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.

(2) "Commissioner" means the commissioner of health and human services.

(3) "Health and human services agencies" has the meaning assigned by Section 531.001.

(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 medical assistance under Chapter 32, Human Resources Code.

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

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.002. PURPOSE. The commission shall implement the Medicaid managed care program as part of the health care delivery system developed under Chapter 532 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.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

For expiration of Subsections (f) and (g), see Subsection (g).

Sec. 533.0025. DELIVERY OF SERVICES. (a) In this section and Sections 533.00251, 533.002515, 533.00252, 533.00253, and 533.00254, "medical assistance" has the meaning assigned by Section 32.003, Human Resources Code.

(b) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide medical assistance for 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 acute care medical assistance 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 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 medical assistance for acute care in a certain area or to certain medical assistance recipients as prescribed by this section, the commission shall provide medical assistance for 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 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.

(f) The commission shall:
(1) conduct a study to evaluate the feasibility of automatically enrolling applicants determined eligible for benefits under the medical assistance program in a Medicaid managed care plan chosen by the applicant; and
(2) report the results of the study to the legislature not later than December 1, 2014.

(g) Subsection (f) and this subsection expire September 1, 2015.

(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 medical assistance 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 under the medical assistance program.

(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.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.29, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 728 (H.B. 2018), Sec. 11.119, eff. September 1, 2005.

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(a), eff. September 28, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.01, eff. September 1, 2013.

For expiration of Subsections (c), (d), (e), (f), and (g), see Subsection (g).

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:

(1) "Advisory committee" means the STAR + PLUS Nursing Facility Advisory Committee established under Section 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 Medicaid recipients.

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

(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 the medical assistance program.

(c) Subject to Section 533.0025 and notwithstanding any other law, the commission, in consultation with the advisory committee, shall provide benefits under the medical assistance program 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 the commission is responsible for setting the minimum reimbursement rate paid to a nursing facility under the managed care program, including the staff rate enhancement paid to a nursing facility that qualifies for the enhancement;

(2) that a nursing facility is paid not later than the 10th day after the date the facility submits a clean claim;

(3) the appropriate utilization of services consistent with criteria adopted by the commission;

(4) a reduction in the incidence of potentially preventable events and unnecessary institutionalizations;

(5) 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;

(6) 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;

(7) 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;

(8) that rules and procedures relating to the certification and decertification of nursing facility beds under the medical assistance program are not affected; and

(9) 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.

(d) Subject to Subsection (e), the commission shall ensure that a nursing facility provider authorized to provide services under the medical assistance program on September 1, 2013, is allowed to participate in the STAR + PLUS Medicaid managed care program through August 31, 2017.

(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.

(g) Subsections (c), (d), (e), and (f) and this subsection expire September 1, 2019.
Sec. 533.002515. PLANNED PREPARATION FOR DELIVERY OF NURSING FACILITY BENEFITS THROUGH STAR + PLUS MEDICAID MANAGED CARE PROGRAM. (a) The commission shall develop a plan in preparation for implementing the requirement under Section 533.00251(c) that the commission provide benefits under the medical assistance program to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. The plan required by this section must be completed in two phases as follows:

(1) phase one: contract planning phase; and
(2) phase two: initial testing phase.

(b) In phase one, the commission shall develop a contract template to be used by the commission when the commission contracts with a managed care organization to provide nursing facility services under the STAR + PLUS Medicaid managed care program. In addition to the requirements of Section 533.005 and any other applicable law, the template must include:

(1) nursing home credentialing requirements;
(2) appeals processes;
(3) termination provisions;
(4) prompt payment requirements and a liquidated damages provision that contains financial penalties for failure to meet prompt payment requirements;
(5) a description of medical necessity criteria;
(6) a requirement that the managed care organization provide recipients and recipients' families freedom of choice in selecting a nursing facility; and

(7) a description of the managed care organization's role in discharge planning and imposing prior authorization requirements.

(c) In phase two, the commission shall:

(1) design and test the portal required under Section 533.00251(c)(7);
(2) establish and inform managed care organizations of
the minimum technological or system requirements needed to use the portal required under Section 533.00251(c)(7);

(3) establish operating policies that require that managed care organizations maintain a portal through which providers may confirm recipient eligibility on a monthly basis; and

(4) establish the manner in which managed care organizations are to assist the commission in collecting from recipients applied income or cost-sharing payments, including copayments, as applicable.

(d) This section expires September 1, 2015.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.02, eff. September 1, 2013.

For expiration of this section, see Subsection (f).

Sec. 533.00252. STAR + PLUS NURSING FACILITY ADVISORY COMMITTEE. (a) The STAR + PLUS Nursing Facility Advisory Committee is established to advise the commission on the implementation of and other activities related to the provision of medical assistance benefits to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program under Section 533.00251, including advising the commission regarding its duties with respect to:

(1) developing quality-based outcomes and process measures for long-term services and supports provided in nursing facilities;

(2) developing quality-based long-term care payment systems and quality initiatives for nursing facilities;

(3) transparency of information received from managed care organizations;

(4) the reporting of outcome and process measures;

(5) the sharing of data among health and human services agencies; and

(6) patient care coordination, quality of care improvement, and cost savings.

(b) The governor, lieutenant governor, and speaker of the house of representatives shall each appoint five members of the advisory committee as follows:
one member who is a physician and medical director of a nursing facility provider with experience providing the long-term continuum of care, including home care and hospice;

(2) one member who is a nonprofit nursing facility provider;

(3) one member who is a for-profit nursing facility provider;

(4) one member who is a consumer representative; and

(5) one member who is from a managed care organization providing services as provided by Section 533.00251.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) A member of the advisory committee serves without compensation.

(e) The advisory committee is subject to the requirements of Chapter 551.

(f) On September 1, 2016:

(1) the advisory committee is abolished; and

(2) this section expires.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.02, eff. September 1, 2013.

Sec. 533.00253. STAR KIDS MEDICAID MANAGED CARE PROGRAM.

(a) In this section:

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee established under Section 533.00254.

(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 the medical assistance program.

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

(b) Subject to Section 533.0025, the commission shall, in consultation with the advisory committee and 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 medical assistance benefits to children with disabilities. The managed care program developed under this section must:

(1) provide medical assistance 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 medical assistance 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.

(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 that is comprehensive, holistic, consumer-directed, evidence-based, and takes into consideration social and medical
issues, for purposes of prioritizing the recipient's needs that threaten independent living;

(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.

(d) The commission shall provide medical assistance 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.

(e) The commission shall ensure that there is a plan for transitioning the provision of Medicaid program 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.

(f) The commission shall seek ongoing input from the Children's Policy Council regarding the establishment and implementation of the STAR Kids managed care program.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.02, eff. September 1, 2013.

For expiration of this section, see Subsection (f).

Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE.

(a) The STAR Kids Managed Care Advisory Committee is established
to advise the commission on the establishment and implementation of the STAR Kids managed care program under Section 533.00253.

(b) The executive commissioner shall appoint the members of the advisory committee. The committee must consist of:

(1) families whose children will receive private duty nursing under the program;
(2) health care providers;
(3) providers of home and community-based services, including at least one private duty nursing provider and one pediatric therapy provider; and
(4) other stakeholders as the executive commissioner determines appropriate.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) A member of the advisory committee serves without compensation.

(e) The advisory committee is subject to the requirements of Chapter 551.

(f) On September 1, 2016:

(1) the advisory committee is abolished; and
(2) this section expires.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.02, eff. September 1, 2013.

For expiration of Subsections (e) and (f), see Subsection (f).

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, other than those provided through the NorthSTAR demonstration project.

(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.

(e) The commission and the Department of State Health Services shall establish a Behavioral Health Integration Advisory Committee:

(1) whose membership must include:

(A) individuals with behavioral health conditions who are current or former recipients of publicly funded behavioral health services;

(B) representatives of managed care organizations that have expertise in offering behavioral health services;

(C) public and private providers of behavioral health services; and

(D) providers of behavioral health services who are both Medicaid primary care providers and providers for
individuals that are dually eligible for Medicaid and Medicare; and

(2) that shall:

(A) meet at least quarterly to address the planning and development needs of the behavioral health services network established under this section;

(B) seek input from the behavioral health community on the implementation of this section; and

(C) issue formal recommendations to the commission regarding the implementation of this section.

(f) The commission shall provide administrative support to facilitate the duties of the advisory committee established under Subsection (e). This subsection and Subsection (e) expire September 1, 2017.

(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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1143 (S.B. 58), Sec. 1, eff. September 1, 2013.

Sec. 533.00256. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM.

(a) In consultation with the Medicaid and CHIP Quality-Based Payment Advisory Committee established under Section 536.002 and other 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, as defined by Section 536.001; 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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.01, eff. September 1, 2013.

For expiration of Subsections (h) and (k), see Subsection (k).

Sec. 533.00257. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES. (a) In this section:

(1) "Managed transportation organization" means:

(A) a rural or urban transit district created under Chapter 458, Transportation Code;

(B) a public transportation provider defined by Section 461.002, Transportation Code;

(C) a regional contracted broker defined by Section 531.02414;

(D) a local private transportation provider approved by the commission to provide Medicaid nonemergency medical transportation services; or

(E) any other entity the commission determines meets the requirements of this section.

(2) "Medical transportation program" has the meaning assigned by Section 531.02414.

(3) "Transportation service area provider" means a for-profit or nonprofit entity or political subdivision of this state that provides demand response, curb-to-curb, nonemergency transportation under the medical transportation program.

(b) Subject to Subsection (i), the commission shall provide medical transportation program services on a regional basis through a managed transportation delivery model using managed transportation organizations and providers, as appropriate, that:

(1) operate under a capitated rate system;

(2) assume financial responsibility under a full-risk model;

(3) operate a call center;

(4) use fixed routes when available and appropriate; and

(5) agree to provide data to the commission if the
(c) The commission shall procure managed transportation organizations under the medical transportation program through a competitive bidding process for each managed transportation region as determined by the commission.

(d) A managed transportation organization that participates in the medical transportation program must attempt to contract with medical transportation providers that:

1. are considered significant traditional providers, as defined by rule by the executive commissioner;

2. meet the minimum quality and efficiency measures required under Subsection (g) and other requirements that may be imposed by the managed transportation organization; and

3. agree to accept the prevailing contract rate of the managed transportation organization.

(e) To the extent allowed under federal law, a managed transportation organization may own, operate, and maintain a fleet of vehicles or contract with an entity that owns, operates, and maintains a fleet of vehicles. The commission shall seek appropriate federal waivers or other authorizations to implement this subsection as necessary.

(f) The commission shall consider the ownership, operation, and maintenance of a fleet of vehicles by a managed transportation organization to be a related-party transaction for purposes of applying experience rebates, administrative costs, and other administrative controls determined by the commission.

(g) The commission shall require that managed transportation organizations and providers participating in the medical transportation program meet minimum quality and efficiency measures as determined by the commission.

(h) The commission may contract with transportation service area providers providing services under the medical transportation program on September 1, 2013, in not more than three contiguous rural or small urban transit districts located within a managed transportation region to execute appropriate interlocal agreements to consolidate and coordinate medical transportation program
service delivery activities within the area served by the providers for the evaluation of:

(1) cost-savings measures;
(2) efficiencies;
(3) best practices; and
(4) available matching funds.

(i) The commission may delay providing medical transportation program services through a managed transportation delivery model in areas of this state in which the commission on September 1, 2013, is operating a full-risk transportation broker model.

(j) Notwithstanding Subsection (i), the commission may not delay providing medical transportation program services through a managed transportation delivery model in:

(1) a county with a population of 750,000 or more:
   (A) in which all or part of a municipality with a population of one million or more is located; and
   (B) that is located adjacent to a county with a population of two million or more; or
(2) a county with a population of at least 55,000 but not more than 65,000 that is located adjacent to a county with a population of at least 500,000 but not more than 1.5 million.

(k) Subsection (h) and this subsection expire August 31, 2015.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 7(a), eff. September 1, 2013.
A 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.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 21(b), eff. September 1, 2007.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(b), eff. September 28, 2011.

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 the Medicaid and Medicare programs.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(b), eff. September 28, 2011.

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

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

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

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

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

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

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

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

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

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 76 (S.B. 348), Sec. 1, eff. May 18, 2013.
Sec. 533.00285. STAR + PLUS QUALITY COUNCIL. (a) The STAR + PLUS Quality Council is established to advise the commission on the development of policy recommendations that will ensure eligible recipients receive quality, person-centered, consumer-directed acute care services and long-term services and supports in an integrated setting under the STAR + PLUS Medicaid managed care program.

(b) The executive commissioner shall appoint the members of the council, who must be stakeholders from the acute care services and long-term services and supports community, including:

1. representatives of health and human services agencies;
2. recipients under the STAR + PLUS Medicaid managed care program;
3. representatives of advocacy groups representing individuals with disabilities and seniors who are recipients under the STAR + PLUS Medicaid managed care program;
4. representatives of service providers for individuals with disabilities; and
5. representatives of health maintenance organizations.

(c) The executive commissioner shall appoint the presiding officer of the council.

(d) The council shall meet at least quarterly or more frequently if the presiding officer determines that it is necessary to carry out the responsibilities of the council.

(e) Not later than November 1 of each year, the council in coordination with the commission shall submit a report to the executive commissioner that includes:

1. an analysis and assessment of the quality of acute care services and long-term services and supports provided under the STAR + PLUS Medicaid managed care program;
2. recommendations regarding how to improve the quality of acute care services and long-term services and supports provided under the program; and
recommendations regarding how to ensure that recipients eligible to receive services and supports under the program receive person-centered, consumer-directed care in the most integrated setting achievable.

(f) Not later than December 1 of each even-numbered year, the commission, in consultation with the council, shall submit a report to the legislature regarding the assessments and recommendations contained in any report submitted by the council under Subsection (e) during the most recent state fiscal biennium.

(g) The council is subject to the requirements of Chapter 551.

(h) A member of the council serves without compensation.

(i) On January 1, 2017:

(1) the council is abolished; and

(2) this section expires.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.03, eff. September 1, 2013.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(b), eff. September 28, 2011.

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

(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.

(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 the Medicaid program, 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.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(c), eff. September 28, 2011.

Sec. 533.004. MANDATORY CONTRACTS. (a) 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.

(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.

(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.


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;

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

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

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

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

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan 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;

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

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

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

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

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

(13) a requirement that, 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;

(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;

(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;

(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;

(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;

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

(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;

(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 will provide recipients sufficient access to:

(i) preventive care;
(ii) primary care;
(iii) specialty care;
(iv) after-hours urgent care;
(v) chronic care;
(vi) long-term services and supports;
(vii) nursing services; and
(viii) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(B) 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 Paragraph (A) and specific data with respect to Paragraphs (A)(iii), (vi), (vii), and (viii) on the average length of time between:

(i) the date a provider makes a referral for the care or service and the date the organization approves or denies the referral; and

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

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

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

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider
(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;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

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

(B) focuses on measuring outcomes; and

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

(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 exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under the Medicaid program;

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

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

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

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

(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;

(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;

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

(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;

(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; and

(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 reduction; or
the Medicaid fee schedule or cost containment initiatives implemented by the commission.

(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, 2018.

(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.

(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.

(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.

(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).


Amended by:
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 Medicaid 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 Medicaid 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.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 10, eff. September 1, 2007.
Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.02, eff. September 1, 2013.

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.

(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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.03, eff. September 1, 2013.

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.

Added by Acts 2011, 82nd Leg., R.S., Ch. 371 (S.B. 219), Sec. 3, eff. September 1, 2011.

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.
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 the Medicaid...
program;

(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.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1192 (S.B. 1150), Sec. 1, eff. September 1, 2013.

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 Medicaid recipients;

(B) each hospital in the region that has been designated as a disproportionate share hospital under the state Medicaid program; 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 on Accreditation of Healthcare Organizations 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 on Accreditation of Healthcare Organizations may not be the sole ground for exclusion from the provider network.


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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(e), eff. September 28, 2011.

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.

(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 commission 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 commission 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 commission 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.

(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 commission plans to begin the enrollment process in a region and again not later than the 15th day before the date on which the commission 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.

(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. 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.

(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.

(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.

(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).

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.
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.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 6(b), eff. September 1, 2005.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(f), eff. September 28, 2011.

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.04, eff. September 1, 2013.

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.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 6(b), eff. September 1, 2005.

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.

Added by Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(g), eff. September 28, 2011.

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 the commission 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.

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).

Added by Acts 2001, 77th Leg., ch. 584, Sec. 6.
Amended by:
Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(h), eff. September 28, 2011.

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.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

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 32.059, Human Resources Code, as added by Chapter 208, Acts of the 78th Legislature, Regular Session, 2003; and

(2) show evidence of ability to manage complex diseases in the Medicaid population.

(d) Expired.

(e) Expired.

(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.


Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 19(a), eff. September 1, 2005.

Acts 2005, 79th Leg., Ch. 1047 (H.B. 1252), Sec. 1, eff. September 1, 2005.

Acts 2007, 80th Leg., R.S., Ch. 921 (H.B. 3167), Sec. 17.001(38), eff. September 1, 2007.

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.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

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.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

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 investigations and enforcement 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.

(d) Repealed by Acts 2011, 82nd Leg., 1st C.S., Ch. 7, Sec. 1.02(1), eff. September 28, 2011.

(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.


Amended by:
  Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 11(a), eff. September 1, 2007.
  Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(i), eff. September 28, 2011.
  Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 1.02(l), eff. September 28, 2011.

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 the state Medicaid program;

(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.

(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 the state Medicaid program, 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.

(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).

(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.

(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.

Added by Acts 1999, 76th Leg., ch. 1447, Sec. 8, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.08, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 1276, Sec. 10A.516, eff. Sept. 1, 2003. Amended by: Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 5.01, eff. September 1, 2013.

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.


Sec. 533.01315. REIMBURSEMENT FOR SERVICES PROVIDED OUTSIDE OF REGULAR BUSINESS HOURS. (a) This section applies only to a recipient receiving medical assistance 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).

Added by Acts 2007, 80th Leg., R.S., Ch. 298 (H.B. 1579), Sec. 1,
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.
Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.30, eff. Sept. 1, 2003.

Sec. 533.014. PROFIT SHARING. (a) The commission 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 for the purpose of funding the state Medicaid program.
(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.
Added by Acts 1999, 76th Leg., ch. 1447, Sec. 8, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.08, eff. Sept. 1, 1999.
Amended by:
Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 4.05, eff. September 1, 2013.

Sec. 533.015. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. To the extent possible, the commission shall coordinate all external oversight activities to minimize duplication of oversight of managed care plans under the state Medicaid program and disruption of operations under those plans.
Added by Acts 1999, 76th Leg., ch. 1447, Sec. 8, eff. June 19, 1999;
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.


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.

Added by Acts 2011, 82nd Leg., R.S., Ch. 843 (H.B. 3531), Sec. 1, eff. September 1, 2011.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 204 (H.B. 915), Sec. 14, eff. September 1, 2013.

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.


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.


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.

Added by Acts 2007, 80th Leg., R.S., Ch. 268 (S.B. 10), Sec. 12(a), eff. September 1, 2007.
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 complaint system guidelines for managed care organizations that serve Medicaid 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.

Added by Acts 2007, 80th Leg., R.S., Ch. 730 (H.B. 2636), Sec. 1K.001, eff. April 1, 2009.
Renumbered from Government Code, Section 533.019 by Acts 2009, 81st Leg., R.S., Ch. 87 (S.B. 1969), Sec. 27.001(38), eff. September 1, 2009.

SUBCHAPTER B. REGIONAL ADVISORY COMMITTEES

Sec. 533.021. APPOINTMENT. Not later than the 180th day before the date the commission plans to begin to provide health care services to recipients in a health care service region through managed care, the commission, in consultation with health and human services agencies, shall appoint a Medicaid managed care advisory committee for that region.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.022. COMPOSITION. A committee consists of representatives from entities and communities in the region as considered necessary by the commission to ensure representation of interested persons, including representatives of:

(1) hospitals;
(2) managed care organizations;
(3) primary care providers;
(4) state agencies;
(5) consumer advocates;
(6) recipients;
(7) rural providers;
(8) long-term care providers;
(9) specialty care providers, including pediatric providers; and
(10) political subdivisions with a constitutional or statutory obligation to provide health care to indigent patients.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.023. PRESIDING OFFICER; SUBCOMMITTEES. The commissioner or the commissioner's designated representative serves as the presiding officer of a committee. The presiding officer may appoint subcommittees as necessary.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.024. MEETINGS. (a) A committee shall meet at least quarterly for the first year after appointment of the committee and at least annually after that time.

(b) A committee is subject to Chapter 551, Government Code.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.025. POWERS AND DUTIES. A committee shall:

(1) comment on the implementation of Medicaid managed care in the region;

(2) provide recommendations to the commission on the improvement of Medicaid managed care in the region not later than the 30th day after the date of each committee meeting; and

(3) seek input from the public, including public comment at each committee meeting.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.026. INFORMATION FROM COMMISSION. On request, the commission shall provide to a committee information relating to recipient enrollment and disenrollment, recipient and provider complaints, administrative procedures, program expenditures, and education and training procedures.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.027. COMPENSATION; REIMBURSEMENT. (a) A member
of a committee other than a representative of a health and human services agency is not entitled to receive compensation or reimbursement for travel expenses.

(b) A member of a committee who is an agency representative is entitled to reimbursement for expenses incurred in the performance of committee duties by the appointing agency in accordance with the travel provisions for state employees in the General Appropriations Act.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.028. OTHER LAW. Except as provided by this chapter, a committee is subject to Article 6252-33, Revised Statutes.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

Sec. 533.029. FUNDING. The commission shall fund activities under this section with money otherwise appropriated for that purpose.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997.

SUBCHAPTER C. STATEWIDE ADVISORY COMMITTEE

Sec. 533.041. APPOINTMENT AND COMPOSITION. (a) The executive commissioner shall appoint a state Medicaid managed care advisory committee. The advisory committee consists of representatives of:

(1) hospitals;
(2) managed care organizations and participating health care providers;
(3) primary care providers and specialty care providers;
(4) state agencies;
(5) low-income recipients or consumer advocates representing low-income recipients;
(6) recipients with disabilities, including recipients with intellectual and developmental disabilities or physical disabilities, or consumer advocates representing those
recipients;
(7) parents of children who are recipients;
(8) rural providers;
(9) advocates for children with special health care needs;
(10) pediatric health care providers, including specialty providers;
(11) long-term services and supports providers, including nursing facility providers and direct service workers;
(12) obstetrical care providers;
(13) community-based organizations serving low-income children and their families;
(14) community-based organizations engaged in perinatal services and outreach;
(15) recipients who are 65 years of age or older;
(16) recipients with mental illness;
(17) nonphysician mental health providers participating in the Medicaid managed care program; and
(18) entities with responsibilities for the delivery of long-term services and supports or other Medicaid program service delivery, including:
(A) independent living centers;
(B) area agencies on aging;
(C) aging and disability resource centers established under the Aging and Disability Resource Center initiative funded in part by the federal Administration on Aging and the Centers for Medicare and Medicaid Services;
(D) community mental health and intellectual disability centers; and
(E) the NorthSTAR Behavioral Health Program provided under Chapter 534, Health and Safety Code.

(b) The advisory committee must include a member of each regional Medicaid managed care advisory committee appointed by the commission under Subchapter B.

(c) The executive commissioner shall appoint the presiding officer of the advisory committee.

(d) To the greatest extent possible, the executive
commissioner shall appoint members of the advisory committee who reflect the geographic diversity of the state and include members who represent rural Medicaid program recipients.

Added by Acts 1999, 76th Leg., ch. 1447, Sec. 9, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.09, eff. Sept. 1, 1999.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.05, eff. September 1, 2013.

Sec. 533.042. MEETINGS. (a) The advisory committee shall meet at the call of the presiding officer at least semiannually, but no more frequently than quarterly.

(b) The advisory committee:

(1) shall develop procedures that provide the public with reasonable opportunity to appear before the committee and speak on any issue under the jurisdiction of the committee; and

(2) is subject to Chapter 551.

Added by Acts 1999, 76th Leg., ch. 1447, Sec. 9, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.09, eff. Sept. 1, 1999.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.06, eff. September 1, 2013.

Sec. 533.043. POWERS AND DUTIES. (a) The advisory committee shall:

(1) provide recommendations and ongoing advisory input to the commission on the statewide implementation and operation of Medicaid managed care, including:

(A) program design and benefits;

(B) systemic concerns from consumers and providers;

(C) the efficiency and quality of services delivered by Medicaid managed care organizations;

(D) contract requirements for Medicaid managed care organizations;

(E) Medicaid managed care provider network adequacy;
(F) trends in claims processing; and

(G) other issues as requested by the executive commissioner;

(2) assist the commission with issues relevant to Medicaid managed care to improve the policies established for and programs operating under Medicaid managed care, including the early and periodic screening, diagnosis, and treatment program, provider and patient education issues, and patient eligibility issues; and

(3) disseminate or make available to each regional advisory committee appointed under Subchapter B information on best practices with respect to Medicaid managed care that is obtained from a regional advisory committee.

(b) The commission and the Department of Aging and Disability Services shall ensure coordination and communication between the advisory committee, regional Medicaid managed care advisory committees appointed by the commission under Subchapter B, and other advisory committees or groups that perform functions related to Medicaid managed care, including the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, in a manner that enables the state Medicaid managed care advisory committee to act as a central source of agency information and stakeholder input relevant to the implementation and operation of Medicaid managed care.

(c) The advisory committee may establish work groups that meet at other times for purposes of studying and making recommendations on issues the committee determines appropriate.

Added by Acts 1999, 76th Leg., ch. 1447, Sec. 9, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.09, eff. Sept. 1, 1999.

Amended by:

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.07, eff. September 1, 2013.

Sec. 533.044. OTHER LAW. (a) Except as provided by Subsection (b) and other provisions of this subchapter, the advisory committee is subject to Chapter 2110.

(b) Section 2110.008 does not apply to the advisory committee.
Sec. 533.045. COMPENSATION; REIMBURSEMENT. (a) Except as provided by Subsection (b), a member of the advisory committee is not entitled to receive compensation or reimbursement for travel expenses.

(b) A member of the advisory committee who is a Medicaid program recipient or the relative of a Medicaid program recipient is entitled to a per diem allowance and reimbursement at rates established in the General Appropriations Act.

Added by Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.08, eff. September 1, 2013.

SUBCHAPTER D. INTEGRATED CARE MANAGEMENT MODEL

Sec. 533.061. INTEGRATED CARE MANAGEMENT MODEL. (a) The executive commissioner, by rule, shall develop an integrated care management model of Medicaid managed care. The "integrated care management model" is a noncapitated primary care case management model of Medicaid managed care with enhanced components to:

(1) improve patient health and social outcomes;
(2) improve access to care;
(3) constrain health care costs; and
(4) integrate the spectrum of acute care and long-term care services and supports.

(b) In developing the integrated care management model, the executive commissioner shall ensure that the integrated care management model utilizes managed care principles and strategies to assure proper utilization of acute care and long-term care services and supports. The components of the model must include:

(1) the assignment of recipients to a medical home;
(2) utilization management to assure appropriate access and utilization of services, including prescription drugs;
(3) health risk or functional needs assessment;
(4) a method for reporting to medical homes and other appropriate health care providers on the utilization by recipients of health care services and the associated cost of utilization of those services;
(5) mechanisms to reduce inappropriate emergency department utilization by recipients, including the provision of after-hours primary care;
(6) mechanisms that ensure a robust system of care coordination for assessing, planning, coordinating, and monitoring recipients with complex, chronic, or high-cost health care or social support needs, including attendant care and other services needed to remain in the community;
(7) implementation of a comprehensive, community-based initiative to educate recipients about effective use of the health care delivery system;
(8) strategies to prevent or delay institutionalization of recipients through the effective utilization of home and community-based support services; and
(9) any other components the executive commissioner determines will improve a recipient's health outcome and are cost-effective.

(c) For purposes of this chapter, the integrated care management model is a managed care plan.

Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 20(a), eff. September 1, 2005.
Added by Acts 2005, 79th Leg., Ch. 1248 (H.B. 1771), Sec. 1, eff. June 18, 2005.

Sec. 533.062. CONTRACTING FOR INTEGRATED CARE MANAGEMENT.
(a) The commission may contract with one or more administrative services organizations to perform the coordination of care and other services and functions of the integrated care management model developed under Section 533.061.

(b) The commission may require that each administrative services organization contracting with the commission under this section assume responsibility for exceeding administrative costs
and not meeting performance standards in connection with the
 provision of acute care and long-term care services and supports
 under the terms of the contract.

 (c) The commission may include in a contract awarded under
 this section a written guarantee of state savings on Medicaid
 expenditures for recipients receiving services provided under the
 integrated care management model developed under Section 533.061.

 (d) The commission may require that each administrative
 services organization contracting with the commission under this
 section establish pay-for-performance incentives for providers to
 improve patient outcomes.

 (e) In this section, "administrative services organization"
 means an entity that performs administrative and management
 functions, such as the development of a physician and provider
 network, care coordination, service coordination, utilization
 review and management, quality management, and patient and provider
 education, for a noncapitated system of health care services,
 medical services, or long-term care services and supports.

 Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 20(a), eff.
 September 1, 2005.

 Added by Acts 2005, 79th Leg., Ch. 1248 (H.B. 1771), Sec. 1, eff.
 June 18, 2005.

 Sec. 533.063. STATEWIDE INTEGRATED CARE MANAGEMENT ADVISORY
 COMMITTEE. (a) The executive commissioner may appoint an advisory
 committee to assist the executive commissioner in the development
 and implementation of the integrated care management model.

 (b) The advisory committee is subject to Chapter 551.

 Added by Acts 2005, 79th Leg., Ch. 349 (S.B. 1188), Sec. 20(a), eff.
 September 1, 2005.

 Added by Acts 2005, 79th Leg., Ch. 1248 (H.B. 1771), Sec. 1, eff.
 June 18, 2005.