GOVERNMENT CODE
CHAPTER 533. IMPLEMENTATION OF MEDICAID MANAGED CARE PROGRAM
SUBCHAPTER A. GENERAL PROVISIONS

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.

Sec. 533.0025. DELIVERY OF SERVICES. (a) In this section, "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 through the most cost-effective model of Medicaid managed care as determined by the commission. If the commission determines that it is more cost-effective, the commission may provide medical assistance for acute care in a certain part of this state or to a certain population of recipients using:

(1) a health maintenance organization model, including the acute care portion of Medicaid Star + Plus pilot programs;

(2) a primary care case management model;

(3) a prepaid health plan model;

(4) an exclusive provider organization model; or

(5) another Medicaid managed care model or arrangement.

(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) Notwithstanding Subsection (b)(1), the commission may not provide medical assistance using a health maintenance organization in Cameron County, Hidalgo County, or Maverick County.

Added by Acts 2003, 78th Leg., ch. 198, Sec. 2.29, eff. Sept. 1, 2003. Amended by Acts 2005, 79th Leg., ch. 728, Sec. 11.119, eff. Sept. 1, 2005.

Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. 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; and

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

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 1447, Sec. 2, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.02, eff. Sept. 1, 1999.

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.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 1447, Sec. 3, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.03, eff. Sept. 1, 1999; Acts 2001, 77th Leg., ch. 1420, Sec. 14.766, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 1276, Sec. 10A.515, eff. Sept. 1, 2003.

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 not later than the 45th day after the date a claim for payment is received with documentation reasonably necessary for the managed care organization to process the claim, or within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

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

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

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

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of 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 the organization use advanced practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network;

(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; and

(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; and

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

(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).

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 493, Sec. 2, eff. Sept. 1, 1999; Acts 1999, 76th Leg., ch. 1447, Sec. 4, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.04, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 2.35, eff. Sept. 1, 2003; Acts 2005, 79th Leg., ch. 349, Sec. 6(a), eff. Sept. 1, 2005.

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.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 1447, Sec. 5, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.05, eff. Sept. 1, 1999.

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. Amended by Acts 1999, 76th Leg., ch. 1447, Sec. 6, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.06, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, Sec. 2.203, eff. Sept. 1, 2003.

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 requirements for the managed care organizations, 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; and

(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

(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, Sec. 6(b), eff. Sept. 1, 2005.

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, Sec. 6(b), eff. Sept. 1, 2005.

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;

(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; and

(6) temporarily assign Medicaid-eligible newborn infants to the traditional fee-for-service component of the state Medicaid program for a period not to exceed the earlier of:

(A) 60 days; or

(B) the date on which the Texas Department of Human Services has completed the newborn's Medicaid eligibility determination, including assignment of the newborn's Medicaid eligibility number.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 1447, Sec. 7, eff. June 19, 1999; Acts 1999, 76th Leg., ch. 1460, Sec. 9.07, eff. Sept. 1, 1999.

Sec. 533.0076. LIMITATIONS ON RECIPIENT DISENROLLMENT. (a) Except as provided by Subsections (b) and (c), and to the extent permitted by federal law, the commission may prohibit a recipient from disenrolling in a managed care plan under this chapter and enrolling 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 in that plan at any time for cause in accordance with federal law.

Added by Acts 2001, 77th Leg., ch. 584, Sec. 6, eff. Jan. 1, 2002.

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)-(e) Expired.

Text of subsec. (f) as added by Acts 2005, 79th Leg., ch. 349, Sec. 19(a)

(f) 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.

Text of subsec. (f) as added by Acts 2005, 79th Leg., ch. 1047, Sec. 1

(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.

Added by Acts 1997, 75th Leg., ch. 1262, Sec. 2, eff. June 20, 1997. Amended by Acts 2001, 77th Leg., ch. 698, Sec. 1, eff. Sept. 1, 2001; Acts 2003, 78th Leg., ch. 589, Sec. 7, eff. June 20, 2003; Acts 2005, 79th Leg., ch. 349, Sec. 19(a), eff. Sept. 1, 2005; Acts 2005, 79th Leg., ch. 1047, Sec. 1, eff. Sept. 1, 2005.

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 to the commission:

(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 the managed care organization, including a health maintenance organization, primary care case management, and an 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 and be updated as required by the commission.

(c) The commission's office of investigations and enforcement shall review the information submitted under this section as appropriate in the investigation of fraud in the Medicaid managed care program. The comptroller may review the information in connection with the health care fraud study conducted by the comptroller.

(d) For a subcontractor who reenrolled as a provider in the Medicaid program as required by Section 2.07, Chapter 1153, Acts of the 75th Legislature, Regular Session, 1997, or who modified a contract in compliance with that section, a managed care organization is not required to submit, and the provider is not required to provide, fraud control information different than the information submitted in connection with the reenrollment or contract modification.

(e) Information submitted to the commission under Subsection (a)(1) is confidential and not subject to disclosure under Chapter 552, Government Code.

Added by Acts 1999, 76th Leg., ch. 493, Sec. 1, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 198, Sec. 2.36, eff. Sept. 1, 2003.

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.

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.

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.

Added by Acts 2001, 77th Leg., ch. 506, Sec. 1, eff. Sept. 1, 2001.

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) 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.

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.

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; Acts 1999, 76th Leg., ch. 1460, Sec. 9.08, eff. Sept. 1, 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.

Added by Acts 2001, 77th Leg., ch. 506, Sec. 1, eff. Sept. 1, 2001.

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.

Added by Acts 2001, 77th Leg., ch. 506, Sec. 1, eff. Sept. 1, 2001.

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.

Added by Acts 2001, 77th Leg., ch. 506, Sec. 1, eff. Sept. 1, 2001.

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 commission shall appoint a state Medicaid managed care advisory committee. The advisory committee consists of representatives of:

(1) hospitals;

(2) managed care organizations;

(3) primary care providers;

(4) state agencies;

(5) consumer advocates representing low-income recipients;

(6) consumer advocates representing recipients with a disability;

(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 care providers, including nursing home providers;

(12) obstetrical care providers;

(13) community-based organizations serving low-income children and their families; and

(14) community-based organizations engaged in perinatal services and outreach.

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

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.

Sec. 533.042. MEETINGS. The advisory committee shall meet at least quarterly, shall develop procedures that provide the public with reasonable opportunity to appear before the committtee and speak on any issue under the jurisdiction of the committee, and 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.

Sec. 533.043. POWERS AND DUTIES. The advisory committee shall:

(1) provide recommendations to the commission on the statewide implementation and operation of Medicaid managed care;

(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.

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.

Sec. 533.044. OTHER LAW. Except as provided by this subchapter, the advisory committee is subject to Chapter 2110.

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.

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, Sec. 20(a), eff. Sept 1, 2005; Acts 2005, 79th Leg., ch. 1248, 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, Sec. 20(a), eff. Sept 1, 2005; Acts 2005, 79th Leg., ch. 1248, 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, Sec. 20(a), eff. Sept 1, 2005; Acts 2005, 79th Leg., ch. 1248, Sec. 1, eff. June 18, 2005.