximum premium payment rates the commission establishes under Section 540.0352(b).

(c) The commission shall pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider practices. In pursuing the strategies, the commission shall review and consider strategies employed or under consideration by other states. If necessary, the commission may request a waiver or other authorization from a federal agency to implement strategies the commission identifies under this subsection. (Gov. Code, Secs. 533.013(a), (c), (e).)

Source Law

Sec. 533.013. PREMIUM PAYMENT RATE DETERMINATION; REVIEW AND COMMENT. (a) In determining premium payment rates paid to a managed care organization under a managed care plan, the commission shall consider:

(1) the regional variation in costs of health care services;

(2) the range and type of health care services to be covered by premium payment rates;

(3) the number of managed care plans in a region;

(4) the current and projected number of recipients in each region, including the current and projected number for each category of recipient;

(5) the ability of the managed care plan to meet costs of operation under the proposed premium payment rates;

(6) the applicable requirements of the federal Balanced Budget Act of 1997 and implementing regulations that require adequacy of premium payments to managed care organizations participating in Medicaid;

(7) the adequacy of the management fee paid for assisting enrollees of Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) who are voluntarily enrolled in the managed care plan;

(8) the impact of reducing premium payment rates for the category of recipients who are pregnant; and

(9) the ability of the managed care plan to pay under the proposed premium payment rates inpatient and outpatient hospital provider payment rates that are comparable to the inpatient and outpatient hospital provider payment rates paid by the commission under a primary care case management model or a partially capitated model.

(c) The premium payment rates paid to a managed care organization that is licensed under Chapter 843, Insurance Code, shall be established by a competitive bid process but may not exceed the maximum premium payment rates established by the commission under Subsection (b).

(e) The commission shall pursue and, if appropriate, implement premium rate-setting strategies that encourage provider payment reform and more efficient service delivery and provider practices. In pursuing premium rate-setting strategies under this section, the commission shall review and consider strategies employed or under consideration by other states. If necessary, the commission may request a waiver or other authorization from a federal agency to implement strategies identified under this subsection.

Revisor's Note

Section 533.013(c), Government Code, refers to a managed care organization that "is licensed" under Chapter 843, Insurance Code. The revised law substitutes "holds a certificate of authority" for the quoted language for the reason stated in Revisor's Note (2) to Section 540.0206 of this chapter.

Revised Law

Sec. 540.0352. MAXIMUM PREMIUM PAYMENT RATES FOR CERTAIN

PROGRAMS. (a) This section applies only to a Medicaid managed care organization that holds a certificate of authority issued under Chapter 843, Insurance Code, and with respect to Medicaid managed care pilot programs, Medicaid behavioral health pilot programs, and Medicaid STAR+PLUS pilot programs implemented in a health care service region after June 1, 1999.

(b) In determining the maximum premium payment rates paid to a Medicaid managed care organization to which this section applies, the commission shall consider and adjust for the regional variation in costs of services under the traditional fee-for-service component of Medicaid, utilization patterns, and other factors that influence the potential for cost savings. For a service area with a service area factor of .93 or less, or another appropriate service area factor, as the commission determines, the commission may not discount premium payment rates in an amount that is more than the amount necessary to meet federal budget neutrality requirements for projected fee-for-service costs unless:

(1) a historical review of managed care financial results among managed care organizations in the service area the organization serves demonstrates that additional savings are warranted; or

(2) a review of Medicaid fee-for-service delivery in the service area the organization serves has historically shown:

(A) significant recipient overutilization of certain services covered by the premium payment rates in comparison to utilization patterns throughout the rest of this state; or

(B) an above-market cost for services for which there is substantial evidence that Medicaid managed care delivery will reduce the cost of those services. (Gov. Code, Secs. 533.013(b), (d).)

Source Law

(b) In determining the maximum premium payment rates paid to a managed care organization that is licensed under Chapter 843, Insurance Code, the commission shall consider and adjust for the regional variation in costs of services under the traditional

fee-for-service component of Medicaid, utilization patterns, and other factors that influence the potential for cost savings. For a service area with a service area factor of .93 or less, or another appropriate service area factor, as determined by the commission, the commission may not discount premium payment rates in an amount that is more than the amount necessary to meet federal budget neutrality requirements for projected fee-for-service costs unless:

(1) a historical review of managed care financial results among managed care organizations in the service area served by the organization demonstrates that additional savings are warranted;

(2) a review of Medicaid fee-for-service delivery in the service area served by the organization has historically shown a significant overutilization by recipients of certain services covered by the premium payment rates in comparison to utilization patterns throughout the rest of the state; or

(3) a review of Medicaid fee-for-service delivery in the service area served by the organization has historically shown an above-market cost for services for which there is substantial evidence that Medicaid managed care delivery will reduce the cost of those services.

(d) Subsection (b) applies only to a managed care organization with respect to Medicaid managed care pilot programs, Medicaid behavioral health pilot programs, and Medicaid Star + Plus pilot programs implemented in a health care service region after June 1, 1999.

Revisor's Note

Section 533.013(b), Government Code, refers to a managed care organization that "is licensed" under Chapter 843, Insurance Code. The revised law substitutes "holds a certificate of authority" for the quoted language for the reason stated in Revisor's Note (2) to Section 540.0206 of this chapter.

Revised Law

Sec. 540.0353. USE OF ENCOUNTER DATA IN DETERMINING PREMIUM PAYMENT RATES AND OTHER PAYMENT AMOUNTS. (a) In determining premium payment rates and other amounts paid to managed care organizations under a managed care plan, the commission may not base or derive the rates or amounts on or from encounter data, or incorporate in the determination an analysis of encounter data, unless a certifier of encounter data certifies that:

(1) the encounter data for the most recent state fiscal year is complete, accurate, and reliable; and

(2) there is no statistically significant variability in the encounter data attributable to incompleteness, inaccuracy, or another deficiency as compared to equivalent data for similar populations and when evaluated against professionally accepted standards.

(b) In determining whether data is equivalent data for similar populations under Subsection (a)(2), a certifier of encounter data shall, at a minimum, consider:

(1) the regional variation in recipient utilization patterns and health care service costs;

(2) the range and type of health care services premium payment rates are to cover;

(3) the number of managed care plans in the region; and

(4) the current number of recipients in each region, including the number for each recipient category. (Gov. Code, Sec. 533.0131.)

Source Law

Sec. 533.0131. USE OF ENCOUNTER DATA IN DETERMINING PREMIUM PAYMENT RATES. (a) In determining premium payment rates and other amounts paid to managed care organizations under a managed care plan, the commission may not base or derive the rates or amounts on or from encounter data, or incorporate in the determination an analysis of encounter data, unless a certifier of encounter data certifies that:

(1) the encounter data for the most recent state fiscal year is complete, accurate, and reliable; and

(2) there is no statistically significant variability in the encounter data attributable to incompleteness, inaccuracy, or another deficiency as compared to equivalent data for similar populations and when evaluated against professionally accepted standards.

(b) For purposes of determining whether data is equivalent data for similar populations under Subsection (a)(2), a certifier of encounter data shall, at a minimum, consider:

(1) the regional variation in utilization patterns of recipients and costs of health care services;

(2) the range and type of health care services to be covered by premium payment rates;

(3) the number of managed care plans in the region; and

(4) the current number of recipients in each region, including the number for each category of recipient.

SUBCHAPTER I. ENCOUNTER DATA

Revised Law

Sec. 540.0401. PROVIDER REPORTING OF ENCOUNTER DATA. The commission shall collaborate with Medicaid managed care organizations and health care providers in the organizations' provider networks to develop incentives and mechanisms to encourage providers to report complete and accurate encounter data to the organizations in a timely manner. (Gov. Code, Sec. 533.016.)

Source Law

> Sec. 533.016. PROVIDER REPORTING OF ENCOUNTER DATA. The commission shall collaborate with managed care organizations that contract with the commission and health care providers under the organizations' provider networks to develop incentives and mechanisms to encourage providers to report complete and accurate encounter data to managed care organizations in a timely manner.

Revised Law

Sec. 540.0402. CERTIFIER OF ENCOUNTER DATA QUALIFICATIONS. (a) The state Medicaid director shall appoint a person as the certifier of encounter data.

(b) The certifier of encounter data must have:

(1) demonstrated expertise in estimating premium payment rates paid to a managed care organization under a managed care plan; and

(2) access to actuarial expertise, including expertise in estimating premium payment rates paid to a managed care organization under a managed care plan.

(c) A person may not be appointed as the certifier of encounter data if the person participated with the commission in developing premium payment rates for managed care organizations under managed care plans in this state during the three-year period before the date the certifier is appointed. (Gov. Code, Sec. 533.017.)

Source Law

> Sec. 533.017. QUALIFICATIONS OF CERTIFIER OF ENCOUNTER DATA. (a) The person acting as the state Medicaid director shall appoint a person as the certifier of encounter data.

(b) The certifier of encounter data must have:

(1) demonstrated expertise in estimating premium payment rates paid to a managed care organization under a managed care plan; and

(2) access to actuarial expertise, including expertise in estimating premium payment rates paid to a managed care organization under a managed care plan.

(c) A person may not be appointed under this section as the certifier of encounter data if the person participated with the commission in developing premium payment rates for managed care organizations under managed care plans in this state during the three-year period before the date the certifier is appointed.

Revised Law

Sec. 540.0403. ENCOUNTER DATA CERTIFICATION. (a) The certifier of encounter data shall certify the completeness, accuracy, and reliability of encounter data for each state fiscal year.

(b) The commission shall make available to the certifier of encounter data all records and data the certifier considers appropriate for evaluating whether to certify the encounter data. The commission shall provide to the certifier selected resources and assistance in obtaining, compiling, and interpreting the records and data. (Gov. Code, Sec. 533.018.)

Source Law

Sec. 533.018. CERTIFICATION OF ENCOUNTER DATA. (a) The certifier of encounter data shall certify the completeness, accuracy, and reliability of encounter data for each state fiscal year.

(b) The commission shall make available to the certifier all records and data the certifier considers appropriate for evaluating whether to certify the encounter data. The commission shall provide to the certifier selected resources and assistance in obtaining, compiling, and interpreting the records and data.

SUBCHAPTER J. MANAGED CARE PLAN REQUIREMENTS

Revised Law

Sec. 540.0451. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A Medicaid managed care plan must be accredited by a nationally recognized accreditation organization. The commission may:

(1) require all Medicaid managed care plans to be accredited by the same organization; or

(2) allow for accreditation by different

organizations.

(b) The commission may use the data, scoring, and other information provided to or received from an accreditation organization in the commission's contract oversight process. (Gov. Code, Sec. 533.0031.)

Source Law

> Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A managed care plan offered by a Medicaid managed care organization must be accredited by a nationally recognized accreditation organization. The commission may choose whether to require all managed care plans offered by Medicaid managed care organizations to be accredited by the same organization or to allow for accreditation by different organizations.
>
> (b) The commission may use the data, scoring, and other information provided to or received from an accreditation organization in the commission's contract oversight processes.

Revised Law

Sec. 540.0452. MEDICAL DIRECTOR QUALIFICATIONS. An individual who serves as a medical director for a managed care plan must be a physician licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code. (Gov. Code, Sec. 533.0073.)

Source Law

> Sec. 533.0073. MEDICAL DIRECTOR QUALIFICATIONS. A person who serves as a medical director for a managed care plan must be a physician licensed to practice medicine in this state under Subtitle B, Title 3, Occupations Code.

Revisor's Note

> Section 533.0073, Government Code, requires a "person" who serves as a medical director for a managed care plan to be a physician. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is a natural person and not an entity described by the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), which applies to this code.

SUBCHAPTER K. MEDICAID MANAGED CARE PLAN ENROLLMENT AND DISENROLLMENT

Revised Law

Sec. 540.0501. RECIPIENT ENROLLMENT IN AND DISENROLLMENT FROM MEDICAID MANAGED CARE PLAN. The commission shall:

(1) encourage recipients to choose appropriate Medicaid managed care plans and primary health care providers by:

(A) providing initial information to recipients and providers in a region about the need for recipients to choose plans and providers not later than the 90th day before the date a Medicaid managed care organization plans to begin providing health care services to recipients in that region through managed care;

(B) providing follow-up information before assignment of plans and providers and after assignment, if necessary, to recipients who delay in choosing plans and providers; and

(C) allowing plans and providers to provide information to recipients or engage in marketing activities under marketing guidelines the commission establishes under Section 540.0055(a) after the commission approves the information or activities;

(2) in assigning plans and providers to recipients who fail to choose plans and providers, consider:

(A) the importance of maintaining existing provider-patient and physician-patient relationships, including relationships with specialists, public health clinics, and community health centers;

(B) to the extent possible, the need to assign family members to the same providers and plans; and

(C) geographic convenience of plans and providers for recipients;

(3) retain responsibility for enrolling recipients in and disenrolling recipients from plans, except that the commission may delegate the responsibility to an independent contractor who

receives no form of payment from, and has no financial ties to, any managed care organization;

(4) develop and implement an expedited process for determining eligibility for and enrolling pregnant women and newborn infants in plans; and

(5) ensure immediate access to prenatal services and newborn care for pregnant women and newborn infants enrolled in plans, including ensuring that a pregnant woman may obtain an appointment with an obstetrical care provider for an initial maternity evaluation not later than the 30th day after the date the woman applies for Medicaid. (Gov. Code, Sec. 533.0075.)

Source Law

Sec. 533.0075. RECIPIENT ENROLLMENT. The commission shall:

(1) encourage recipients to choose appropriate managed care plans and primary health care providers by:

(A) providing initial information to recipients and providers in a region about the need for recipients to choose plans and providers not later than the 90th day before the date on which a managed care organization plans to begin to provide health care services to recipients in that region through managed care;

(B) providing follow-up information before assignment of plans and providers and after assignment, if necessary, to recipients who delay in choosing plans and providers; and

(C) allowing plans and providers to provide information to recipients or engage in marketing activities under marketing guidelines established by the commission under Section 533.008 after the commission approves the information or activities;

(2) consider the following factors in assigning managed care plans and primary health care providers to recipients who fail to choose plans and providers:

(A) the importance of maintaining existing provider-patient and physician-patient relationships, including relationships with specialists, public health clinics, and community health centers;

(B) to the extent possible, the need to assign family members to the same providers and plans; and

(C) geographic convenience of plans and providers for recipients;

(3) retain responsibility for enrollment and disenrollment of recipients in managed care plans, except that the commission may delegate the responsibility to an independent contractor who receives no form of payment from, and has no financial ties to, any managed care organization;

(4) develop and implement an expedited

process for determining eligibility for and enrolling pregnant women and newborn infants in managed care plans; and

(5) ensure immediate access to prenatal services and newborn care for pregnant women and newborn infants enrolled in managed care plans, including ensuring that a pregnant woman may obtain an appointment with an obstetrical care provider for an initial maternity evaluation not later than the 30th day after the date the woman applies for Medicaid.

Revisor's Note

Section 533.0075(1)(C), Government Code, refers to marketing guidelines the Health and Human Services Commission establishes under Section 533.008, Government Code. The relevant portion of Section 533.008 requiring the commission to establish those guidelines is revised in this chapter as Section 540.0055(a), and the revised law is drafted accordingly.

Revised Law

Sec. 540.0502. AUTOMATIC ENROLLMENT IN MEDICAID MANAGED CARE PLAN. (a) If the commission determines that it is feasible and notwithstanding any other law, the commission may implement an automatic enrollment process under which an applicant determined eligible for Medicaid is automatically enrolled in a Medicaid managed care plan the applicant chooses.

(b) The commission may elect to implement the automatic enrollment process for certain recipient populations. (Gov. Code, Sec. 533.0025(h).)

Source Law

(h) If the commission determines that it is feasible, the commission may, notwithstanding any other law, implement an automatic enrollment process under which applicants determined eligible for Medicaid benefits are automatically enrolled in a Medicaid managed care plan chosen by the applicant. The commission may elect to implement the automatic enrollment process as to certain populations of recipients.

Revised Law

Sec. 540.0503. ENROLLMENT OF CERTAIN RECIPIENTS IN SAME MEDICAID MANAGED CARE PLAN. The commission shall ensure that all recipients who are children and who reside in the same household

may, at the family's election, be enrolled in the same Medicaid managed care plan. (Gov. Code, Sec. 533.0027.)

Source Law

> Sec. 533.0027. PROCEDURES TO ENSURE CERTAIN RECIPIENTS ARE ENROLLED IN SAME MANAGED CARE PLAN. The commission shall ensure that all recipients who are children and who reside in the same household may, at the family's election, be enrolled in the same managed care plan.

Revised Law

Sec. 540.0504. QUALITY-BASED ENROLLMENT INCENTIVE PROGRAM FOR MEDICAID MANAGED CARE ORGANIZATIONS. The commission shall create an incentive program that automatically enrolls in a Medicaid managed care plan a greater percentage of recipients who did not actively choose a plan, based on:

(1) the quality of care provided through the Medicaid managed care organization offering the plan;

(2) the organization's ability to efficiently and effectively provide services, considering the acuity of populations the organization primarily serves; and

(3) the organization's performance with respect to exceeding or failing to achieve appropriate outcome and process measures the commission develops, including measures based on potentially preventable events. (Gov. Code, Sec. 533.00511(b).)

Source Law

> (b) The commission shall create an incentive program that automatically enrolls a greater percentage of recipients who did not actively choose their managed care plan in a managed care plan, based on:
>
> (1) the quality of care provided through the managed care organization offering that managed care plan;
>
> (2) the organization's ability to efficiently and effectively provide services, taking into consideration the acuity of populations primarily served by the organization; and
>
> (3) the organization's performance with respect to exceeding, or failing to achieve, appropriate outcome and process measures developed by the commission, including measures based on potentially preventable events.

Revised Law

Sec. 540.0505. LIMITATIONS ON RECIPIENT DISENROLLMENT FROM

MEDICAID MANAGED CARE PLAN. (a) Except as provided by Subsections (b) and (c) and to the extent permitted by federal law, a recipient enrolled in a Medicaid managed care plan may not disenroll from that plan and enroll in another Medicaid managed care plan during the 12-month period after the date the recipient initially enrolls in a plan.

(b) At any time before the 91st day after the date of a recipient's initial enrollment in a Medicaid managed care plan, the recipient may disenroll from that plan for any reason and enroll in another Medicaid managed care plan.

(c) The commission shall allow a recipient who is enrolled in a Medicaid managed care plan to disenroll from that plan and enroll in another Medicaid managed care plan:

(1) at any time for cause in accordance with federal law; and

(2) once for any reason after the periods described by Subsections (a) and (b). (Gov. Code, Sec. 533.0076.)

Source Law

> Sec. 533.0076. LIMITATIONS ON RECIPIENT DISENROLLMENT. (a) Except as provided by Subsections (b) and (c), and to the extent permitted by federal law, a recipient enrolled in a managed care plan under this chapter may not disenroll from that plan and enroll in another managed care plan during the 12-month period after the date the recipient initially enrolls in a plan.
>
> (b) At any time before the 91st day after the date of a recipient's initial enrollment in a managed care plan under this chapter, the recipient may disenroll in that plan for any reason and enroll in another managed care plan under this chapter.
>
> (c) The commission shall allow a recipient who is enrolled in a managed care plan under this chapter to disenroll from that plan and enroll in another managed care plan:
>
> (1) at any time for cause in accordance with federal law; and
>
> (2) once for any reason after the periods described by Subsections (a) and (b).

SUBCHAPTER L. CONTINUITY OF CARE AND COORDINATION OF BENEFITS

Revised Law

Sec. 540.0551. GUIDANCE REGARDING CONTINUATION OF SERVICES UNDER CERTAIN CIRCUMSTANCES. The commission shall provide guidance and additional education to Medicaid managed care organizations

regarding federal law requirements to continue providing services during an internal appeal, a Medicaid fair hearing, or any other review. (Gov. Code, Sec. 533.005(g).)

Source Law

> (g) The commission shall provide guidance and additional education to managed care organizations with which the commission enters into contracts described by Subsection (a) regarding requirements under federal law to continue to provide services during an internal appeal, a Medicaid fair hearing, or any other review.

Revisor's Note

Section 533.005(g), Government Code, refers to "managed care organizations with which the commission enters into contracts described by Subsection (a)" of Section 533.005, Government Code. Section 533.005(a) describes a contract between a managed care organization and the commission for the organization to provide health care services to Medicaid recipients. The revised law substitutes "Medicaid managed care organizations" for the quoted language for the reason stated in the revisor's note to Section 540.0053.

Revised Law

Sec. 540.0552. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS. (a) In this section, "Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient who has primary health benefit plan coverage in addition to Medicaid coverage when:

(1) the recipient has exceeded the primary health benefit plan coverage limit; or

(2) the service is not covered by the primary health benefit plan issuer.

(b) The commission, in coordination with Medicaid managed care organizations, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and

timely delivery of Medicaid wrap-around benefits for recipients who have primary health benefit plan coverage in addition to Medicaid coverage. In developing the policy, the commission shall consider requiring a Medicaid managed care organization to allow, notwithstanding Sections _____ [[[Section 531.073]]], 540.0273, and 540.0280 or any other law, a recipient using a prescription drug for which the recipient's primary health benefit plan issuer previously provided coverage to continue receiving the prescription drug without requiring additional prior authorization.

(c) If the commission determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, the Medicaid managed care organization that paid the claim shall:

(1) work with the commission on the recovery process; and

(2) make every attempt to reduce health care provider and recipient abrasion.

(d) The executive commissioner may seek a waiver from the federal government as needed to:

(1) address federal policies related to coordination of benefits and third-party liability; and

(2) maximize federal financial participation for recipients who have primary health benefit plan coverage in addition to Medicaid coverage.

(e) The commission may include in the Medicaid managed care eligibility files an indication of whether a recipient has primary health benefit plan coverage or is enrolled in a group health benefit plan for which the commission provides premium assistance under the health insurance premium payment program. For a recipient with that coverage or for whom that premium assistance is provided, the files may include the following up-to-date, accurate information related to primary health benefit plan coverage to the extent the information is available to the commission:

(1) the primary health benefit plan issuer's name and address;

(2) the recipient's policy number;

(3) the primary health benefit plan coverage start and end dates; and

(4) the primary health benefit plan coverage benefits, limits, copayment, and coinsurance information.

(f) To the extent allowed by federal law, the commission shall maintain processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed, regardless of whether the provider is enrolled as a Medicaid provider. The commission shall allow a provider who is not enrolled as a Medicaid provider to order, refer, or prescribe services to a recipient based on the provider's national provider identifier number and may not require an additional state provider identifier number to receive reimbursement for the services. The commission may seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider, regardless of whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage.

(h) If a recipient who has complex medical needs wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the Medicaid managed care plan in which the recipient is enrolled, the organization shall develop a simple, timely, and efficient process to, and shall make a good-faith effort to, negotiate a single-case agreement with the specialty provider.

Until the organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rules, including 1 T.A.C. Section 353.4.

(i) A single-case agreement entered into under this section is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements. (Gov. Code, Sec. 533.038.)

Source Law

Sec. 533.038. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS. (a) In this section, "Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient with both Medicaid and primary health benefit plan coverage when the recipient has exceeded the primary health benefit plan coverage limit or when the service is not covered by the primary health benefit plan issuer.

(b) The commission, in coordination with Medicaid managed care organizations and in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage. In developing the policy, the commission shall consider requiring a Medicaid managed care organization to allow, notwithstanding Sections 531.073 and 533.005(a)(23) or any other law, a recipient using a prescription drug for which the recipient's primary health benefit plan issuer previously provided coverage to continue receiving the prescription drug without requiring additional prior authorization.

(c) If the commission determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, the Medicaid managed care organization that paid the claim shall work with the commission on the recovery process and make every attempt to reduce health care provider and recipient abrasion.

(d) The executive commissioner may seek a waiver from the federal government as needed to:

(1) address federal policies related to coordination of benefits and third-party liability; and

(2) maximize federal financial participation for recipients with both primary health benefit plan coverage and Medicaid coverage.

(e) The commission may include in the Medicaid managed care eligibility files an indication of whether a recipient has primary health benefit plan coverage or is enrolled in a group health benefit plan for which the commission provides premium assistance under the health insurance premium payment program. For recipients with that coverage or for whom that

premium assistance is provided, the files may include the following up-to-date, accurate information related to primary health benefit plan coverage to the extent the information is available to the commission:

(1) the health benefit plan issuer's name and address and the recipient's policy number;

(2) the primary health benefit plan coverage start and end dates; and

(3) the primary health benefit plan coverage benefits, limits, copayment, and coinsurance information.

(f) To the extent allowed by federal law, the commission shall maintain processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed, regardless of whether the provider is enrolled as a Medicaid provider. The commission shall allow a provider who is not enrolled as a Medicaid provider to order, refer, or prescribe services to a recipient based on the provider's national provider identifier number and may not require an additional state provider identifier number to receive reimbursement for the services. The commission may seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider, regardless of whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage.

(h) If a recipient who has complex medical needs wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the managed care plan in which the recipient is enrolled, the managed care organization shall develop a simple, timely, and efficient process to and shall make a good-faith effort to, negotiate a single-case agreement with the specialty provider. Until the Medicaid managed care organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rule, including 1 T.A.C. Section 353.4.

(i) A single-case agreement entered into under this section is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements.

Revisor's Note

(1) Section 533.038(b), Government Code, requires the Health and Human Services Commission to consult with the "STAR Kids Managed Care Advisory Committee described by Section 533.00254," Government

Code. That advisory committee will be abolished, and Section 533.00254 expires, December 31, 2023, in accordance with Section 533.00254(b). Because the effective date of the revised law is later than the date the advisory committee is to be abolished and the cited section expires, the revised law omits the quoted language as obsolete.

(2) Section 533.038(b), Government Code, refers to continuous receipt of certain prescription drugs without additional prior authorization, notwithstanding Section 533.005(a)(23), Government Code. The provisions of Section 533.005(a)(23) that require Medicaid managed care organizations to maintain an outpatient pharmacy benefit plan that includes or allows for certain prior authorization requirements are revised in this chapter as Sections 540.0273 and 540.0280, and the revised law is drafted accordingly.

SUBCHAPTER M. PROVIDER NETWORK ADEQUACY

Revised Law

Sec. 540.0601. MONITORING OF PROVIDER NETWORKS. The commission shall establish and implement a process for the direct monitoring of a Medicaid managed care organization's provider network and providers in the network. The process:

(1) must be used to ensure compliance with contractual obligations related to:

(A) the number of providers accepting new patients under the Medicaid managed care program; and

(B) the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider;

(2) may use reasonable methods to ensure compliance with contractual obligations, including telephone calls made at random times without notice to assess the availability of providers

and services to new and existing recipients; and

(3) may be implemented directly by the commission or through a contractor. (Gov. Code, Sec. 533.007(l).)

Source Law

(l) The commission shall establish and implement a process for the direct monitoring of a managed care organization's provider network and providers in the network. The process:
(1) must be used to ensure compliance with contractual obligations related to:
(A) the number of providers accepting new patients under the Medicaid managed care program; and
(B) the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider;
(2) may use reasonable methods to ensure compliance with contractual obligations, including telephone calls made at random times without notice to assess the availability of providers and services to new and existing recipients; and
(3) may be implemented directly by the commission or through a contractor.

Revised Law

Sec. 540.0602. REPORT ON OUT-OF-NETWORK PROVIDER SERVICES. To ensure appropriate access to an adequate provider network, each Medicaid managed care organization providing health care services to recipients in a health care service region shall submit to the commission, in the format and manner the commission prescribes, a report detailing the number, type, and scope of services out-of-network providers provide to recipients enrolled in a Medicaid managed care plan the organization provides. (Gov. Code, Sec. 533.007(g) (part).)

Source Law

(g) To ensure appropriate access to an adequate provider network, each managed care organization that contracts with the commission to provide health care services to recipients in a health care service region shall submit to the commission, in the format and manner prescribed by the commission, a report detailing the number, type, and scope of services provided by out-of-network providers to recipients enrolled in a managed care plan provided by the managed care organization. . . .

Revised Law

Sec. 540.0603. REPORT ON COMMISSION INVESTIGATION OF PROVIDER COMPLAINT. Not later than the 60th day after the date a

provider files a complaint with the commission regarding reimbursement for or overuse of out-of-network providers by a Medicaid managed care organization, the commission shall provide to the provider a report regarding the conclusions of the commission's investigation. The report must include:

(1) a description of any corrective action required of the organization that was the subject of the complaint; and

(2) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider. (Gov. Code, Sec. 533.007(i).)

Source Law

> (i) Not later than the 60th day after the date a provider files a complaint with the commission regarding reimbursement for or overuse of out-of-network providers by a managed care organization, the commission shall provide to the provider a report regarding the conclusions of the commission's investigation. The report must include:
>
> (1) a description of the corrective action, if any, required of the managed care organization that was the subject of the complaint; and
>
> (2) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider.

Revised Law

Sec. 540.0604. ADDITIONAL REIMBURSEMENT FOLLOWING PROVIDER COMPLAINT. (a) If, after an investigation, the commission determines that a Medicaid managed care organization owes additional reimbursement to a provider, the organization shall, not later than the 90th day after the date the provider filed the complaint, pay the additional reimbursement or provide to the provider a reimbursement payment plan under which the organization must pay the entire amount of the additional reimbursement not later than the 120th day after the date the provider filed the complaint.

(b) The commission may require a Medicaid managed care organization to pay interest on any amount of the additional reimbursement that is not paid on or before the 90th day after the date the provider to whom the amount is owed filed the complaint.

If the commission requires the organization to pay interest, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount beginning on the 90th day after the date the provider to whom the amount is owed filed the complaint and accrues until the date the organization pays the entire reimbursement amount. (Gov. Code, Sec. 533.007(j).)

Source Law

> (j) If, after an investigation, the commission determines that additional reimbursement is owed to a provider, the managed care organization shall, not later than the 90th day after the date the provider filed the complaint, pay the additional reimbursement or provide to the provider a reimbursement payment plan under which the managed care organization must pay the entire amount of the additional reimbursement not later than the 120th day after the date the provider filed the complaint. If the managed care organization does not pay the entire amount of the additional reimbursement on or before the 90th day after the date the provider filed the complaint, the commission may require the managed care organization to pay interest on the unpaid amount. If required by the commission, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount from the 90th day after the date the provider filed the complaint until the date the entire amount of the additional reimbursement is paid.

Revised Law

Sec. 540.0605. CORRECTIVE ACTION PLAN FOR INADEQUATE NETWORK AND PROVIDER REIMBURSEMENT. (a) The commission shall initiate a corrective action plan requiring a Medicaid managed care organization to maintain an adequate provider network, provide reimbursement to support that network, and educate recipients enrolled in Medicaid managed care plans provided by the organization regarding the proper use of the plan's provider network, if:

(1) as the commission determines, the organization exceeds maximum limits the commission established for out-of-network access to health care services; or

(2) based on the commission's investigation of a provider complaint regarding reimbursement, the commission determines that the organization did not reimburse an out-of-network provider based on a reasonable reimbursement

methodology.

(b) The corrective action plan required by Subsection (a) must include at least one of the following elements:

(1) a requirement that reimbursements the Medicaid managed care organization pays to out-of-network providers for a health care service provided to a recipient enrolled in a Medicaid managed care plan provided by the organization equal the allowable rate for the service, as determined under Sections 32.028 and 32.0281, Human Resources Code, for all health care services provided during the period the organization:

(A) is not in compliance with the utilization benchmarks the commission determines; or

(B) is not reimbursing out-of-network providers based on a reasonable methodology, as the commission determines;

(2) an immediate freeze on the enrollment of additional recipients in a Medicaid managed care plan the organization provides that continues until the commission determines that the provider network under the plan can adequately meet the needs of additional recipients; and

(3) other actions the commission determines are necessary to ensure that recipients enrolled in a Medicaid managed care plan the organization provides have access to appropriate health care services and that providers are properly reimbursed for providing medically necessary health care services to those recipients. (Gov. Code, Secs. 533.007(g) (part), (h).)

Source Law

> (g) . . . If, as determined by the commission, a managed care organization exceeds maximum limits established by the commission for out-of-network access to health care services, or if, based on an investigation by the commission of a provider complaint regarding reimbursement, the commission determines that a managed care organization did not reimburse an out-of-network provider based on a reasonable reimbursement methodology, the commission shall initiate a corrective action plan requiring the managed care organization to maintain an adequate provider network, provide reimbursement to support that network, and educate recipients enrolled in managed care plans provided by the managed care organization regarding the proper use of the provider

network under the plan.

(h) The corrective action plan required by Subsection (g) must include at least one of the following elements:

(1) a requirement that reimbursements paid by the managed care organization to out-of-network providers for a health care service provided to a recipient enrolled in a managed care plan provided by the managed care organization equal the allowable rate for the service, as determined under Sections 32.028 and 32.0281, Human Resources Code, for all health care services provided during the period:

(A) the managed care organization is not in compliance with the utilization benchmarks determined by the commission; or

(B) the managed care organization is not reimbursing out-of-network providers based on a reasonable methodology, as determined by the commission;

(2) an immediate freeze on the enrollment of additional recipients in a managed care plan provided by the managed care organization, to continue until the commission determines that the provider network under the managed care plan can adequately meet the needs of additional recipients; and

(3) other actions the commission determines are necessary to ensure that recipients enrolled in a managed care plan provided by the managed care organization have access to appropriate health care services and that providers are properly reimbursed for providing medically necessary health care services to those recipients.

Revised Law

Sec. 540.0606. REMEDIES FOR NONCOMPLIANCE WITH CORRECTIVE ACTION PLAN. The commission shall pursue any appropriate remedy authorized in the contract between the Medicaid managed care organization and the commission if the organization fails to comply with a corrective action plan under Section 540.0605(a). (Gov. Code, Sec. 533.007(k).)

Source Law

(k) The commission shall pursue any appropriate remedy authorized in the contract between the managed care organization and the commission if the managed care organization fails to comply with a corrective action plan under Subsection (g).

Revisor's Note

Section 533.007(k), Government Code, refers to a corrective action plan under Section 533.007(g), Government Code. The relevant portion of Section 533.007(g) is revised in this chapter as Section 540.0605(a), and the revised law is drafted accordingly.

SUBCHAPTER N. PROVIDERS

Revised Law

Sec. 540.0651. INCLUSION OF CERTAIN PROVIDERS IN MEDICAID MANAGED CARE ORGANIZATION PROVIDER NETWORK. (a) The commission shall require that each Medicaid managed care organization that contracts to provide health care services to recipients in a region:

(1) seek participation in the organization's provider network from:

(A) each health care provider in the region who has traditionally provided care to recipients;

(B) each hospital in the region that has been designated as a disproportionate share hospital under Medicaid; and

(C) each specialized pediatric laboratory in the region, including a laboratory located in a children's hospital;

(2) include in the organization's provider network for at least three years:

(A) each health care provider in the region who:

(i) previously provided care to Medicaid and charity care recipients at a significant level as the commission prescribes;

(ii) agrees to accept the organization's prevailing provider contract rate; and

(iii) has the credentials the organization requires, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network;

(B) each accredited primary care residency program in the region; and

(C) each disproportionate share hospital the commission designates as a statewide significant traditional provider; and

(3) subject to Section 32.047, Human Resources Code, and notwithstanding any other law, include in the organization's

provider network each optometrist, therapeutic optometrist, and ophthalmologist described by Section ___ [[[Section 531.021191(b)(1)(A) or (B)]]] who, and an institution of higher education described by Section ___ [[[Section 531.021191(a)(4)]]] in the region that:

(A) agrees to comply with the organization's terms;

(B) agrees to accept the organization's prevailing provider contract rate;

(C) agrees to abide by the organization's required standards of care; and

(D) is an enrolled Medicaid provider.

(b) A contract between a Medicaid managed care organization and the commission for the organization to provide health care services to recipients in a health care service region that includes a rural area must require the organization to include in the organization's provider network rural hospitals, physicians, home and community support services agencies, and other rural health care providers who:

(1) are sole community providers;

(2) provide care to Medicaid and charity care recipients at a significant level as the commission prescribes;

(3) agree to accept the organization's prevailing provider contract rate; and

(4) have the credentials the organization requires, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network. (Gov. Code, Secs. 533.006, 533.0067.)

Source Law

Sec. 533.006. PROVIDER NETWORKS. (a) The commission shall require that each managed care organization that contracts with the commission to provide health care services to recipients in a region:

(1) seek participation in the organization's provider network from:

(A) each health care provider in the region who has traditionally provided care to

recipients;

(B) each hospital in the region that has been designated as a disproportionate share hospital under Medicaid; and

(C) each specialized pediatric laboratory in the region, including those laboratories located in children's hospitals; and

(2) include in its provider network for not less than three years:

(A) each health care provider in the region who:

(i) previously provided care to Medicaid and charity care recipients at a significant level as prescribed by the commission;

(ii) agrees to accept the prevailing provider contract rate of the managed care organization; and

(iii) has the credentials required by the managed care organization, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network;

(B) each accredited primary care residency program in the region; and

(C) each disproportionate share hospital designated by the commission as a statewide significant traditional provider.

(b) A contract between a managed care organization and the commission for the organization to provide health care services to recipients in a health care service region that includes a rural area must require that the organization include in its provider network rural hospitals, physicians, home and community support services agencies, and other rural health care providers who:

(1) are sole community providers;

(2) provide care to Medicaid and charity care recipients at a significant level as prescribed by the commission;

(3) agree to accept the prevailing provider contract rate of the managed care organization; and

(4) have the credentials required by the managed care organization, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network.

Sec. 533.0067. EYE HEALTH CARE SERVICE PROVIDERS. Subject to Section 32.047, Human Resources Code, but notwithstanding any other law, the commission shall require that each managed care organization that contracts with the commission under any Medicaid managed care model or arrangement to provide health care services to recipients in a region include in the organization's provider network each optometrist, therapeutic optometrist, and ophthalmologist described by Section 531.021191(b)(1)(A) or (B) and an institution of higher education described by Section 531.021191(a)(4) in the region who:

(1) agrees to comply with the terms and conditions of the organization;

(2) agrees to accept the prevailing provider contract rate of the organization;

(3) agrees to abide by the standards of care required by the organization; and

(4) is an enrolled provider under

Medicaid.

Revisor's Note

(1) Section 533.0067, Government Code, refers to a managed care organization that contracts with the Health and Human Services Commission "under any Medicaid managed care model or arrangement" to provide health care services to certain Medicaid recipients. Because a contract to provide health care services to a recipient could only be under a Medicaid managed care model or arrangement, the revised law omits the quoted language as superfluous.

(2) Section 533.0067(1), Government Code, refers to the "terms and conditions" imposed by a managed care organization. The revised law omits "conditions" from the quoted phrase for the reason stated in Revisor's Note (3) to Section 540.0206 of this chapter.

Revised Law

Sec. 540.0652. PROVIDER ACCESS STANDARDS; BIENNIAL REPORT. (a) The commission shall establish minimum provider access standards for a Medicaid managed care organization's provider network. The provider access standards must ensure that a Medicaid managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) after-hours urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

(8) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(9) any other services the commission identifies.

(b) To the extent feasible, the provider access standards must:

(1) distinguish between access to providers in urban and rural settings;

(2) consider the number and geographic distribution of Medicaid-enrolled providers in a particular service delivery area; and

(3) subject to Section _____ [[[Section 531.0216(c)]]] and consistent with Section 111.007, Occupations Code, consider and include the availability of telehealth services and telemedicine medical services in a Medicaid managed care organization's provider network.

(c) The commission shall biennially submit to the legislature and make available to the public a report that contains:

(1) information and statistics on:

(A) recipient access to providers through Medicaid managed care organizations' provider networks; and

(B) Medicaid managed care organization compliance with contractual obligations related to provider access standards;

(2) a compilation and analysis of information Medicaid managed care organizations submit to the commission under Section 540.0260(4);

(3) for both primary care providers and specialty providers, information on provider-to-recipient ratios in a Medicaid managed care organization's provider network and benchmark ratios to indicate whether deficiencies exist in a given network; and

(4) a description of, and analysis of the results from, the commission's monitoring process established under Section 540.0601. (Gov. Code, Sec. 533.0061.)

Source Law

Sec. 533.0061. PROVIDER ACCESS STANDARDS;

REPORT. (a) The commission shall establish minimum provider access standards for the provider network of a managed care organization that contracts with the commission to provide health care services to recipients. The access standards must ensure that a managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) after-hours urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

(8) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(9) any other services identified by the commission.

(b) To the extent it is feasible, the provider access standards established under this section must:

(1) distinguish between access to providers in urban and rural settings;

(2) consider the number and geographic distribution of Medicaid-enrolled providers in a particular service delivery area; and

(3) subject to Section 531.0216(c) and consistent with Section 111.007, Occupations Code, consider and include the availability of telehealth services and telemedicine medical services within the provider network of a Medicaid managed care organization.

(c) The commission shall biennially submit to the legislature and make available to the public a report containing information and statistics about recipient access to providers through the provider networks of the managed care organizations and managed care organization compliance with contractual obligations related to provider access standards established under this section. The report must contain:

(1) a compilation and analysis of information submitted to the commission under Section 533.005(a)(20)(D);

(2) for both primary care providers and specialty providers, information on provider-to-recipient ratios in an organization's provider network, as well as benchmark ratios to indicate whether deficiencies exist in a given network; and

(3) a description of, and analysis of the results from, the commission's monitoring process established under Section 533.007(l).

Revised Law

Sec. 540.0653. PENALTIES AND OTHER REMEDIES FOR FAILURE TO COMPLY WITH PROVIDER ACCESS STANDARDS. If a Medicaid managed care organization fails to comply with one or more provider access standards the commission establishes under Section 540.0652 and the commission determines the organization has not made substantial efforts to mitigate or remedy the noncompliance, the commission:

(1) may:

(A) elect to not retain or renew the commission's contract with the organization; or

(B) require the organization to pay liquidated damages in accordance with Section 540.0260(3); and

(2) if the organization's noncompliance occurs in a given service delivery area for two consecutive calendar quarters, shall suspend default enrollment to the organization in that service delivery area for at least one calendar quarter. (Gov. Code, Sec. 533.0062.)

Source Law

> Sec. 533.0062. PENALTIES AND OTHER REMEDIES FOR FAILURE TO COMPLY WITH PROVIDER ACCESS STANDARDS. If a managed care organization that has contracted with the commission to provide health care services to recipients fails to comply with one or more provider access standards established under Section 533.0061 and the commission determines the organization has not made substantial efforts to mitigate or remedy the noncompliance, the commission:
>
> (1) may:
>
> (A) elect to not retain or renew the commission's contract with the organization; or
>
> (B) require the organization to pay liquidated damages in accordance with Section 533.005(a)(20)(C); and
>
> (2) shall suspend default enrollment to the organization in a given service delivery area for at least one calendar quarter if the organization's noncompliance occurs in the service delivery area for two consecutive calendar quarters.

Revised Law

Sec. 540.0654. PROVIDER NETWORK DIRECTORIES. (a) The commission shall ensure that a Medicaid managed care organization:

(1) posts on the organization's Internet website:

(A) the organization's provider network directory; and

(B) a direct telephone number and e-mail address through which a recipient enrolled in the organization's managed care plan or the recipient's provider may contact the organization to receive assistance with:

(i) identifying in-network providers and services available to the recipient; and

(ii) scheduling an appointment for the recipient with an available in-network provider or to access available in-network services; and

(2) updates the online directory required under Subdivision (1)(A) at least monthly.

(b) A Medicaid managed care organization is required to send a paper form of the organization's provider network directory for the program only to a recipient who requests to receive the directory in paper form. (Gov. Code, Sec. 533.0063.)

Source Law

Sec. 533.0063. PROVIDER NETWORK DIRECTORIES. (a) The commission shall ensure that a managed care organization that contracts with the commission to provide health care services to recipients:

(1) posts on the organization's Internet website:

(A) the organization's provider network directory; and

(B) a direct telephone number and e-mail address through which a recipient enrolled in the organization's managed care plan or the recipient's provider may contact the organization to receive assistance with:

(i) identifying in-network providers and services available to the recipient; and

(ii) scheduling an appointment for the recipient with an available in-network provider or to access available in-network services; and

(2) updates the online directory required under Subdivision (1)(A) at least monthly.

(b) A managed care organization is required to send a paper form of the organization's provider network directory for the program only to a recipient who requests to receive the directory in paper form.

Revised Law

Sec. 540.0655. PROVIDER PROTECTION PLAN. (a) The commission shall develop and implement a provider protection plan designed to:

(1) reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement implemented under this chapter or Chapter _____ [[[Sections 533.00257, 533.002571, 533.00258, and 533.002581]]]; and

(2) ensure efficient provider enrollment and reimbursement.

(b) To the greatest extent possible, the commission shall

incorporate the measures in the provider protection plan into each contract between a managed care organization and the commission to provide health care services to recipients.

(c) The provider protection plan must provide for:

(1) a Medicaid managed care organization's prompt payment to and proper reimbursement of providers;

(2) prompt and accurate claim adjudication through:

(A) educating providers on properly submitting clean claims and on appeals;

(B) accepting uniform forms, including HCFA Forms 1500 and UB-92 and subsequent versions of those forms, through an electronic portal; and

(C) establishing standards for claims payments in accordance with a provider's contract;

(3) adequate and clearly defined provider network standards that:

(A) are specific to provider type, including physicians, general acute care facilities, and other provider types defined in the commission's network adequacy standards in effect on January 1, 2013; and

(B) ensure choice among multiple providers to the greatest extent possible;

(4) a prompt credentialing process for providers;

(5) uniform efficiency standards and requirements for Medicaid managed care organizations for submitting and tracking preauthorization requests for Medicaid services;

(6) establishing an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network may:

(A) submit electronic claims, prior authorization requests, claims appeals and reconsiderations, clinical data, and other documents that the organization requests for prior authorization and claims processing; and

(B) obtain electronic remittance advice,

explanation of benefits statements, and other standardized reports;

(7) measuring Medicaid managed care organization retention rates of significant traditional providers;

(8) creating a work group to review and make recommendations to the commission concerning any requirement under this subsection for which immediate implementation is not feasible at the time the plan is otherwise implemented, including the required process for submitting and accepting attachments for claims processing and prior authorization requests through an electronic process under Subdivision (6) and, for any requirement that is not implemented immediately, recommendations regarding the expected:

(A) fiscal impact of implementing the requirement; and

(B) timeline for implementing the requirement; and

(9) any other provision the commission determines will ensure efficiency or reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement. (Gov. Code, Sec. 533.0055.)

Source Law

Sec. 533.0055. PROVIDER PROTECTION PLAN. (a) The commission shall develop and implement a provider protection plan that is designed to reduce administrative burdens placed on providers participating in a Medicaid managed care model or arrangement implemented under this chapter and to ensure efficiency in provider enrollment and reimbursement. The commission shall incorporate the measures identified in the plan, to the greatest extent possible, into each contract between a managed care organization and the commission for the provision of health care services to recipients.

(b) The provider protection plan required under this section must provide for:

(1) prompt payment and proper reimbursement of providers by managed care organizations;

(2) prompt and accurate adjudication of claims through:

(A) provider education on the proper submission of clean claims and on appeals;

(B) acceptance of uniform forms, including HCFA Forms 1500 and UB-92 and subsequent

versions of those forms, through an electronic portal; and

(C) the establishment of standards for claims payments in accordance with a provider's contract;

(3) adequate and clearly defined provider network standards that are specific to provider type, including physicians, general acute care facilities, and other provider types defined in the commission's network adequacy standards in effect on January 1, 2013, and that ensure choice among multiple providers to the greatest extent possible;

(4) a prompt credentialing process for providers;

(5) uniform efficiency standards and requirements for managed care organizations for the submission and tracking of preauthorization requests for services provided under Medicaid;

(6) establishment of an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network may:

(A) submit electronic claims, prior authorization requests, claims appeals and reconsiderations, clinical data, and other documentation that the managed care organization requests for prior authorization and claims processing; and

(B) obtain electronic remittance advice, explanation of benefits statements, and other standardized reports;

(7) the measurement of the rates of retention by managed care organizations of significant traditional providers;

(8) the creation of a work group to review and make recommendations to the commission concerning any requirement under this subsection for which immediate implementation is not feasible at the time the plan is otherwise implemented, including the required process for submission and acceptance of attachments for claims processing and prior authorization requests through an electronic process under Subdivision (6) and, for any requirement that is not implemented immediately, recommendations regarding the expected:

(A) fiscal impact of implementing the requirement; and

(B) timeline for implementation of the requirement; and

(9) any other provision that the commission determines will ensure efficiency or reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement.

Revised Law

Sec. 540.0656. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) In this section, "applicant provider" means a physician or other health care provider applying for expedited credentialing.

(b) Notwithstanding any other law and subject to Subsection (c), a Medicaid managed care organization shall establish and

implement an expedited credentialing process that allows an applicant provider to provide services to recipients on a provisional basis.

(c) The commission shall identify the types of providers for which a Medicaid managed care organization must establish and implement an expedited credentialing process.

(d) To qualify for expedited credentialing and payment under Subsection (e), an applicant provider must:

(1) be a member of an established health care provider group that has a current contract with a Medicaid managed care organization;

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described by Subdivision (1); and

(4) submit all documentation and other information the Medicaid managed care organization requires as necessary to enable the organization to begin the credentialing process the organization requires to include a provider in the organization's provider network.

(e) On an applicant provider's submission of the information the Medicaid managed care organization requires under Subsection (d), and for Medicaid reimbursement purposes only, the organization shall treat the provider as if the provider were in the organization's provider network when the provider provides services to recipients, subject to Subsections (f) and (g).

(f) Except as provided by Subsection (g), a Medicaid managed care organization that determines on completion of the credentialing process that an applicant provider does not meet the organization's credentialing requirements may recover from the provider the difference between payments for in-network benefits and out-of-network benefits.

(g) A Medicaid managed care organization that determines on completion of the credentialing process that an applicant provider does not meet the organization's credentialing requirements and

that the provider made fraudulent claims in the provider's application for credentialing may recover from the provider the entire amount the organization paid the provider. (Gov. Code, Sec. 533.0064.)

Source Law

Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) In this section, "applicant provider" means a physician or other health care provider applying for expedited credentialing under this section.

(b) Notwithstanding any other law and subject to Subsection (c), a managed care organization that contracts with the commission to provide health services to recipients shall, in accordance with this section, establish and implement an expedited credentialing process that would allow applicant providers to provide services to recipients on a provisional basis.

(c) The commission shall identify the types of providers for which an expedited credentialing process must be established and implemented under this section.

(d) To qualify for expedited credentialing under this section and payment under Subsection (e), an applicant provider must:

(1) be a member of an established health care provider group that has a current contract in force with a managed care organization described by Subsection (b);

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described by Subdivision (1); and

(4) submit all documentation and other information required by the managed care organization as necessary to enable the organization to begin the credentialing process required by the organization to include a provider in the organization's provider network.

(e) On submission by the applicant provider of the information required by the managed care organization under Subsection (d), and for Medicaid reimbursement purposes only, the organization shall treat the provider as if the provider were in the organization's provider network when the provider provides services to recipients, subject to Subsections (f) and (g).

(f) Except as provided by Subsection (g), if, on completion of the credentialing process, a managed care organization determines that the applicant provider does not meet the organization's credentialing requirements, the organization may recover from the provider the difference between payments for in-network benefits and out-of-network benefits.

(g) If a managed care organization determines on completion of the credentialing process that the applicant provider does not meet the organization's credentialing requirements and that the provider made fraudulent claims in the provider's application for credentialing, the organization may recover from the provider the entire amount of any payment paid to the provider.

Revised Law

Sec. 540.0657. FREQUENCY OF PROVIDER RECREDENTIALING. (a) A Medicaid managed care organization shall formally recredential a physician or other provider with the frequency required by the single, consolidated Medicaid provider enrollment and credentialing process, if that process is created under Section ___ [[[Section 531.02118]]].

(b) Notwithstanding any other law, the required frequency of recredentialing may be less frequent than once in any three-year period. (Gov. Code, Sec. 533.0065.)

Source Law

> Sec. 533.0065. FREQUENCY OF PROVIDER CREDENTIALING. A managed care organization that contracts with the commission to provide health care services to Medicaid recipients under a managed care plan issued by the organization shall formally recredential a physician or other provider with the frequency required by the single, consolidated Medicaid provider enrollment and credentialing process, if that process is created under Section 531.02118. The required frequency of recredentialing may be less frequent than once in any three-year period, notwithstanding any other law.

Revised Law

Sec. 540.0658. PROVIDER INCENTIVES FOR PROMOTING PREVENTIVE SERVICES. To the extent possible, the commission shall work to ensure that a Medicaid managed care organization provides payment incentives to a health care provider in the organization's provider network whose performance in promoting recipient use of preventive services exceeds minimum established standards. (Gov. Code, Sec. 533.0066.)

Source Law

> 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.

Revised Law

Sec. 540.0659. REIMBURSEMENT RATE FOR CERTAIN SERVICES PROVIDED BY CERTAIN HEALTH CENTERS AND CLINICS OUTSIDE REGULAR

BUSINESS HOURS. (a) This section applies only to a recipient receiving benefits through a Medicaid managed care model or arrangement.

(b) The commission shall ensure that a federally qualified health center, rural health clinic, or municipal health department's public clinic is reimbursed for health care services provided to a recipient outside of regular business hours, including on a weekend or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, regardless of whether the recipient has a referral from the recipient's primary care provider.

(c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (b). (Gov. Code, Sec. 533.01315.)

Source Law

> Sec. 533.01315. REIMBURSEMENT FOR SERVICES PROVIDED OUTSIDE OF REGULAR BUSINESS HOURS. (a) This section applies only to a recipient receiving benefits through any Medicaid managed care model or arrangement.
>
> (b) The commission shall ensure that a federally qualified health center, rural health clinic, or municipal health department's public clinic is reimbursed for health care services provided to a recipient outside of regular business hours, including on a weekend or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, regardless of whether the recipient has a referral from the recipient's primary care provider.
>
> (c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (b).

SUBCHAPTER O. DELIVERY OF SERVICES: GENERAL PROVISIONS

Revised Law

Sec. 540.0701. ACUTE CARE SERVICE DELIVERY THROUGH MOST COST-EFFECTIVE MODEL; MANAGED CARE SERVICE DELIVERY AREAS. (a) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide Medicaid acute care services through the most cost-effective model of Medicaid capitated managed care as the commission determines. The

commission shall require mandatory participation in a Medicaid capitated managed care program for all individuals eligible for Medicaid acute care benefits, but may implement alternative models or arrangements, including a traditional fee-for-service arrangement, if the commission determines the alternative would be more cost-effective or efficient.

(b) In determining whether a model or arrangement described by Subsection (a) is more cost-effective, the executive commissioner must consider:

(1) the scope, duration, and types of health benefits or services to be provided in a certain part of this state or to a certain recipient population;

(2) administrative costs necessary to meet federal and state statutory and regulatory requirements;

(3) the anticipated effect of market competition associated with the configuration of Medicaid service delivery models the commission determines; and

(4) the gain or loss to this state of a tax collected under Chapter 222, Insurance Code.

(c) If the commission determines that it is not more cost-effective to use a Medicaid managed care model to provide certain types of Medicaid acute care in a certain area or to certain recipients as prescribed by this section, the commission shall provide Medicaid acute care through a traditional fee-for-service arrangement.

(d) The commission shall determine the most cost-effective alignment of managed care service delivery areas. The executive commissioner may consider:

(1) the number of lives impacted;

(2) the usual source of health care services for residents in an area; and

(3) other factors that impact health care service delivery in the area. (Gov. Code, Secs. 533.0025(b), (c), (d), (e).)

Source Law

Sec. 533.0025. DELIVERY OF SERVICES. (b) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide Medicaid acute care services through the most cost-effective model of Medicaid capitated managed care as determined by the commission. The commission shall require mandatory participation in a Medicaid capitated managed care program for all persons eligible for Medicaid acute care benefits, but may implement alternative models or arrangements, including a traditional fee-for-service arrangement, if the commission determines the alternative would be more cost-effective or efficient.

(c) In determining whether a model or arrangement described by Subsection (b) is more cost-effective, the executive commissioner must consider:

(1) the scope, duration, and types of health benefits or services to be provided in a certain part of this state or to a certain population of recipients;

(2) administrative costs necessary to meet federal and state statutory and regulatory requirements;

(3) the anticipated effect of market competition associated with the configuration of Medicaid service delivery models determined by the commission; and

(4) the gain or loss to this state of a tax collected under Chapter 222, Insurance Code.

(d) If the commission determines that it is not more cost-effective to use a Medicaid managed care model to provide certain types of Medicaid acute care in a certain area or to certain recipients as prescribed by this section, the commission shall provide Medicaid acute care through a traditional fee-for-service arrangement.

(e) The commission shall determine the most cost-effective alignment of managed care service delivery areas. The executive commissioner may consider the number of lives impacted, the usual source of health care services for residents in an area, and other factors that impact the delivery of health care services in the area.

Revisor's Note

Section 533.0025(b), Government Code, requires the Health and Human Services Commission to provide Medicaid acute care services through the most cost-effective model of Medicaid capitated managed care "[e]xcept as otherwise provided by this section," meaning Section 533.0025, Government Code. Section 533.0025 is revised in various provisions of this chapter. The revised law refers only to the provisions revised as this section because the relevant

exceptions to Section 533.0025(b) are revised in this section.

Revised Law

Sec. 540.0702. TRANSITION OF CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN PROGRAM RECIPIENTS TO MEDICAID MANAGED CARE PROGRAM. (a) In this section, "children and pregnant women program" means the Medicaid benefits program administered by the Department of State Health Services that provides case management services to children who have a health condition or health risk and pregnant women who have a high-risk condition.

(b) The commission shall transition to a Medicaid managed care model all case management services provided to children and pregnant women program recipients. In transitioning the services, the commission shall ensure a recipient is provided case management services through the Medicaid managed care plan in which the recipient is enrolled.

(c) In implementing this section, the commission shall ensure that:

(1) there is a seamless transition in case management services for children and pregnant women program recipients; and

(2) case management services provided under the program are not interrupted. (Gov. Code, Sec. 533.002555.)

Source Law

Sec. 533.002555. TRANSITION OF CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) In this section, "children and pregnant women program" means the benefits program provided under Medicaid and administered by the Department of State Health Services that provides case management services to children who have a health condition or health risk and pregnant women who have a high-risk condition.

(b) The commission shall transition to a Medicaid managed care model all case management services provided to recipients under the children and pregnant women program. In transitioning services under this section, the commission shall ensure a recipient is provided case management services through the managed care plan in which the recipient is enrolled.

(c) In implementing this section, the commission shall ensure:

(1) a seamless transition in case management for recipients receiving benefits under the

children and pregnant women program; and

(2) case management services provided under the program are not interrupted.

Revised Law

Sec. 540.0703. BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES. (a) In this section, "behavioral health services" means mental health and substance use disorder services.

(b) To the greatest extent possible, the commission shall integrate the following services into the Medicaid managed care program:

(1) behavioral health services, including targeted case management and psychiatric rehabilitation services; and

(2) physical health services.

(c) A Medicaid managed care organization shall:

(1) develop a network of public and private behavioral health services providers; and

(2) ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services.

(d) In implementing this section, the commission shall ensure that:

(1) an appropriate assessment tool is used to authorize services;

(2) providers are well-qualified and able to provide an appropriate array of services;

(3) appropriate performance and quality outcomes are measured;

(4) two health home pilot programs are established in two health service areas, representing two distinct regions of this state, for individuals who are diagnosed with:

(A) a serious mental illness; and

(B) at least one other chronic health condition;

(5) a health home established under a pilot program under Subdivision (4) complies with the principles for patient-centered medical homes described in Section 540.0712; and

(6) all behavioral health services provided under this section are based on an approach to treatment in which the expected outcome of treatment is recovery.

(e) If the commission determines that it is cost-effective and beneficial to recipients, the commission shall include a peer specialist as a benefit to recipients or as a provider type.

(f) To the extent of any conflict between this section and any other law relating to behavioral health services, this section prevails.

(g) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 533.00255.)

Source Law

Sec. 533.00255. BEHAVIORAL HEALTH AND PHYSICAL HEALTH SERVICES NETWORK. (a) In this section, "behavioral health services" means mental health and substance abuse disorder services.

(b) The commission shall, to the greatest extent possible, integrate into the Medicaid managed care program implemented under this chapter the following services for Medicaid-eligible persons:

(1) behavioral health services, including targeted case management and psychiatric rehabilitation services; and

(2) physical health services.

(c) A managed care organization that contracts with the commission under this chapter shall develop a network of public and private providers of behavioral health services and ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services.

(d) In implementing this section, the commission shall ensure that:

(1) an appropriate assessment tool is used to authorize services;

(2) providers are well-qualified and able to provide an appropriate array of services;

(3) appropriate performance and quality outcomes are measured;

(4) two health home pilot programs are established in two health service areas, representing two distinct regions of the state, for persons who are diagnosed with:

(A) a serious mental illness; and

(B) at least one other chronic health condition;

(5) a health home established under a pilot program under Subdivision (4) complies with the principles for patient-centered medical homes described in Section 533.0029; and

(6) all behavioral health services provided under this section are based on an approach to treatment where the expected outcome of treatment is recovery.

(g) The commission shall, if the commission

determines that it is cost-effective and beneficial to recipients, include a peer specialist as a benefit to recipients or as a provider type.

(h) To the extent of any conflict between this section and any other law relating to behavioral health services, this section prevails.

(i) The executive commissioner shall adopt rules necessary to implement this section.

Revisor's Note

(1) Section 533.00255(a), Government Code, refers to "substance abuse" disorder services. The revised law substitutes "substance use" for "substance abuse" for the reason stated in the revisor's note to Section 540.0262 of this chapter.

(2) Section 533.00255(b), Government Code, requires the Health and Human Services Commission to integrate certain services "for Medicaid-eligible persons" into the Medicaid managed care program "implemented under this chapter," meaning Chapter 533, Government Code. Chapter 533, Government Code, revised in relevant part as this chapter, is the only chapter under which the Medicaid managed care program is implemented, and only Medicaid-eligible persons may receive services through the Medicaid managed care program. The revised law omits the quoted language as superfluous.

Revised Law

Sec. 540.0704. TARGETED CASE MANAGEMENT AND PSYCHIATRIC REHABILITATIVE SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES. (a) A provider in the provider network of a Medicaid managed care organization that contracts with the commission to provide behavioral health services under Section 540.0703 may contract with the organization to provide targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(b) Commission rules and guidelines concerning contract and training requirements applicable to the provision of behavioral health services may apply to a provider that contracts with a

Medicaid managed care organization under Subsection (a) only to the extent those contract and training requirements are specific to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(c) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization under Subsection (a) may not require the provider to provide a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week. This subsection does not prohibit a Medicaid managed care organization that contracts with the commission to provide behavioral health services under Section 540.0703 from specifically contracting with a provider for the provision of a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week.

(d) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization to provide targeted case management and psychiatric rehabilitative services specific to children and adolescents who are at risk of juvenile justice involvement, expulsion from school, displacement from the home, hospitalization, residential treatment, or serious injury to self, others, or animals may not require the provider to also provide less intensive psychiatric rehabilitative services specified by commission rules and guidelines as applicable to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families, if that provider has a referral arrangement to provide access to those less intensive psychiatric rehabilitative services.

(e) Commission rules and guidelines applicable to a provider that contracts with a Medicaid managed care organization under Subsection (a) may not require the provider to provide services not covered under Medicaid. (Gov. Code, Sec. 533.002552.)

Source Law

Sec. 533.002552. TARGETED CASE MANAGEMENT AND PSYCHIATRIC REHABILITATIVE SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES. (a) A provider in the provider network of a managed care organization that contracts with the commission to provide behavioral health services under Section 533.00255 may contract with the managed care organization to provide targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(b) Commission rules and guidelines concerning contract and training requirements applicable to the provision of behavioral health services may apply to a provider that contracts with a managed care organization under Subsection (a) only to the extent those contract and training requirements are specific to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(c) Commission rules and guidelines applicable to a provider that contracts with a managed care organization under Subsection (a) may not require the provider to provide a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week. This subsection does not prohibit a managed care organization that contracts with the commission to provide behavioral health services under Section 533.00255 from specifically contracting with a provider for the provision of a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week.

(d) Commission rules and guidelines applicable to a provider that contracts with a managed care organization to provide targeted case management and psychiatric rehabilitative services specific to children and adolescents who are at risk of juvenile justice involvement, expulsion from school, displacement from the home, hospitalization, residential treatment, or serious injury to self, others, or animals may not require the provider to also provide less intensive psychiatric rehabilitative services specified by commission rules and guidelines as applicable to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families, if that provider has a referral arrangement to provide access to those less intensive psychiatric rehabilitative services.

(e) Commission rules and guidelines applicable to a provider that contracts with a managed care organization under Subsection (a) may not require the provider to provide services not covered under Medicaid.

Revised Law

Sec. 540.0705. BEHAVIORAL HEALTH SERVICES PROVIDED THROUGH THIRD PARTY OR SUBSIDIARY. (a) In this section, "behavioral health services" has the meaning assigned by Section 540.0703.

(b) For a Medicaid managed care organization that provides behavioral health services through a contract with a third party or

an arrangement with a subsidiary of the organization, the commission shall:

(1) require the effective sharing and integration of care coordination, service authorization, and utilization management data between the organization and the third party or subsidiary;

(2) encourage the colocation of physical health and behavioral health care coordination staff, to the extent feasible;

(3) require warm call transfers between physical health and behavioral health care coordination staff;

(4) require the organization and the third party or subsidiary to implement joint rounds for physical health and behavioral health services network providers or some other effective means for sharing clinical information; and

(5) ensure that the organization makes available a seamless provider portal for both physical health and behavioral health services network providers, to the extent allowed by federal law. (Gov. Code, Sec. 533.002553.)

Source Law

Sec. 533.002553. BEHAVIORAL HEALTH SERVICES PROVIDED THROUGH THIRD PARTY OR SUBSIDIARY. (a) In this section, "behavioral health services" has the meaning assigned by Section 533.00255.

(b) For a managed care organization that contracts with the commission under this chapter and that provides behavioral health services through a contract with a third party or an arrangement with a subsidiary of the managed care organization, the commission shall:

(1) require the effective sharing and integration of care coordination, service authorization, and utilization management data between the managed care organization and the third party or subsidiary;

(2) encourage, to the extent feasible, the colocation of physical health and behavioral health care coordination staff;

(3) require warm call transfers between physical health and behavioral health care coordination staff;

(4) require the managed care organization and the third party or subsidiary to implement joint rounds for physical health and behavioral health services network providers or some other effective means for sharing clinical information; and

(5) ensure that the managed care organization makes available a seamless provider portal for both physical health and behavioral health

services network providers, to the extent allowed by federal law.

Revised Law

Sec. 540.0706. PSYCHOTROPIC MEDICATION MONITORING SYSTEM FOR CERTAIN CHILDREN. (a) In this section, "psychotropic medication" has the meaning assigned by Section 266.001, Family Code.

(b) The commission shall implement a system under which the commission will use Medicaid prescription drug data to monitor the prescribing of psychotropic medications for:

(1) children who are in the conservatorship of the Department of Family and Protective Services and enrolled in the STAR Health program or eligible for both Medicaid and Medicare; and

(2) children who are under the supervision of the Department of Family and Protective Services through an agreement under the Interstate Compact on the Placement of Children under Subchapter B, Chapter 162, Family Code.

(c) The commission shall include as a component of the monitoring system a medical review of a prescription to which Subsection (b) applies when that review is appropriate. (Gov. Code, Sec. 533.0161.)

Source Law

Sec. 533.0161. MONITORING OF PSYCHOTROPIC DRUG PRESCRIPTIONS FOR CERTAIN CHILDREN. (a) In this section, "psychotropic drug" has the meaning assigned by Section 261.111, Family Code.

(b) The commission shall implement a system under which the commission will use Medicaid prescription drug data to monitor the prescribing of psychotropic drugs for:

(1) children who are in the conservatorship of the Department of Family and Protective Services and enrolled in the STAR Health Medicaid managed care program or eligible for both Medicaid and Medicare; and

(2) children who are under the supervision of the Department of Family and Protective Services through an agreement under the Interstate Compact on the Placement of Children under Subchapter B, Chapter 162, Family Code.

(c) The commission shall include as a component of the monitoring system required by this section a medical review of a prescription to which Subsection (b) applies when that review is appropriate.

Revisor's Note

(1) Section 533.0161(a), Government Code, provides that the term "psychotropic drug" has the meaning assigned by Section 261.111, Family Code. Section 261.111, Family Code, provides that the term "psychotropic medication" has the meaning assigned by Section 266.001, Family Code. For the convenience of the reader, the revised law substitutes the term "psychotropic medication" for "psychotropic drug" and substitutes a reference to Section 266.001, Family Code, for the reference to Section 261.111, Family Code.

(2) Section 533.0161(b)(1), Government Code, refers to the "STAR Health Medicaid managed care program." The revised law substitutes "STAR Health program" for "STAR Health Medicaid managed care program" because the terms are synonymous and "STAR Health program" is more commonly used.

Revised Law

Sec. 540.0707. MEDICATION THERAPY MANAGEMENT. The executive commissioner shall collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events. (Gov. Code, Sec. 533.00515.)

Source Law

Sec. 533.00515. MEDICATION THERAPY MANAGEMENT. The executive commissioner shall collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.

Revised Law

Sec. 540.0708. SPECIAL DISEASE MANAGEMENT. (a) The commission shall ensure that a Medicaid managed care organization develops and implements special disease management programs to manage a disease or other chronic health condition with respect to

which disease management would be cost-effective for populations the commission identifies. The special disease management programs may manage a disease or other chronic health condition such as:

(1) heart disease;

(2) chronic kidney disease and related medical complications;

(3) respiratory illness, including asthma;

(4) diabetes;

(5) end-stage renal disease;

(6) HIV infection; or

(7) AIDS.

(b) A Medicaid managed care plan must provide, in the manner the commission requires, disease management services including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation criteria; and

(5) physician-directed or physician-supervised care.

(c) The executive commissioner by rule shall prescribe the minimum requirements that a Medicaid managed care organization must meet in providing a special disease management program to be eligible to receive a contract under this section. The organization must at a minimum be required to:

(1) provide disease management services that have performance measures for particular diseases that are comparable to the relevant performance measures applicable to a provider of disease management services under Section 32.057, Human Resources Code;

(2) show evidence of ability to manage complex diseases in the Medicaid population; and

(3) if a special disease management program the organization provides has low active participation rates, identify

the reason for the low rates and develop an approach to increase active participation in special disease management programs for high-risk recipients.

(d) If a Medicaid managed care organization implements a special disease management program to manage chronic kidney disease and related medical complications as provided by Subsection (a) and the organization develops a program to provide screening for and diagnosis and treatment of chronic kidney disease and related medical complications to recipients under the organization's Medicaid managed care plan, the program for screening, diagnosis, and treatment must use generally recognized clinical practice guidelines and laboratory assessments that identify chronic kidney disease on the basis of impaired kidney function or the presence of kidney damage. (Gov. Code, Sec. 533.009.)

Source Law

Sec. 533.009. SPECIAL DISEASE MANAGEMENT. (a) The commission shall ensure that managed care organizations under contract with the commission to provide health care services to recipients develop and implement special disease management programs to manage a disease or other chronic health conditions, such as heart disease, chronic kidney disease and its medical complications, respiratory illness, including asthma, diabetes, end-stage renal disease, HIV infection, or AIDS, and with respect to which the commission identifies populations for which disease management would be cost-effective.

(b) A managed health care plan provided under this chapter must provide disease management services in the manner required by the commission, including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation criteria; and

(5) physician-directed or physician-supervised care.

(c) The executive commissioner, by rule, shall prescribe the minimum requirements that a managed care organization, in providing a disease management program, must meet to be eligible to receive a contract under this section. The managed care organization must, at a minimum, be required to:

(1) provide disease management services that have performance measures for particular diseases that are comparable to the relevant performance measures applicable to a provider of disease management services under Section 32.057, Human Resources Code;

(2) show evidence of ability to manage complex diseases in the Medicaid population; and

(3) if a disease management program provided by the organization has low active participation rates, identify the reason for the low rates and develop an approach to increase active participation in disease management programs for high-risk recipients.

(f) If a managed care organization implements a special disease management program to manage chronic kidney disease and its medical complications as provided by Subsection (a) and the managed care organization develops a program to provide screening for and diagnosis and treatment of chronic kidney disease and its medical complications to recipients under the organization's managed care plan, the program for screening, diagnosis, and treatment must use generally recognized clinical practice guidelines and laboratory assessments that identify chronic kidney disease on the basis of impaired kidney function or the presence of kidney damage.

Revised Law

Sec. 540.0709. SPECIAL PROTOCOLS FOR INDIGENT POPULATIONS. In conjunction with an academic center, the commission may study the treatment of indigent populations to develop special protocols for use by Medicaid managed care organizations in providing health care services to recipients. (Gov. Code, Sec. 533.010.)

Source Law

Sec. 533.010. SPECIAL PROTOCOLS. In conjunction with an academic center, the commission may study the treatment of indigent populations to develop special protocols for managed care organizations to use in providing health care services to recipients.

Revised Law

Sec. 540.0710. DIRECT ACCESS TO EYE HEALTH CARE SERVICES. (a) Notwithstanding any other law, the commission shall ensure that a Medicaid managed care plan offered by a Medicaid managed care organization and any other Medicaid managed care model or arrangement implemented under this chapter allow a recipient receiving services through the plan or other model or arrangement to, in the manner and to the extent required by Section 32.072, Human Resources Code:

(1) select an in-network ophthalmologist or therapeutic optometrist in the managed care network to provide eye health care services other than surgery; and

(2) have direct access to the selected in-network ophthalmologist or therapeutic optometrist for the nonsurgical

services.

(b) This section does not affect the obligation of an ophthalmologist or therapeutic optometrist in a managed care network to comply with the terms of the Medicaid managed care plan. (Gov. Code, Sec. 533.0026.)

Source Law

> Sec. 533.0026. DIRECT ACCESS TO EYE HEALTH CARE SERVICES UNDER MEDICAID MANAGED CARE MODEL OR ARRANGEMENT. (a) Notwithstanding any other law, the commission shall ensure that a managed care plan offered by a managed care organization that contracts with the commission under this chapter and any other Medicaid managed care model or arrangement implemented under this chapter allow a recipient who receives services through the plan or other model or arrangement to, in the manner and to the extent required by Section 32.072, Human Resources Code:
>
> (1) select an in-network ophthalmologist or therapeutic optometrist in the managed care network to provide eye health care services, other than surgery; and
>
> (2) have direct access to the selected in-network ophthalmologist or therapeutic optometrist for the provision of the nonsurgical services.
>
> (b) This section does not affect the obligation of an ophthalmologist or therapeutic optometrist in a managed care network to comply with the terms and conditions of the managed care plan.

Revisor's Note

Section 533.0026(b), Government Code, refers to the "terms and conditions" of a Medicaid managed care plan. The revised law omits "conditions" from the quoted phrase for the reason stated in Revisor's Note (3) to Section 540.0206 of this chapter.

Revised Law

Sec. 540.0711. DELIVERY OF BENEFITS USING TELECOMMUNICATIONS OR INFORMATION TECHNOLOGY. (a) In this section, "home telemonitoring service" means a health service that requires:

(1) scheduled remote monitoring of data related to a patient's health; and

(2) transmission of the data to a licensed home and community support services agency or hospital, as those terms are defined by Section _____ [[[Section 531.02164(a)]]].

(b) The commission shall establish policies and procedures to improve access to care under the Medicaid managed care program by encouraging the use under the program of:

(1) telehealth services;

(2) telemedicine medical services;

(3) home telemonitoring services; and

(4) other telecommunications or information technology.

(c) To the extent allowed by federal law, the executive commissioner by rule shall establish policies and procedures that allow a Medicaid managed care organization to conduct assessments and provide care coordination services using telecommunications or information technology. In establishing the policies and procedures, the executive commissioner shall consider:

(1) the extent to which a Medicaid managed care organization determines using the telecommunications or information technology is appropriate;

(2) whether the recipient requests that the assessment or service be provided using telecommunications or information technology;

(3) whether the recipient consents to receiving the assessment or service using telecommunications or information technology;

(4) whether conducting the assessment, including an assessment for an initial waiver eligibility determination, or providing the service in person is not feasible because of the existence of an emergency or state of disaster, including a public health emergency or natural disaster; and

(5) whether the commission determines using the telecommunications or information technology is appropriate under the circumstances.

(d) If a Medicaid managed care organization conducts an assessment of or provides care coordination services to a recipient using telecommunications or information technology, the

organization shall:

(1) monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse; and

(2) determine whether additional social services or supports are needed.

(e) To the extent allowed by federal law, the commission shall allow a recipient who is assessed or provided with care coordination services by a Medicaid managed care organization using telecommunications or information technology to provide consent or other authorizations to receive services verbally instead of in writing.

(f) The commission shall determine categories of recipients of home and community-based services who must receive in-person visits. Except during circumstances described by Subsection (c)(4), a Medicaid managed care organization shall, for a recipient of home and community-based services for which the commission requires in-person visits, conduct:

(1) at least one in-person visit with the recipient to make an initial waiver eligibility determination; and

(2) additional in-person visits with the recipient if necessary, as determined by the organization.

(g) Notwithstanding this section, the commission may, on a case-by-case basis, require a Medicaid managed care organization to discontinue the use of telecommunications or information technology for assessment or care coordination services if the commission determines that the discontinuation is in the recipient's best interest. (Gov. Code, Secs. 531.001(4-a), 533.039.)

Source Law

Sec. 531.001. DEFINITIONS. In this subtitle:

(4-a) "Home telemonitoring service" means a health service that requires scheduled remote monitoring of data related to a patient's health and transmission of the data to a licensed home and community support services agency or a hospital, as those terms are defined by Section 531.02164(a).

Sec. 533.039. DELIVERY OF BENEFITS USING TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY. (a) The commission shall establish policies and procedures to improve access to care under the Medicaid managed care program by encouraging the use of telehealth services, telemedicine medical services, home telemonitoring services, and other telecommunications or information technology under the program.

(b) To the extent permitted by federal law, the executive commissioner by rule shall establish policies and procedures that allow a Medicaid managed care organization to conduct assessments and provide care coordination services using telecommunications or information technology. In establishing the policies and procedures, the executive commissioner shall consider:

(1) the extent to which a managed care organization determines using the telecommunications or information technology is appropriate;

(2) whether the recipient requests that the assessment or service be provided using telecommunications or information technology;

(3) whether the recipient consents to receiving the assessment or service using telecommunications or information technology;

(4) whether conducting the assessment, including an assessment for an initial waiver eligibility determination, or providing the service in person is not feasible because of the existence of an emergency or state of disaster, including a public health emergency or natural disaster; and

(5) whether the commission determines using the telecommunications or information technology is appropriate under the circumstances.

(c) If a Medicaid managed care organization conducts an assessment of or provides care coordination services to a recipient using telecommunications or information technology, the managed care organization shall:

(1) monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse; and

(2) determine whether additional social services or supports are needed.

(d) To the extent permitted by federal law, the commission shall allow a recipient who is assessed or provided with care coordination services by a Medicaid managed care organization using telecommunications or information technology to provide consent or other authorizations to receive services verbally instead of in writing.

(e) The commission shall determine categories of recipients of home and community-based services who must receive in-person visits. Except during circumstances described by Subsection (b)(4), a Medicaid managed care organization shall, for a recipient of home and community-based services for which the commission requires in-person visits, conduct:

(1) at least one in-person visit with the recipient to make an initial waiver eligibility determination; and

(2) additional in-person visits with the recipient if necessary, as determined by the managed care organization.

(f) Notwithstanding the provisions of this section, the commission may, on a case-by-case basis, require a Medicaid managed care organization to

discontinue the use of telecommunications or information technology for assessment or service coordination services if the commission determines that the discontinuation is in the best interest of the recipient.

Revisor's Note

(1) Section 531.001(4-a), Government Code, provides a definition of "home telemonitoring service" that applies "[i]n this subtitle," meaning Subtitle I, Title 4, Government Code. The definition of "home telemonitoring service" is revised to apply only to this section of the revised law, rather than the entire subtitle. The term is used only in Section 533.039, Government Code, which is revised as this section, and in Sections 531.0216 and 531.02164, Government Code, which are revised as Sections _____ and _____. To preserve the applicability of the definition to Sections 531.0216 and 531.02164, the definition is also revised in Chapter _____ to apply to Sections ____ and ____, which are the revised law for Sections 531.0216 and 531.02164.

(2) Section 533.039(f), Government Code, refers to requiring the discontinuation of the use of telecommunications or information technology under certain circumstances for "service coordination services." Sections 533.039(b), (c), and (d), Government Code, refer to providing "care coordination services" using telecommunications or information technology. Accordingly, the revised law substitutes "care coordination services" for "service coordination services" for consistency in the terminology used within the section.

Revised Law

Sec. 540.0712. PROMOTION AND PRINCIPLES OF PATIENT-CENTERED MEDICAL HOME. (a) In this section, "patient-centered medical home" means a medical relationship:

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

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

(B) facilitates partnerships between the physician, the patient, any 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 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 patient's ongoing care;

(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 Medicaid 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. (Gov. Code, Sec. 533.0029.)

Source Law

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.

Revised Law

Sec. 540.0713. VALUE-ADDED SERVICES. The commission shall actively encourage Medicaid managed care organizations to offer benefits, including health care services or benefits or other types of services, that:

(1) are in addition to the services ordinarily covered by the Medicaid managed care plan the organization offers; and

(2) have the potential to improve the health status of recipients enrolled in the plan. (Gov. Code, Sec. 533.019.)

Source Law

Sec. 533.019. VALUE-ADDED SERVICES. The commission shall actively encourage managed care organizations that contract with the commission to offer benefits, including health care services or benefits or other types of services, that:

(1) are in addition to the services ordinarily covered by the managed care plan offered by the managed care organization; and

(2) have the potential to improve the health status of enrollees in the plan.

Revisor's Note

Section 533.019(2), Government Code, refers to "enrollees," meaning Medicaid recipients who are enrolled in a Medicaid managed care plan a Medicaid managed care organization offers. Throughout this chapter, the revised law substitutes "recipients enrolled" and "enrolled recipients" for "enrollees" in a particular Medicaid managed care plan or program for clarity and consistency in the terminology used within the chapter.

SUBCHAPTER P. DELIVERY OF SERVICES: STAR+PLUS MEDICAID MANAGED CARE PROGRAM

Revised Law

Sec. 540.0751. DELIVERY OF ACUTE CARE SERVICES AND LONG-TERM SERVICES AND SUPPORTS. Subject to Sections 540.0701 and 540.0753, the commission shall expand the STAR+PLUS Medicaid managed care program to all areas of this state to serve individuals eligible for Medicaid acute care services and long-term services and supports. (Gov. Code, Sec. 533.00251(b).)

Source Law

(b) Subject to Section 533.0025, the commission shall expand the STAR + PLUS Medicaid managed care program to all areas of this state to serve individuals eligible for acute care services and long-term services and supports under Medicaid.

Revisor's Note

Section 533.00251(b), Government Code, refers to the expansion of the STAR+PLUS Medicaid managed care program, "[s]ubject to Section 533.0025," Government

Code. The relevant provisions of Section 533.0025 requiring delivering Medicaid services through the most cost-effective model of managed care are revised in this chapter as Sections 540.0701 and 540.0753. The revised law is drafted accordingly.

Revised Law

Sec. 540.0752. DELIVERY OF MEDICAID BENEFITS TO NURSING FACILITY RESIDENTS. (a) In this section:

(1) "Clean claim" means a claim that meets the same criteria the commission uses for a clean claim in reimbursing nursing facility claims.

(2) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to recipients.

(b) Subject to Section 540.0701 and notwithstanding any other law, the commission shall provide Medicaid benefits through the STAR+PLUS Medicaid managed care program to recipients who reside in nursing facilities. In implementing this subsection, the commission shall ensure that:

(1) a nursing facility is paid not later than the 10th day after the date the facility submits a clean claim;

(2) services are used appropriately, consistent with criteria the commission establishes;

(3) the incidence of potentially preventable events and unnecessary institutionalizations is reduced;

(4) a Medicaid managed care organization providing services under the program:

(A) provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(B) assists in collecting applied income from recipients; and

(C) provides payment incentives to nursing

facility providers that:

(i) reward reductions in preventable acute care costs; and

(ii) encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(5) a portal is established that complies with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the program may submit claims to any participating Medicaid managed care organization;

(6) rules and procedures relating to certifying and decertifying nursing facility beds under Medicaid are not affected;

(7) a Medicaid managed care organization providing services under the program, to the greatest extent possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board; and

(8) the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the program.

(c) The commission shall establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR+PLUS Medicaid managed care program that are consistent with adopted federal and state standards. A Medicaid managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards the commission establishes under this section.

(d) In addition to the minimum performance standards the commission establishes for nursing facility providers seeking to

participate in the STAR+PLUS Medicaid managed care program, the executive commissioner shall adopt rules establishing minimum performance standards applicable to nursing facility providers that participate in the program. The commission is responsible for monitoring provider performance in accordance with the standards and requiring corrective actions, as the commission determines necessary, from providers that do not meet the standards. The commission shall share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.

(e) A managed care organization may not require prior authorization for a nursing facility resident in need of emergency hospital services. (Gov. Code, Secs. 533.00251(a)(2), (3), (c) as eff. Sept. 1, 2023, (e), (f), (h).)

Source Law

> Sec. 533.00251. DELIVERY OF CERTAIN BENEFITS, INCLUDING NURSING FACILITY BENEFITS, THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) In this section and Sections 533.002515 and 533.00252:
>
> (2) "Clean claim" means a claim that meets the same criteria for a clean claim used by the Department of Aging and Disability Services for the reimbursement of nursing facility claims.
>
> (3) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to recipients.
>
> (c) [as effective on September 1, 2023] Subject to Section 533.0025 and notwithstanding any other law, the commission shall provide benefits under Medicaid to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. In implementing this subsection, the commission shall ensure:
>
> (1) that a nursing facility is paid not later than the 10th day after the date the facility submits a clean claim;
>
> (2) the appropriate utilization of services consistent with criteria established by the commission;
>
> (3) a reduction in the incidence of potentially preventable events and unnecessary institutionalizations;
>
> (4) that a managed care organization providing services under the managed care program provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;
>
> (5) that a managed care organization providing services under the managed care program:

(A) assists in collecting applied income from recipients; and

(B) provides payment incentives to nursing facility providers that reward reductions in preventable acute care costs and encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(6) the establishment of a portal that is in compliance with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization;

(7) that rules and procedures relating to the certification and decertification of nursing facility beds under Medicaid are not affected;

(8) that a managed care organization providing services under the managed care program, to the greatest extent possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board; and

(9) that the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the managed care program.

(e) The commission shall establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care program that are consistent with adopted federal and state standards. A managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by the commission under this section.

(f) A managed care organization may not require prior authorization for a nursing facility resident in need of emergency hospital services.

(h) In addition to the minimum performance standards the commission establishes for nursing facility providers seeking to participate in the STAR+PLUS Medicaid managed care program, the executive commissioner shall adopt rules establishing minimum performance standards applicable to nursing facility providers that participate in the program. The commission is responsible for monitoring provider performance in accordance with the standards and requiring corrective actions, as the commission determines necessary, from providers that do not meet the standards. The commission shall share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.

Revisor's Note

(1) Section 533.00251(a), Government Code, provides definitions applicable to Sections 533.00251, 533.002515, and 533.00252, Government Code. The revised law omits the reference to Section

533.002515, Government Code, because that section expired by its own terms September 1, 2015. The revised law also omits the reference to Section 533.00252, Government Code, because that section was repealed by Chapters 837 (S.B. 200) and 946 (S.B. 277), Acts of the 84th Legislature, Regular Session, 2015, effective January 1, 2016.

(2) Section 533.00251(a)(2), Government Code, refers to the Department of Aging and Disability Services. The Department of Aging and Disability Services was abolished September 1, 2017, in accordance with Section 531.0202(b), Government Code, which is executed law that expires September 1, 2023. The powers and duties of that department were transferred to the Health and Human Services Commission. Section 531.0011, Government Code, revised in this subtitle as Section _____, provides that a reference to the department means the commission or the appropriate division of the commission. Because the department no longer exists and the commission has assumed the powers and duties of the department, the revised law substitutes "commission" for "Department of Aging and Disability Services."

(3) Section 533.00251(c), Government Code, requires the Health and Human Services Commission to provide Medicaid benefits to nursing facility residents through the STAR+PLUS Medicaid managed care program, "[s]ubject to Section 533.0025," Government Code. The relevant provision of Section 533.0025 requiring delivering Medicaid services through the most cost-effective model of managed care is revised in this chapter as Section 540.0701. The revised law is drafted accordingly.

Revised Law

Sec. 540.0753. DELIVERY OF BASIC ATTENDANT AND HABILITATION SERVICES. Subject to Section _____ [[[Section 534.152]]], the commission shall:

(1) implement the option for the delivery of basic attendant and habilitation services to individuals with disabilities under the STAR+PLUS Medicaid managed care program that:

(A) is the most cost-effective; and

(B) maximizes federal funding for the delivery of services for that program and other similar programs; and

(2) provide voluntary training to individuals receiving services under the STAR+PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss a personal attendant providing basic attendant and habilitation services under the program. (Gov. Code, Sec. 533.0025(i).)

Source Law

> (i) Subject to Section 534.152, the commission shall:
>
> (1) implement the most cost-effective option for the delivery of basic attendant and habilitation services for individuals with disabilities under the STAR + PLUS Medicaid managed care program that maximizes federal funding for the delivery of services for that program and other similar programs; and
>
> (2) provide voluntary training to individuals receiving services under the STAR + PLUS Medicaid managed care program or their legally authorized representatives regarding how to select, manage, and dismiss personal attendants providing basic attendant and habilitation services under the program.

Revised Law

Sec. 540.0754. EVALUATION OF CERTAIN 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 recipients who are:

(1) enrolled in the STAR+PLUS Medicaid managed care program; and

(2) eligible to receive health care benefits under both Medicaid and the Medicare program. (Gov. Code, Sec. 533.0028.)

Source Law

> Sec. 533.0028. EVALUATION OF CERTAIN STAR + PLUS MEDICAID 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 STAR + PLUS Medicaid managed care program who are eligible to receive health care benefits under both Medicaid and the Medicare program.

Revised Law

Sec. 540.0755. UTILIZATION REVIEW; ANNUAL REPORT. (a) The commission's office of contract management shall establish an annual utilization review process for Medicaid 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. The review process must include a thorough investigation of each Medicaid managed care organization's procedures for determining whether a recipient should be enrolled in the STAR+PLUS home and community-based services (HCBS) waiver 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 Medicaid managed care organization participating in the STAR+PLUS Medicaid managed care program; or

(2) only the Medicaid managed care organizations that, using a risk-based assessment process, the office determines have a higher likelihood of inappropriate recipient placement in the STAR+PLUS home and community-based services (HCBS) waiver program.

(c) Not later than December 1 of each year and 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 Medicaid. 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 Medicaid managed care organization; and

(3) extrapolate those findings and make recommendations for improving the STAR+PLUS Medicaid managed care program's efficiency.

(d) If a utilization review conducted under this section results in a determination to recoup money from a Medicaid managed care organization, a service provider who contracts with the organization may not be held liable for providing services in good faith based on the organization's authorization. (Gov. Code, Sec. 533.00281.)

Source Law

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.

(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 Medicaid 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.

Revisor's Note

(1) Sections 533.00281(a) and (b), Government Code, refer to the "home and community-based services and supports (HCBS) program." The revised law substitutes "home and community-based services (HCBS) waiver program" for the quoted language for consistency in terminology used throughout this chapter and because the terms are synonymous and the latter is more commonly used.

(2) Section 533.00281(b)(2), Government Code, refers to "client" placement in the STAR+PLUS home and community-based services and supports (HCBS) program. The revised law substitutes the term "recipient" for "client" for the reason stated in Revisor's Note (2) to Section 540.0054 of this chapter.

(3) Section 533.00281(d)(3), Government Code, requires the Health and Human Services Commission to prepare a report that includes recommendations on improving the efficiency of "the program." It is clear from the context of other portions of Section 533.00281 that "the program" to which Section 533.00281(d)(3) refers is the STAR+PLUS Medicaid managed care program. Therefore, the revised law substitutes "STAR+PLUS Medicaid managed care program" for "program" for clarity and the convenience of the reader.

SUBCHAPTER Q. DELIVERY OF SERVICES: STAR HEALTH PROGRAM

Revised Law

Sec. 540.0801. TRAUMA-INFORMED CARE TRAINING. (a) A STAR Health program managed care contract between a Medicaid managed

care organization and the commission must require that trauma-informed care training be offered to each contracted physician or provider.

(b) The commission shall encourage each Medicaid managed care organization providing health care services to recipients under the STAR Health program to make training in post-traumatic stress disorder and attention-deficit/hyperactivity disorder available to a contracted physician or provider within a reasonable time after the date the physician or provider begins providing services under the Medicaid managed care plan the organization offers. (Gov. Code, Sec. 533.0052.)

Source Law

> Sec. 533.0052. STAR HEALTH PROGRAM: TRAUMA-INFORMED CARE TRAINING. (a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients under the STAR Health program must include a requirement that trauma-informed care training be offered to each contracted physician or provider.
>
> (b) The commission shall encourage each managed care organization providing health care services to recipients under the STAR Health program to make training in post-traumatic stress disorder and attention-deficit/hyperactivity disorder available to a contracted physician or provider within a reasonable time after the date the physician or provider begins providing services under the managed care plan.

Revised Law

Sec. 540.0802. MENTAL HEALTH PROVIDERS. A STAR Health program managed care contract between a Medicaid managed care organization and the commission must require the organization to ensure that the organization maintains a network of mental and behavioral health providers, including child psychiatrists and other appropriate providers, in all Department of Family and Protective Services regions in this state, regardless of whether community-based care has been implemented in any region. (Gov. Code, Sec. 533.00522.)

Source Law

> Sec. 533.00522. STAR HEALTH PROGRAM: MENTAL HEALTH PROVIDERS. A contract between a Medicaid managed care organization and the commission for the organization to provide health care services to

recipients under the STAR Health program must require the organization to ensure the organization maintains a network of mental and behavioral health providers, including child psychiatrists and other appropriate providers, in all Department of Family and Protective Services regions in this state, regardless of whether community-based care has been implemented in any region.

Revised Law

Sec. 540.0803. HEALTH SCREENING REQUIREMENTS AND COMPLIANCE WITH TEXAS HEALTH STEPS. (a) A Medicaid managed care organization providing health care services to a recipient under the STAR Health program must ensure that the recipient receives a complete early and periodic screening, diagnosis, and treatment checkup in accordance with the requirements specified in the managed care contract between the organization and the commission.

(b) The commission shall encourage each Medicaid managed care organization providing health care services to a recipient under the STAR Health program to ensure that the organization's network providers comply with the regimen of care prescribed by the Texas Health Steps program under Section 32.056, Human Resources Code, if applicable, including the requirement to provide a mental health screening during each of the recipient's Texas Health Steps medical exams a network provider conducts.

(c) The commission shall include a provision in a STAR Health program managed care contract between a Medicaid managed care organization and the commission specifying progressive monetary penalties for the organization's failure to comply with Subsection (a). (Gov. Code, Secs. 533.0053, 533.0054.)

Source Law

Sec. 533.0053. COMPLIANCE WITH TEXAS HEALTH STEPS. The commission shall encourage each managed care organization providing health care services to a recipient under the STAR Health program to ensure that the organization's network providers comply with the regimen of care prescribed by the Texas Health Steps program under Section 32.056, Human Resources Code, if applicable, including the requirement to provide a mental health screening during each of the recipient's Texas Health Steps medical exams conducted by a network provider.

Sec. 533.0054. HEALTH SCREENING REQUIREMENTS FOR ENROLLEE UNDER STAR HEALTH PROGRAM. (a) A managed care organization that contracts with the commission to provide health care services to recipients under

the STAR Health program must ensure that enrollees receive a complete early and periodic screening, diagnosis, and treatment checkup in accordance with the requirements specified in the contract between the managed care organization and the commission.

(b) The commission shall include a provision in a contract with a managed care organization to provide health care services to recipients under the STAR Health program specifying progressive monetary penalties for the organization's failure to comply with Subsection (a).

Revised Law

Sec. 540.0804. HEALTH CARE AND OTHER SERVICES FOR CHILDREN IN SUBSTITUTE CARE. (a) The commission shall annually evaluate the use of benefits offered to children in foster care under the STAR Health program and provide recommendations to the Department of Family and Protective Services and each single source continuum contractor in this state to better coordinate the provision of health care and use of those benefits for those children.

(b) In conducting the evaluation, the commission shall:

(1) collaborate with residential child-care providers regarding any unmet needs of children in foster care and the development of capacity for providing quality medical, behavioral health, and other services for those children; and

(2) identify options to obtain federal matching funds under Medicaid to pay for a safe home-like or community-based residential setting for a child in the conservatorship of the Department of Family and Protective Services:

(A) who is identified or diagnosed as having a serious behavioral or mental health condition that requires intensive treatment;

(B) who is identified as a victim of serious abuse or serious neglect;

(C) for whom a traditional substitute care placement contracted for or purchased by the department is not available or would further denigrate the child's behavioral or mental health condition; or

(D) for whom the department determines a safe home-like or community-based residential placement could stabilize

the child's behavioral or mental health condition in order to return the child to a traditional substitute care placement.

(c) The commission shall report the commission's findings to the standing committees of the senate and house of representatives having jurisdiction over the Department of Family and Protective Services. (Gov. Code, Sec. 533.00521.)

Source Law

Sec. 533.00521. STAR HEALTH PROGRAM: HEALTH CARE FOR FOSTER CHILDREN. (a) The commission shall annually evaluate the use of benefits under the Medicaid program in the STAR Health program offered to children in foster care and provide recommendations to the Department of Family and Protective Services and each single source continuum contractor in this state to better coordinate the provision of health care and use of those benefits for children in foster care.

(b) In conducting the evaluation required under Subsection (a), the commission shall:

(1) collaborate with residential child-care providers regarding any unmet needs of children in foster care and the development of capacity for providing quality medical, behavioral health, and other services for children in foster care; and

(2) identify options to obtain federal matching funds under the Medical Assistance Program to pay for a safe home-like or community-based residential setting for a child in the conservatorship of the Department of Family and Protective Services:

(A) who is identified or diagnosed as having a serious behavioral or mental health condition that requires intensive treatment;

(B) who is identified as a victim of serious abuse or serious neglect;

(C) for whom a traditional substitute care placement contracted for or purchased by the department is not available or would further denigrate the child's behavioral or mental health condition; or

(D) for whom the department determines a safe home-like or community-based residential placement could stabilize the child's behavioral or mental health condition in order to return the child to a traditional substitute care placement.

(c) The commission shall report its findings to the standing committees of the senate and house of representatives having jurisdiction over the Department of Family and Protective Services.

Revisor's Note

Section 533.00521(b)(2), Government Code, refers to "the Medical Assistance Program," which is another term for Medicaid. The revised law substitutes "Medicaid" for the quoted language for consistency of terminology throughout this chapter.

Revised Law

Sec. 540.0805. PLACEMENT CHANGE NOTICE AND CARE COORDINATION. A STAR Health program managed care contract between a Medicaid managed care organization and the commission must require the organization to ensure continuity of care for a child whose placement has changed by:

(1) notifying each specialist treating the child of the placement change; and

(2) coordinating the transition of care from the child's previous treating primary care physician and specialists to the child's new treating primary care physician and specialists, if any. (Gov. Code, Sec. 533.0056.)

Source Law

> Sec. 533.0056. STAR HEALTH PROGRAM: NOTIFICATION OF PLACEMENT CHANGE. A contract between a managed care organization and the commission for the organization to provide health care services to recipients under the STAR Health program must require the organization to ensure continuity of care for a child whose placement has changed by:
>
> (1) notifying each specialist treating the child of the placement change; and
>
> (2) coordinating the transition of care from the child's previous treating primary care physician and treating specialists to the child's new treating primary care physician and treating specialists, if any.

Revised Law

Sec. 540.0806. MEDICAID BENEFITS FOR CERTAIN CHILDREN FORMERLY IN FOSTER CARE. (a) This section applies only with respect to a child who:

(1) resides in this state; and

(2) is eligible for assistance or services under:

(A) Subchapter D, Chapter 162, Family Code; or

(B) Subchapter K, Chapter 264, Family Code.

(b) Except as provided by Subsection (c), the commission shall ensure that each child to whom this section applies remains or is enrolled in the STAR Health program until the child is enrolled in another Medicaid managed care program.

(c) A child to whom this section applies who received

Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) or was receiving Supplemental Security Income before becoming eligible for assistance or services under Subchapter D, Chapter 162, Family Code, or Subchapter K, Chapter 264, Family Code, may receive Medicaid benefits in accordance with the program established under this subsection. To the extent allowed by federal law, the commission, in consultation with the Department of Family and Protective Services, shall develop and implement a program that allows the adoptive parent or permanent managing conservator of a child described by this subsection to elect on behalf of the child to receive or continue receiving Medicaid benefits under the:

(1) STAR Health program; or

(2) STAR Kids managed care program.

(d) The commission shall protect the continuity of care for each child to whom this section applies and ensure coordination between the STAR Health program and any other Medicaid managed care program for each child who is transitioning between Medicaid managed care programs.

(e) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 533.00531.)

Source Law

Sec. 533.00531. MEDICAID BENEFITS FOR CERTAIN CHILDREN FORMERLY IN FOSTER CARE. (a) This section applies only with respect to a child who:

(1) resides in this state; and

(2) is eligible for assistance or services under:

(A) Subchapter D, Chapter 162, Family Code; or

(B) Subchapter K, Chapter 264, Family Code.

(b) Except as provided by Subsection (c), the commission shall ensure that each child described by Subsection (a) remains or is enrolled in the STAR Health program unless or until the child is enrolled in another Medicaid managed care program.

(c) If a child described by Subsection (a) received Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) or was receiving Supplemental Security Income before becoming eligible for assistance or services under Subchapter D, Chapter 162, Family Code, or Subchapter K, Chapter 264, Family Code, as applicable, the child may receive Medicaid benefits in accordance with the program established under this subsection. To the extent permitted by federal law, the commission, in consultation with the

Department of Family and Protective Services, shall develop and implement a program that allows the adoptive parent or permanent managing conservator of a child described by this subsection to elect on behalf of the child to receive or, if applicable, continue receiving Medicaid benefits under the:

(1) STAR Health program; or

(2) STAR Kids managed care program.

(d) The commission shall protect the continuity of care for each child described under this section and, if applicable, ensure coordination between the STAR Health program and any other Medicaid managed care program for each child who is transitioning between Medicaid managed care programs.

(e) The executive commissioner shall adopt rules necessary to implement this section.

SUBCHAPTER R. DELIVERY OF SERVICES: STAR KIDS MANAGED CARE PROGRAM

Revised Law

Sec. 540.0851. STAR KIDS MANAGED CARE PROGRAM. (a) In this section, "health home" means a primary care provider practice or specialty care provider practice that incorporates several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under Medicaid.

(b) Subject to Sections 540.0701 and 540.0753, the commission shall establish a mandatory STAR Kids capitated managed care program tailored to provide Medicaid benefits to children with disabilities. The program must:

(1) provide Medicaid benefits customized to meet the health care needs of program recipients through a defined system of care;

(2) better coordinate recipient care under the program;

(3) improve recipient:

(A) access to health care services; and

(B) health outcomes;

(4) achieve cost containment and cost efficiency;

(5) reduce:

(A) the administrative complexity of delivering Medicaid benefits; and

(B) the incidence of unnecessary

institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;

(6) require a health home; and

(7) for recipients who receive long-term services and supports outside of the Medicaid managed care organization, coordinate and collaborate with long-term care service providers and long-term care management providers. (Gov. Code, Secs. 533.00253(a)(2), (b).)

Source Law

Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM. (a) In this section:

(2) "Health home" means a primary care provider practice, or, if appropriate, a specialty care provider practice, incorporating several features, including comprehensive care coordination, family-centered care, and data management, that are focused on improving outcome-based quality of care and increasing patient and provider satisfaction under Medicaid.

(b) Subject to Section 533.0025, the commission shall, in consultation with the Children's Policy Council established under Section 22.035, Human Resources Code, establish a mandatory STAR Kids capitated managed care program tailored to provide Medicaid benefits to children with disabilities. The managed care program developed under this section must:

(1) provide Medicaid benefits that are customized to meet the health care needs of recipients under the program through a defined system of care;

(2) better coordinate care of recipients under the program;

(3) improve the health outcomes of recipients;

(4) improve recipients' access to health care services;

(5) achieve cost containment and cost efficiency;

(6) reduce the administrative complexity of delivering Medicaid benefits;

(7) reduce the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;

(8) require a health home; and

(9) coordinate and collaborate with long-term care service providers and long-term care management providers, if recipients are receiving long-term services and supports outside of the managed care organization.

Revisor's Note

(1) Section 533.00253(b), Government Code,

requires the Health and Human Services Commission to establish a mandatory STAR Kids capitated managed care program, "[s]ubject to Section 533.0025," Government Code. The relevant provisions of Section 533.0025 requiring delivering Medicaid services through the most cost-effective model of Medicaid capitated managed care are revised in this chapter as Sections 540.0701 and 540.0753. The revised law is drafted accordingly.

(2) Section 533.00253(b), Government Code, refers to the Children's Policy Council established under former Section 22.035, Human Resources Code. Former Section 22.035(n), Human Resources Code, abolished the Children's Policy Council on September 1, 2017. Therefore, the revised law omits the reference to the Children's Policy Council.

Revised Law

Sec. 540.0852. CARE MANAGEMENT AND CARE NEEDS ASSESSMENT. (a) The commission may require that care management services made available as provided by Section 540.0851(b)(5)(B):

(1) incorporate best practices as the commission determines;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification methodology that identifies recipients who have the greatest need for services;

(4) include a care needs assessment for a recipient;

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transitioning care;

(7) include monitoring and reporting outcomes that, at

a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics the commission determines appropriate; and

(8) use innovations in providing services.

(b) To improve the care needs assessment tool used for a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, the commission shall consider changes that will:

(1) reduce the amount of time needed to complete the initial care needs assessment and a reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c) To the extent feasible and allowed by federal law, the commission shall streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity. (Gov. Code, Secs. 533.00253(c), (c-1), (c-2).)

Source Law

(c) The commission may require that care management services made available as provided by Subsection (b)(7):

(1) incorporate best practices, as determined by the commission;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification methodology that identifies recipients who have the greatest need for services;

(4) provide a care needs assessment for a recipient;

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transition of care;

(7) include monitoring and reporting outcomes that, at a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics determined appropriate by the commission; and

(8) use innovations in the provision of services.

(c-1) To improve the care needs assessment tool used for purposes of a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, the commission in consultation and collaboration with the advisory committee shall consider changes that will:

(1) reduce the amount of time needed to complete the care needs assessment initially and at reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c-2) To the extent feasible and allowed by federal law, the commission shall streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity.

Revisor's Note

Section 533.00253(c-1), Government Code, requires the Health and Human Services Commission to consult and collaborate with the "advisory committee." Section 533.00253(a)(1), Government Code, defines "advisory committee" for purposes of Section 533.00253 to mean the STAR Kids Managed Care Advisory Committee. The revised law omits the reference to the advisory committee for the reason stated in Revisor's Note (1) to Section 540.0552 of this chapter.

Revised Law

Sec. 540.0853. BENEFITS FOR CHILDREN IN MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM. The commission shall:

(1) provide Medicaid benefits through the STAR Kids managed care program to children receiving benefits under the medically dependent children (MDCP) waiver program; and

(2) ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this section. (Gov. Code, Sec. 533.00253(d).)

Source Law

(d) The commission shall provide Medicaid benefits through the STAR Kids managed care program established under this section to children who are receiving benefits under the medically dependent children (MDCP) waiver program. The commission shall ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this subsection.

Revised Law

Sec. 540.0854. BENEFITS TRANSITION FROM STAR KIDS TO STAR+PLUS MEDICAID MANAGED CARE PROGRAM. The commission shall ensure that there is a plan for transitioning the provision of Medicaid benefits to recipients 21 years of age or older from the STAR Kids managed care program to the STAR+PLUS Medicaid managed care program in a manner that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age. (Gov. Code, Sec. 533.00253(e).)

Source Law

(e) The commission shall ensure that there is a plan for transitioning the provision of Medicaid benefits to recipients 21 years of age or older from under the STAR Kids program to under the STAR + PLUS Medicaid managed care program that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age.

Revisor's Note

Section 533.00253(e), Government Code, refers to the "STAR Kids program." The revised law substitutes "STAR Kids managed care program" for consistency in the terminology used throughout the chapter and because the terms are synonymous and "STAR Kids managed care program" is more commonly used.

Revised Law

Sec. 540.0855. UTILIZATION REVIEW OF PRIOR AUTHORIZATIONS. At least once every two years, the commission shall conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program to ensure that all imposed clinical prior authorizations are based on publicly available clinical

criteria and are not being used to negatively impact a recipient's access to care. (Gov. Code, Sec. 533.00253(n).)

Source Law

(n) The commission, at least once every two years, shall conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care.

Revisor's Note
(End of Subchapter)

Section 533.00253(a)(1), Government Code, defines "advisory committee" to mean the STAR Kids Managed Care Advisory Committee described by Section 533.00254, Government Code. The revised law omits the provision for the reason stated in Revisor's Note (1) to Section 540.0552 of this chapter. The omitted law reads:

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee described by Section 533.00254.

Revisor's Note
(End of Chapter)

Section 533.083, Government Code, requires the Health and Human Services Commission, based on the results of a pilot program implemented under former Section 533.082, Government Code, which expired September 1, 2018, to identify appropriate incentive-based provider payment goals and outcome measures and require Medicaid managed care organizations to implement the payment goals and outcome measures not later than September 1, 2018. The revised law omits that section as executed. The omitted law reads:

Sec. 533.083. ASSESSMENT AND IMPLEMENTATION OF PILOT PROGRAM FINDINGS. Not later than September 1, 2018, and notwithstanding any other law, the commission shall:

(1) based on the results of the pilot program, identify which types of

incentive-based provider payment goals and outcome measures are most appropriate for statewide implementation and the services that can be provided using those goals and outcome measures; and

(2) require that a managed care organization that has contracted with the commission to provide health care services to recipients implement the payment goals and outcome measures identified under Subdivision (1).