GOVERNMENT CODE

TITLE 4. EXECUTIVE BRANCH

SUBTITLE I. HEALTH AND HUMAN SERVICES

CHAPTER 533. 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) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

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

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

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

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

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

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

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.209, eff. April 2, 2015.

Sec. 533.002. PURPOSE. The commission shall implement the Medicaid managed care program by contracting with managed care

organizations in a manner that, to the extent possible:

(1) improves the health of Texans by:

(A) emphasizing prevention;

(B) promoting continuity of care; and

(C) providing a medical home for recipients;

(2) ensures that each recipient receives high quality, comprehensive health care services in the recipient's local community;

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

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

(5) provides incentives to managed care organizations to improve the quality of health care services for recipients by providing value-added services; and

(6) reduces administrative and other nonfinancial barriers for recipients in obtaining health care services.

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

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.210, eff. April 2, 2015.

Sec. 533.0025. DELIVERY OF SERVICES. (a) Repealed by Acts 2015, 84th Leg., R.S., Ch. 1, Sec. 2.287(15), eff. April 2, 2015.

(b) Except as otherwise provided by this section and notwithstanding any other law, the commission shall provide Medicaid acute care services through the most cost-effective model of Medicaid capitated managed care as determined by the commission. The commission shall require mandatory participation in a Medicaid capitated managed care program for all persons eligible for Medicaid acute care benefits, but may implement alternative models or arrangements, including a traditional fee-for-service arrangement, if the commission determines the alternative would be more cost-effective or efficient.

(c) In determining whether a model or arrangement described by Subsection (b) is more cost-effective, the executive commissioner must consider:

(1) the scope, duration, and types of health benefits or services to be provided in a certain part of this state or to a certain population of recipients;

(2) administrative costs necessary to meet federal and state statutory and regulatory requirements;

(3) the anticipated effect of market competition associated with the configuration of Medicaid service delivery models determined by the commission; and

(4) the gain or loss to this state of a tax collected under Chapter 222, Insurance Code.

(d) If the commission determines that it is not more cost-effective to use a Medicaid managed care model to provide certain types of Medicaid acute care in a certain area or to certain recipients as prescribed by this section, the commission shall provide Medicaid acute care through a traditional fee-for-service arrangement.

(e) The commission shall determine the most cost-effective alignment of managed care service delivery areas. The executive commissioner may consider the number of lives impacted, the usual source of health care services for residents in an area, and other factors that impact the delivery of health care services in the area.

(f) Expired.

(g) Expired.

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

(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.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.211, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.287(15), eff. April 2, 2015.

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) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837, Sec. 3.40(a)(14), and Ch. 946, 2.37(b)(13) eff. January 1, 2016.

(2) "Clean claim" means a claim that meets the same criteria for a clean claim used by the Department of Aging and Disability Services for the reimbursement of nursing facility claims.

(3) "Nursing facility" means a convalescent or nursing home or related institution licensed under Chapter 242, Health and Safety Code, that provides long-term services and supports to recipients.

(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 Medicaid.

Text of subsection effective until September 01, 2023

(c) Subject to Section 533.0025 and notwithstanding any other law, the commission shall provide benefits under Medicaid to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. In implementing this subsection, the commission shall ensure:

(1) that the commission is responsible for setting the minimum reimbursement rate paid to a nursing facility under the managed care program;

(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 established 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 Medicaid are not affected;

(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; and

(10) that the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the managed care program.

Text of subsection effective on September 01, 2023

(c) Subject to Section 533.0025 and notwithstanding any other law, the commission shall provide benefits under Medicaid to recipients who reside in nursing facilities through the STAR + PLUS Medicaid managed care program. In implementing this subsection, the commission shall ensure:

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

(2) the appropriate utilization of services consistent with criteria established by the commission;

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

(4) that a managed care organization providing services under the managed care program provides discharge planning, transitional care, and other education programs to physicians and hospitals regarding all available long-term care settings;

(5) that a managed care organization providing services under the managed care program:

(A) assists in collecting applied income from recipients; and

(B) provides payment incentives to nursing

facility providers that reward reductions in preventable acute care costs and encourage transformative efforts in the delivery of nursing facility services, including efforts to promote a resident-centered care culture through facility design and services provided;

(6) the establishment of a portal that is in compliance with state and federal regulations, including standard coding requirements, through which nursing facility providers participating in the STAR + PLUS Medicaid managed care program may submit claims to any participating managed care organization;

(7) that rules and procedures relating to the certification and decertification of nursing facility beds under Medicaid are not affected;

(8) that a managed care organization providing services under the managed care program, to the greatest extent possible, offers nursing facility providers access to:

(A) acute care professionals; and

(B) telemedicine, when feasible and in accordance with state law, including rules adopted by the Texas Medical Board; and

(9) that the commission approves the staff rate enhancement methodology for the staff rate enhancement paid to a nursing facility that qualifies for the enhancement under the managed care program.

(e) The commission shall establish credentialing and minimum performance standards for nursing facility providers seeking to participate in the STAR + PLUS Medicaid managed care program that are consistent with adopted federal and state standards. A managed care organization may refuse to contract with a nursing facility provider if the nursing facility does not meet the minimum performance standards established by the commission under this section.

(f) A managed care organization may not require prior authorization for a nursing facility resident in need of emergency hospital services.

(h) In addition to the minimum performance standards the commission establishes for nursing facility providers seeking to

participate in the STAR+PLUS Medicaid managed care program, the executive commissioner shall adopt rules establishing minimum performance standards applicable to nursing facility providers that participate in the program. The commission is responsible for monitoring provider performance in accordance with the standards and requiring corrective actions, as the commission determines necessary, from providers that do not meet the standards. The commission shall share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.

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

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.212, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.213, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.13, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(a)(14), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.13, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(b)(13), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 1, eff. June 19, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1117 (H.B. 3523), Sec. 2, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 820 (H.B. 2658), Sec. 2, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 820 (H.B. 2658), Sec. 14, eff. September 1, 2023.

For expiration of Subsections (f), (g), (h), (i), (j), and (k), see Subsection (k).

For expiration of Subsections (l), (l-1), and (l-2), see

Subsection (l-2).

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

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee described by 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 Medicaid.

(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 Children's Policy Council established under Section 22.035, Human Resources Code, establish a mandatory STAR Kids capitated managed care program tailored to provide Medicaid benefits to children with disabilities. The managed care program developed under this section must:

(1) provide Medicaid benefits that are customized to meet the health care needs of recipients under the program through a defined system of care;

(2) better coordinate care of recipients under the program;

(3) improve the health outcomes of recipients;

(4) improve recipients' access to health care services;

(5) achieve cost containment and cost efficiency;

(6) reduce the administrative complexity of delivering Medicaid benefits;

(7) reduce the incidence of unnecessary institutionalizations and potentially preventable events by ensuring the availability of appropriate services and care management;

(8) require a health home; and

(9) coordinate and collaborate with long-term care service providers and long-term care management providers, if

recipients are receiving long-term services and supports outside of the managed care organization.

(c) The commission may require that care management services made available as provided by Subsection (b)(7):

(1) incorporate best practices, as determined by the commission;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification methodology that identifies recipients who have the greatest need for services;

(4) provide a care needs assessment for a recipient;

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transition of care;

(7) include monitoring and reporting outcomes that, at a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics determined appropriate by the commission; and

(8) use innovations in the provision of services.

(c-1) To improve the care needs assessment tool used for purposes of a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, the commission in consultation and collaboration with the advisory committee shall consider changes that will:

(1) reduce the amount of time needed to complete the care needs assessment initially and at reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c-2) To the extent feasible and allowed by federal law, the commission shall streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity.

(d) The commission shall provide Medicaid benefits through the STAR Kids managed care program established under this section to children who are receiving benefits under the medically dependent children (MDCP) waiver program. The commission shall ensure that the STAR Kids managed care program provides all of the benefits provided under the medically dependent children (MDCP) waiver program to the extent necessary to implement this subsection.

(e) The commission shall ensure that there is a plan for transitioning the provision of Medicaid benefits to recipients 21 years of age or older from under the STAR Kids program to under the STAR + PLUS Medicaid managed care program that protects continuity of care. The plan must ensure that coordination between the programs begins when a recipient reaches 18 years of age.

(f) The commission shall operate a Medicaid escalation help line through which Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program or the deaf-blind with multiple disabilities (DBMD) waiver program and their legally authorized representatives, parents, guardians, or other representatives have access to assistance. The escalation help line must be:

(1) dedicated to assisting families of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program or the deaf-blind with multiple disabilities (DBMD) waiver program in navigating and resolving issues related to the STAR Kids managed care program, including complying with requirements related to the continuation of benefits during an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; and

(2) operational at all times, including evenings, weekends, and holidays.

(g) The commission shall ensure staff operating the Medicaid escalation help line:

(1) return a telephone call not later than two hours after receiving the call during standard business hours; and

(2) return a telephone call not later than four hours after receiving the call during evenings, weekends, and holidays.

(h) The commission shall require a Medicaid managed care organization participating in the STAR Kids managed care program to:

(1) designate an individual as a single point of contact for the Medicaid escalation help line; and

(2) authorize that individual to take action to resolve escalated issues.

(i) To the extent feasible, a Medicaid managed care organization shall provide information that will enable staff operating the Medicaid escalation help line to assist recipients, such as information related to service coordination and prior authorization denials.

(j) Not later than September 1, 2020, the commission shall assess the utilization of the Medicaid escalation help line and determine the feasibility of expanding the help line to additional Medicaid programs that serve medically fragile children.

(k) Subsections (f), (g), (h), (i), and (j) and this subsection expire September 1, 2024.

(l) Using existing resources, the executive commissioner in consultation and collaboration with the advisory committee shall determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under:

(1) an accountable care organization model in accordance with guidelines established by the Centers for Medicare and Medicaid Services; or

(2) an alternative model developed by or in collaboration with the Centers for Medicare and Medicaid Services Innovation Center.

(l-1) Not later than December 1, 2022, the commission shall prepare and submit a written report to the legislature of the executive commissioner's determination under Subsection (l).

(l-2) Subsections (l) and (l-1) and this subsection expire September 1, 2023.

(m) Expired.

(n) The commission, at least once every two years, shall conduct a utilization review on a sample of cases for children enrolled in the STAR Kids managed care program to ensure that all imposed clinical prior authorizations are based on publicly available clinical criteria and are not being used to negatively impact a recipient's access to care.

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

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.216, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.217, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.14, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.14, eff. January 1, 2016.

Acts 2019, 86th Leg., R.S., Ch. 619 (S.B. 1096), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 4, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 5, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 3, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 4, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 21.001(33), eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 21.002(6), eff. September 1, 2021.

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

Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE. (a) The STAR Kids Managed Care Advisory Committee established by the executive commissioner under Section 531.012 shall:

(1) advise the commission on the operation of the STAR Kids managed care program under Section 533.00253; and

(2) make recommendations for improvements to that program.

(b) On December 31, 2023:

(1) the advisory committee is abolished; and

(2) this section expires.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 6, eff. September 1, 2019.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 5, eff. September 1, 2019.

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.

(a-1) Notwithstanding Subsection (a), for purposes of this section, the term "behavioral health services" does not include mental health and substance disorder services provided through the NorthSTAR demonstration project. This subsection expires on the later of the following dates:

(1) January 1, 2017; or

(2) the last day of the transition deadline for the cessation of the NorthSTAR Behavioral Health Services model if that deadline is extended in accordance with provisions of H.B. No. 1, Acts of the 84th Legislature, Regular Session, 2015 (the General Appropriations Act), by written approval of the Legislative Budget Board or the governor.

(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) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 , Sec. 3.40(a)(16), eff. January 1, 2016.

(f) Repealed by Acts 2015, 84th Leg., R.S., Ch. 837 , Sec. 3.40(a)(16), eff. January 1, 2016.

(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.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.18,

eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.19, eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.40(a)(16), eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.37(b)(15), eff. January 1, 2016.

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

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

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

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

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

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

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.20, eff. September 1, 2015.

Sec. 533.002552. TARGETED CASE MANAGEMENT AND PSYCHIATRIC REHABILITATIVE SERVICES FOR CHILDREN, ADOLESCENTS, AND FAMILIES. (a) A provider in the provider network of a managed care organization that contracts with the commission to provide behavioral health services under Section 533.00255 may contract with the managed care organization to provide targeted case

management and psychiatric rehabilitative services to children, adolescents, and their families.

(b) Commission rules and guidelines concerning contract and training requirements applicable to the provision of behavioral health services may apply to a provider that contracts with a managed care organization under Subsection (a) only to the extent those contract and training requirements are specific to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families.

(c) Commission rules and guidelines applicable to a provider that contracts with a managed care organization under Subsection (a) may not require the provider to provide a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week. This subsection does not prohibit a managed care organization that contracts with the commission to provide behavioral health services under Section 533.00255 from specifically contracting with a provider for the provision of a behavioral health crisis hotline or a mobile crisis team that operates 24 hours per day and seven days per week.

(d) Commission rules and guidelines applicable to a provider that contracts with a managed care organization to provide targeted case management and psychiatric rehabilitative services specific to children and adolescents who are at risk of juvenile justice involvement, expulsion from school, displacement from the home, hospitalization, residential treatment, or serious injury to self, others, or animals may not require the provider to also provide less intensive psychiatric rehabilitative services specified by commission rules and guidelines as applicable to the provision of targeted case management and psychiatric rehabilitative services to children, adolescents, and their families, if that provider has a referral arrangement to provide access to those less intensive psychiatric rehabilitative services.

(e) Commission rules and guidelines applicable to a provider that contracts with a managed care organization under Subsection (a) may not require the provider to provide services not

covered under Medicaid.

Added by Acts 2017, 85th Leg., R.S., Ch. 519 (S.B. 74), Sec. 1, eff. June 9, 2017.

Sec. 533.002553. BEHAVIORAL HEALTH SERVICES PROVIDED THROUGH THIRD PARTY OR SUBSIDIARY. (a) In this section, "behavioral health services" has the meaning assigned by Section 533.00255.

(b) For a managed care organization that contracts with the commission under this chapter and that provides behavioral health services through a contract with a third party or an arrangement with a subsidiary of the managed care organization, the commission shall:

(1) require the effective sharing and integration of care coordination, service authorization, and utilization management data between the managed care organization and the third party or subsidiary;

(2) encourage, to the extent feasible, the colocation of physical health and behavioral health care coordination staff;

(3) require warm call transfers between physical health and behavioral health care coordination staff;

(4) require the managed care organization and the third party or subsidiary to implement joint rounds for physical health and behavioral health services network providers or some other effective means for sharing clinical information; and

(5) ensure that the managed care organization makes available a seamless provider portal for both physical health and behavioral health services network providers, to the extent allowed by federal law.

Added by Acts 2017, 85th Leg., R.S., Ch. 519 (S.B. 74), Sec. 1, eff. June 9, 2017.

Sec. 533.002555. TRANSITION OF CASE MANAGEMENT FOR CHILDREN AND PREGNANT WOMEN PROGRAM RECIPIENTS TO MANAGED CARE PROGRAM. (a) In this section, "children and pregnant women program" means the benefits program provided under Medicaid and administered by the Department of State Health Services that provides case

management services to children who have a health condition or health risk and pregnant women who have a high-risk condition.

(b) The commission shall transition to a Medicaid managed care model all case management services provided to recipients under the children and pregnant women program. In transitioning services under this section, the commission shall ensure a recipient is provided case management services through the managed care plan in which the recipient is enrolled.

(c) In implementing this section, the commission shall ensure:

(1) a seamless transition in case management for recipients receiving benefits under the children and pregnant women program; and

(2) case management services provided under the program are not interrupted.

Added by Acts 2021, 87th Leg., R.S., Ch. 629 (H.B. 133), Sec. 1, eff. September 1, 2021.

Sec. 533.00256. MANAGED CARE CLINICAL IMPROVEMENT PROGRAM. (a) In consultation with appropriate stakeholders with an interest in the provision of acute care services and long-term services and supports under the Medicaid managed care program, the commission shall:

(1) establish a clinical improvement program to identify goals designed to improve quality of care and care management and to reduce potentially preventable events, 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.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 3.16, eff. January 1, 2016.

Acts 2015, 84th Leg., R.S., Ch. 946 (S.B. 277), Sec. 2.16, eff. January 1, 2016.

Sec. 533.00257. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES THROUGH MANAGED TRANSPORTATION ORGANIZATION. (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.

(2-a) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code.

(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) The commission may 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

commission determines that the data is required to receive federal matching funds.

(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) Except as provided by Subsections (k) and (m), 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) Except as provided by Subsections (k) and (m), 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) Expired.

(i) Repealed by Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 9, eff. June 14, 2019.

(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) A managed transportation organization may subcontract with a transportation network company to provide services under this section. A rule or other requirement adopted by the executive commissioner under this section or Section 531.02414 does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. The commission or the managed transportation organization may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this section.

(l) The commission or a managed transportation organization that subcontracts with a transportation network company under Subsection (k) may require the transportation network company or a motor vehicle operator who provides services under this section to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

(m) Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a managed transportation organization under Subsection (k) and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this section. The commission and the managed transportation organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this section.

(n) For purposes of this section and notwithstanding

Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

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

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 5, eff. June 14, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 6, eff. June 14, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 7, eff. June 14, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 9, eff. June 14, 2019.

Sec. 533.002571. DELIVERY OF NONEMERGENCY TRANSPORTATION SERVICES TO CERTAIN MEDICAID RECIPIENTS THROUGH MEDICAID MANAGED CARE ORGANIZATION. (a) In this section:

(1) "Nonemergency transportation service" has the meaning assigned by Section 531.02414.

(2) "Nonmedical transportation service" and "transportation network company" have the meanings assigned by Section 533.00258.

(b) The commission shall require each Medicaid managed care organization to arrange and provide nonemergency transportation services to a recipient enrolled in a managed care plan offered by the organization using the most cost-effective and cost-efficient method of delivery, including by delivering nonmedical transportation services through a transportation network company or other transportation vendor as provided by Section 533.002581, if available and medically appropriate. The commission shall supervise the provision of the services.

(c) Subject to Subsection (d), the executive commissioner shall adopt rules as necessary to ensure the safe and efficient

provision of nonemergency transportation services by a Medicaid managed care organization under this section.

(d) A Medicaid managed care organization may subcontract with a transportation network company to provide nonemergency transportation services under this section. A rule or other requirement adopted by the executive commissioner under Subsection (c) or Section 531.02414 does not apply to the subcontracted transportation network company or a motor vehicle operator who is part of the company's network. The commission or the Medicaid managed care organization may not require a motor vehicle operator who is part of the subcontracted transportation network company's network to enroll as a Medicaid provider to provide services under this section.

(e) The commission or a Medicaid managed care organization that subcontracts with a transportation network company under Subsection (d) may require the transportation network company or a motor vehicle operator who provides services under this section to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

(f) Notwithstanding any other law, a motor vehicle operator who is part of the network of a transportation network company that subcontracts with a Medicaid managed care organization under Subsection (d) and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide services under this section. The commission and the Medicaid managed care organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide services under this section.

(g) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

(h) The commission may temporarily waive the applicability

of Subsection (b) to a Medicaid managed care organization as necessary based on the results of a review conducted under Section 533.007 and until enrollment of recipients in a managed care plan offered by the organization is permitted under that section.

(i) The commission shall extend a contract for the provision of nonemergency transportation services under Section 533.00257 or other law as necessary until the requirements of this section are implemented with respect to each Medicaid managed care organization. This subsection expires September 1, 2023.

Added by Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 8, eff. June 14, 2019.

Sec. 533.00258. NONMEDICAL TRANSPORTATION SERVICES UNDER MEDICAID MANAGED CARE PROGRAM. (a) In this section:

(1) "Nonmedical transportation service" means:

(A) curb-to-curb transportation to or from a medically necessary, nonemergency covered health care service in a standard passenger vehicle that is scheduled not more than 48 hours before the transportation occurs, that is provided to a recipient enrolled in a managed care plan offered by a Medicaid managed care organization, and that the organization determines meets the level of care that is medically appropriate for the recipient, including transportation related to:

(i) discharge of a recipient from a health care facility;

(ii) receipt of urgent care; and

(iii) obtaining pharmacy services and prescription drugs; and

(B) any other transportation to or from a medically necessary, nonemergency covered health care service the commission considers appropriate to be provided by a transportation vendor, as determined by commission rule or policy.

(2) "Transportation network company" has the meaning assigned by Section 2402.001, Occupations Code.

(3) "Transportation vendor" means an entity, including a transportation network company, that contracts with a Medicaid managed care organization to provide nonmedical

transportation services.

(b) The executive commissioner shall adopt rules regarding the manner in which nonmedical transportation services may be arranged and provided.

(c) The rules must require a Medicaid managed care organization to create a process to:

(1) verify that a passenger is eligible to receive nonmedical transportation services;

(2) ensure that nonmedical transportation services are provided only to and from covered health care services in areas in which a transportation network company operates; and

(3) ensure the timely delivery of nonmedical transportation services to a recipient, including by setting reasonable service response goals.

(d) Before September 1, 2020, and subject to Section 533.002581(h), a rule adopted in accordance with Subsection (c)(3) may not impose a penalty on a Medicaid managed care organization that contracts with a transportation vendor under this section if the vendor is unable to provide nonmedical transportation services to a recipient after the Medicaid managed care organization has made a specific request for those services.

(e) The rules must require a transportation vendor to, before permitting a motor vehicle operator to provide nonmedical transportation services:

(1) confirm that the operator:

(A) is at least 18 years of age;

(B) maintains a valid driver's license issued by this state, another state, or the District of Columbia; and

(C) possesses proof of registration and automobile financial responsibility for each motor vehicle to be used to provide nonmedical transportation services;

(2) conduct, or cause to be conducted, a local, state, and national criminal background check for the operator that includes the use of:

(A) a commercial multistate and multijurisdiction criminal records locator or other similar commercial nationwide database; and

(B) the national sex offender public website maintained by the United States Department of Justice or a successor agency;

(3) confirm that any vehicle to be used to provide nonmedical transportation services:

(A) meets the applicable requirements of Chapter 548, Transportation Code; and

(B) except as provided by Subsection (j), has at least four doors; and

(4) obtain and review the operator's driving record.

(f) The rules may not permit a motor vehicle operator to provide nonmedical transportation services if the operator:

(1) has been convicted in the three-year period preceding the issue date of the driving record obtained under Subsection (e)(4) of:

(A) more than three offenses classified by the Department of Public Safety as moving violations; or

(B) one or more of the following offenses:

(i) fleeing or attempting to elude a police officer under Section 545.421, Transportation Code;

(ii) reckless driving under Section 545.401, Transportation Code;

(iii) driving without a valid driver's license under Section 521.025, Transportation Code; or

(iv) driving with an invalid driver's license under Section 521.457, Transportation Code;

(2) has been convicted in the preceding seven-year period of any of the following:

(A) driving while intoxicated under Section 49.04 or 49.045, Penal Code;

(B) use of a motor vehicle to commit a felony;

(C) a felony crime involving property damage;

(D) fraud;

(E) theft;

(F) an act of violence; or

(G) an act of terrorism; or

(3) is found to be registered in the national sex

offender public website maintained by the United States Department of Justice or a successor agency.

(g) The commission may not require:

(1) a motor vehicle operator to enroll as a Medicaid provider to provide nonmedical transportation services; or

(2) a Medicaid managed care organization to credential a motor vehicle operator to provide nonmedical transportation services.

(h) The commission or a Medicaid managed care organization that contracts with a transportation vendor may require the transportation vendor or a motor vehicle operator who provides services under this section to be periodically screened against the list of excluded individuals and entities maintained by the Office of Inspector General of the United States Department of Health and Human Services.

(i) Notwithstanding any other law, a motor vehicle operator who is part of a transportation network company's network and who satisfies the driver requirements in Section 2402.107, Occupations Code, is qualified to provide nonmedical transportation services. The commission and a Medicaid managed care organization may not impose any additional requirements on a motor vehicle operator who satisfies the driver requirements in Section 2402.107, Occupations Code, to provide nonmedical transportation services.

(j) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

Added by Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 8, eff. June 14, 2019.

Sec. 533.002581. DELIVERY OF NONMEDICAL TRANSPORTATION SERVICES UNDER MEDICAID MANAGED CARE PROGRAM. (a) In this section, "nonmedical transportation service" and "transportation vendor" have the meanings assigned by Section 533.00258.

(b) Expired.

(c) Beginning not later than September 1, 2020, the commission shall require each Medicaid managed care organization to arrange for the provision of nonmedical transportation services to recipients enrolled in a managed care plan offered by the organization.

(d) A Medicaid managed care organization may contract with a transportation vendor or other third party to arrange for the provision of nonmedical transportation services. If a Medicaid managed care organization contracts with a third party that is not a transportation vendor to arrange for the provision of nonmedical transportation services, the third party shall contract with a transportation vendor to deliver the nonmedical transportation services.

(e) A Medicaid managed care organization that contracts with a transportation vendor or other third party to arrange for the provision of nonmedical transportation services shall ensure the effective sharing and integration of service coordination, service authorization, and utilization management data between the managed care organization and the transportation vendor or third party.

(f) A Medicaid managed care organization may not require:

(1) a motor vehicle operator to enroll as a Medicaid provider to provide nonmedical transportation services; or

(2) the credentialing of a motor vehicle operator to provide nonmedical transportation services.

(g) For purposes of this section and notwithstanding Section 2402.111(a)(2)(A), Occupations Code, a motor vehicle operator who provides services under this section may use a wheelchair-accessible vehicle equipped with a lift or ramp that is capable of transporting passengers using a fixed-frame wheelchair in the cabin of the vehicle if the vehicle otherwise meets the requirements of Section 2402.111, Occupations Code.

(h) The commission may waive the applicability of Subsection (c) to a Medicaid managed care organization for not more than three months as necessary based on the results of a review conducted under Section 533.007 and until enrollment of recipients in a managed care plan offered by the organization is permitted

under that section.

Added by Acts 2019, 86th Leg., R.S., Ch. 1235 (H.B. 1576), Sec. 8, eff. June 14, 2019.

Sec. 533.0026. DIRECT ACCESS TO EYE HEALTH CARE SERVICES UNDER MEDICAID MANAGED CARE MODEL OR ARRANGEMENT. (a) Notwithstanding any other law, the commission shall ensure that a managed care plan offered by a managed care organization that contracts with the commission under this chapter and any other Medicaid managed care model or arrangement implemented under this chapter allow a recipient who receives services through the plan or other model or arrangement to, in the manner and to the extent required by Section 32.072, Human Resources Code:

(1) select an in-network ophthalmologist or therapeutic optometrist in the managed care network to provide eye health care services, other than surgery; and

(2) have direct access to the selected in-network ophthalmologist or therapeutic optometrist for the provision of the nonsurgical services.

(b) This section does not affect the obligation of an ophthalmologist or therapeutic optometrist in a managed care network to comply with the terms and conditions of the managed care plan.

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

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.218, eff. April 2, 2015.

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 Medicaid and the Medicare program.

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

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.219, eff. April 2, 2015.

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) Expired.

(d) In conjunction with the commission's office of contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with

jurisdiction over Medicaid not later than December 1 of each year. The report must:

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

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

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

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

Added by Acts 2013, 83rd Leg., R.S., Ch. 76 (S.B. 348), Sec. 1, eff. May 18, 2013.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.220, eff. April 2, 2015.

Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. (a) Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization.

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

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

(2) the organization review and issue determinations

on prior authorization requests with respect to a recipient who is not hospitalized at the time of the request according to the following time frames:

(A) within three business days after receiving the request; or

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

(c) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a process for use by a Medicaid managed care organization that receives a prior authorization request, with respect to a recipient who is not hospitalized at the time of the request, that does not include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(2)(A) within which a Medicaid managed care organization must issue a determination on a prior authorization request.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 6, eff. September 1, 2019.

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

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

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

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

Added by Acts 2019, 86th Leg., R.S., Ch. 619 (S.B. 1096), Sec. 2, eff. September 1, 2019.

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

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

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

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

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

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 6, eff. September 1, 2019.

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a uniform process and

timeline for Medicaid managed care organizations to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must include a requirement that the organization implement the process and timeline.

(b) The process and timeline must:

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

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

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

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

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

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

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

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 6, eff. September 1, 2019.

Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. The time frames prescribed by the

utilization review and prior authorization procedures described by Section 533.00282 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 533.00284 together may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care.

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 6, eff. September 1, 2019.

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 Medicaid, shall review and consider whether the pharmacy benefit manager has been in the preceding three years:

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

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

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

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.

Amended by:

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

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.221, eff. April 2, 2015.

Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A managed care plan offered by a Medicaid managed care organization must be accredited by a nationally recognized accreditation organization. The commission may choose whether to require all managed care plans offered by Medicaid managed care organizations to be accredited by the same organization or to allow for accreditation by different organizations.

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

Added by Acts 2019, 86th Leg., R.S., Ch. 680 (S.B. 2138), Sec. 3, eff. June 10, 2019.

Added by Acts 2019, 86th Leg., R.S., Ch. 1330 (H.B. 4533), Sec. 5, eff. September 1, 2019.

Sec. 533.0035. CERTIFICATION BY COMMISSION. (a) Before the commission may award a contract under this chapter to a managed

care organization, the commission shall evaluate and certify that the organization is reasonably able to fulfill the terms of the contract, including all requirements of applicable federal and state law.

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

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

Added by Acts 2021, 87th Leg., R.S., Ch. 609 (S.B. 1244), Sec. 1, eff. September 1, 2021.

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

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

(2) created by a nonprofit corporation that:

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

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

(3) created by a nonprofit corporation that has a contract, agreement, or other arrangement with a hospital district in that region under which the nonprofit corporation acts as an agent of the district and assumes the district's obligation to

arrange for services under the Medicaid expansion for children as authorized by Chapter 444, Acts of the 74th Legislature, Regular Session, 1995.

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

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

(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.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 609 (S.B. 1244), Sec. 2, eff. September 1, 2021.

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:

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

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

(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 complies with the provider access

standards established under Section 533.0061;

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

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

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

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

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

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

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

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

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

(B) the organization's provider network includes:

(i) a sufficient number of primary care

providers;

(ii) a sufficient variety of provider types;

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

(iv) providers located throughout the region where the organization will provide health care services; and

(C) health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

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

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

(B) focuses on measuring outcomes; and

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

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

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

(B) that adheres to the applicable preferred drug

list adopted by the commission under Section 531.072;

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

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

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

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

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

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

(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;

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

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

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

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

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

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

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

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

(vi) must:

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

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

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

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

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

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

(viii) must provide a process for each of

its network pharmacy providers to readily access the maximum allowable cost list specific to that provider; and

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

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

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

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

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

(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;

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board

provider reimbursement rate reductions unless:

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

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

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

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

(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).

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

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

(h) In addition to the requirements specified by Subsection (a), a contract described by that subsection must contain language permitting a managed care organization to offer medically appropriate, cost-effective, evidence-based services from a list approved by the state Medicaid managed care advisory committee and included in the contract in lieu of mental health or substance use disorder services specified in the state Medicaid plan. A recipient is not required to use a service from the list included in the contract in lieu of another mental health or substance use disorder service specified in the state Medicaid plan. The commission shall:

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

(2) take into consideration the actual cost and use of any services from the list included in the contract that are offered by a managed care organization when setting the capitation rates for that organization under the contract.

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.

Amended by:

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

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

Acts 2013, 83rd Leg., R.S., Ch. 418 (S.B. 406), Sec. 20, eff. November 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1191 (S.B. 1106), Sec. 1, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1261 (H.B. 595), Sec. 1, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1310 (S.B. 7), Sec. 2.04, eff. September 1, 2013.

Acts 2013, 83rd Leg., R.S., Ch. 1311 (S.B. 8), Sec. 8, eff. September 1, 2013.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.222, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1272 (S.B. 760), Sec. 4, eff. September 1, 2015.

Acts 2017, 85th Leg., R.S., Ch. 302 (S.B. 654), Sec. 1, eff. September 1, 2017.

Acts 2017, 85th Leg., R.S., Ch. 832 (H.B. 1917), Sec. 1, eff. June 15, 2017.

Acts 2019, 86th Leg., R.S., Ch. 619 (S.B. 1096), Sec. 3, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 981 (S.B. 1177), Sec. 1, eff. September 1, 2019.

Acts 2019, 86th Leg., R.S., Ch. 1343 (S.B. 1283), Sec. 2, eff. September 1, 2019.

Acts 2021, 87th Leg., R.S., Ch. 348 (H.B. 2822), Sec. 2, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 820 (H.B. 2658), Sec. 3, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 915 (H.B. 3607), Sec. 21.001(34), eff. September 1, 2021.

Sec. 533.0051. PERFORMANCE MEASURES AND INCENTIVES FOR VALUE-BASED CONTRACTS. (a) The commission shall establish outcome-based performance measures and incentives to include in each contract between a health maintenance organization and the commission for the provision of health care services to recipients that is procured and managed under a value-based purchasing model. The performance measures and incentives must:

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

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

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

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

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

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

understandable format.

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

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

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.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.223, eff. April 2, 2015.

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. 533.00515. MEDICATION THERAPY MANAGEMENT. The executive commissioner shall collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.

Added by Acts 2021, 87th Leg., R.S., Ch. 820 (H.B. 2658), Sec. 4, eff. September 1, 2021.

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. 533.00521. STAR HEALTH PROGRAM: HEALTH CARE FOR FOSTER CHILDREN. (a) The commission shall annually evaluate the use of benefits under the Medicaid program in the STAR Health program offered to children in foster care and provide recommendations to the Department of Family and Protective Services and each single source continuum contractor in this state to better coordinate the provision of health care and use of those benefits for children in foster care.

(b) In conducting the evaluation required under Subsection (a), the commission shall:

(1) collaborate with residential child-care providers regarding any unmet needs of children in foster care and the development of capacity for providing quality medical, behavioral

health, and other services for children in foster care; and

(2) identify options to obtain federal matching funds under the Medical Assistance Program to pay for a safe home-like or community-based residential setting for a child in the conservatorship of the Department of Family and Protective Services:

(A) who is identified or diagnosed as having a serious behavioral or mental health condition that requires intensive treatment;

(B) who is identified as a victim of serious abuse or serious neglect;

(C) for whom a traditional substitute care placement contracted for or purchased by the department is not available or would further denigrate the child's behavioral or mental health condition; or

(D) for whom the department determines a safe home-like or community-based residential placement could stabilize the child's behavioral or mental health condition in order to return the child to a traditional substitute care placement.

(c) The commission shall report its findings to the standing committees of the senate and house of representatives having jurisdiction over the Department of Family and Protective Services.
Added by Acts 2021, 87th Leg., R.S., Ch. 621 (S.B. 1896), Sec. 13(a), eff. June 14, 2021.

Sec. 533.00522. STAR HEALTH PROGRAM: MENTAL HEALTH PROVIDERS. A contract between a Medicaid managed care organization and the commission for the organization to provide health care services to recipients under the STAR Health program must require the organization to ensure the organization maintains a network of mental and behavioral health providers, including child psychiatrists and other appropriate providers, in all Department of Family and Protective Services regions in this state, regardless of whether community-based care has been implemented in any region.
Added by Acts 2021, 87th Leg., R.S., Ch. 621 (S.B. 1896), Sec. 13(b), eff. June 14, 2021.

Sec. 533.0053. COMPLIANCE WITH TEXAS HEALTH STEPS. The commission shall encourage each managed care organization providing health care services to a recipient under the STAR Health program to ensure that the organization's network providers comply with the regimen of care prescribed by the Texas Health Steps program under Section 32.056, Human Resources Code, if applicable, including the requirement to provide a mental health screening during each of the recipient's Texas Health Steps medical exams conducted by a network provider.

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

Sec. 533.00531. MEDICAID BENEFITS FOR CERTAIN CHILDREN FORMERLY IN FOSTER CARE. (a) This section applies only with respect to a child who:

(1) resides in this state; and

(2) is eligible for assistance or services under:

(A) Subchapter D, Chapter 162, Family Code; or

(B) Subchapter K, Chapter 264, Family Code.

(b) Except as provided by Subsection (c), the commission shall ensure that each child described by Subsection (a) remains or is enrolled in the STAR Health program unless or until the child is enrolled in another Medicaid managed care program.

(c) If a child described by Subsection (a) received Supplemental Security Income (SSI) (42 U.S.C. Section 1381 et seq.) or was receiving Supplemental Security Income before becoming eligible for assistance or services under Subchapter D, Chapter 162, Family Code, or Subchapter K, Chapter 264, Family Code, as applicable, the child may receive Medicaid benefits in accordance with the program established under this subsection. To the extent permitted by federal law, the commission, in consultation with the Department of Family and Protective Services, shall develop and implement a program that allows the adoptive parent or permanent managing conservator of a child described by this subsection to elect on behalf of the child to receive or, if applicable, continue receiving Medicaid benefits under the:

(1) STAR Health program; or

(2) STAR Kids managed care program.

(d) The commission shall protect the continuity of care for each child described under this section and, if applicable, ensure coordination between the STAR Health program and any other Medicaid managed care program for each child who is transitioning between Medicaid managed care programs.

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

Added by Acts 2019, 86th Leg., R.S., Ch. 1022 (H.B. 72), Sec. 2, eff. September 1, 2019.

Sec. 533.0054. HEALTH SCREENING REQUIREMENTS FOR ENROLLEE UNDER STAR HEALTH PROGRAM. (a) A managed care organization that contracts with the commission to provide health care services to recipients under the STAR Health program must ensure that enrollees receive a complete early and periodic screening, diagnosis, and treatment checkup in accordance with the requirements specified in the contract between the managed care organization and the commission.

(b) The commission shall include a provision in a contract with a managed care organization to provide health care services to recipients under the STAR Health program specifying progressive monetary penalties for the organization's failure to comply with Subsection (a).

Added by Acts 2017, 85th Leg., R.S., Ch. 319 (S.B. 11), Sec. 24(a), eff. September 1, 2017.

Sec. 533.0055. PROVIDER PROTECTION PLAN. (a) The commission shall develop and implement a provider protection plan that is designed to reduce administrative burdens placed on providers participating in a Medicaid managed care model or arrangement implemented under this chapter and to ensure efficiency in provider enrollment and reimbursement. The commission shall incorporate the measures identified in the plan, to the greatest extent possible, into each contract between a managed care organization and the commission for the provision of health care

services to recipients.

(b) The provider protection plan required under this section must provide for:

(1) prompt payment and proper reimbursement of providers by managed care organizations;

(2) prompt and accurate adjudication of claims through:

(A) provider education on the proper submission of clean claims and on appeals;

(B) acceptance of uniform forms, including HCFA Forms 1500 and UB-92 and subsequent versions of those forms, through an electronic portal; and

(C) the establishment of standards for claims payments in accordance with a provider's contract;

(3) adequate and clearly defined provider network standards that are specific to provider type, including physicians, general acute care facilities, and other provider types defined in the commission's network adequacy standards in effect on January 1, 2013, and that ensure choice among multiple providers to the greatest extent possible;

(4) a prompt credentialing process for providers;

(5) uniform efficiency standards and requirements for managed care organizations for the submission and tracking of preauthorization requests for services provided under Medicaid;

(6) establishment of an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network may:

(A) submit electronic claims, prior authorization requests, claims appeals and reconsiderations, clinical data, and other documentation that the managed care organization requests for prior authorization and claims processing; and

(B) obtain electronic remittance advice, explanation of benefits statements, and other standardized reports;

(7) the measurement of the rates of retention by managed care organizations of significant traditional providers;

(8) the creation of a work group to review and make recommendations to the commission concerning any requirement under this subsection for which immediate implementation is not feasible at the time the plan is otherwise implemented, including the required process for submission and acceptance of attachments for claims processing and prior authorization requests through an electronic process under Subdivision (6) and, for any requirement that is not implemented immediately, recommendations regarding the expected:

(A) fiscal impact of implementing the requirement; and

(B) timeline for implementation of the requirement; and

(9) any other provision that the commission determines will ensure efficiency or reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement.

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

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.224, eff. April 2, 2015.

Sec. 533.0056. STAR HEALTH PROGRAM: NOTIFICATION OF PLACEMENT CHANGE. A contract between a managed care organization and the commission for the organization to provide health care services to recipients under the STAR Health program must require the organization to ensure continuity of care for a child whose placement has changed by:

(1) notifying each specialist treating the child of the placement change; and

(2) coordinating the transition of care from the child's previous treating primary care physician and treating specialists to the child's new treating primary care physician and treating specialists, if any.

Added by Acts 2017, 85th Leg., R.S., Ch. 317 (H.B. 7), Sec. 40(a), eff. September 1, 2017.

Added by Acts 2017, 85th Leg., R.S., Ch. 319 (S.B. 11), Sec. 25(a), eff. September 1, 2017.

Sec. 533.006. PROVIDER NETWORKS. (a) The commission shall require that each managed care organization that contracts with the commission to provide health care services to recipients in a region:

(1) seek participation in the organization's provider network from:

(A) each health care provider in the region who has traditionally provided care to recipients;

(B) each hospital in the region that has been designated as a disproportionate share hospital under Medicaid; and

(C) each specialized pediatric laboratory in the region, including those laboratories located in children's hospitals; and

(2) include in its provider network for not less than three years:

(A) each health care provider in the region who:

(i) previously provided care to Medicaid and charity care recipients at a significant level as prescribed by the commission;

(ii) agrees to accept the prevailing provider contract rate of the managed care organization; and

(iii) has the credentials required by the managed care organization, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network;

(B) each accredited primary care residency program in the region; and

(C) each disproportionate share hospital designated by the commission as a statewide significant traditional provider.

(b) A contract between a managed care organization and the commission for the organization to provide health care services to recipients in a health care service region that includes a rural area must require that the organization include in its provider

network rural hospitals, physicians, home and community support services agencies, and other rural health care providers who:

(1) are sole community providers;

(2) provide care to Medicaid and charity care recipients at a significant level as prescribed by the commission;

(3) agree to accept the prevailing provider contract rate of the managed care organization; and

(4) have the credentials required by the managed care organization, provided that lack of board certification or accreditation by The Joint Commission may not be the sole ground for exclusion from the provider network.

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.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.225, eff. April 2, 2015.

Sec. 533.0061. PROVIDER ACCESS STANDARDS; REPORT. (a) The commission shall establish minimum provider access standards for the provider network of a managed care organization that contracts with the commission to provide health care services to recipients. The access standards must ensure that a managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) after-hours urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

(8) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(9) any other services identified by the commission.

(b) To the extent it is feasible, the provider access standards established under this section must:

(1) distinguish between access to providers in urban and rural settings;

(2) consider the number and geographic distribution of Medicaid-enrolled providers in a particular service delivery area; and

(3) subject to Section 531.0216(c) and consistent with Section 111.007, Occupations Code, consider and include the availability of telehealth services and telemedicine medical services within the provider network of a Medicaid managed care organization.

(c) The commission shall biennially submit to the legislature and make available to the public a report containing information and statistics about recipient access to providers through the provider networks of the managed care organizations and managed care organization compliance with contractual obligations related to provider access standards established under this section. The report must contain:

(1) a compilation and analysis of information submitted to the commission under Section 533.005(a)(20)(D);

(2) for both primary care providers and specialty providers, information on provider-to-recipient ratios in an organization's provider network, as well as benchmark ratios to indicate whether deficiencies exist in a given network; and

(3) a description of, and analysis of the results from, the commission's monitoring process established under Section 533.007(l).

Added by Acts 2015, 84th Leg., R.S., Ch. 1272 (S.B. 760), Sec. 5, eff. September 1, 2015.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 624 (H.B. 4), Sec. 4, eff. June 15, 2021.

Sec. 533.0062. PENALTIES AND OTHER REMEDIES FOR FAILURE TO COMPLY WITH PROVIDER ACCESS STANDARDS. If a managed care organization that has contracted with the commission to provide health care services to recipients fails to comply with one or more provider access standards established under Section 533.0061 and

the commission determines the organization has not made substantial efforts to mitigate or remedy the noncompliance, the commission:

(1) may:

(A) elect to not retain or renew the commission's contract with the organization; or

(B) require the organization to pay liquidated damages in accordance with Section 533.005(a)(20)(C); and

(2) shall suspend default enrollment to the organization in a given service delivery area for at least one calendar quarter if the organization's noncompliance occurs in the service delivery area for two consecutive calendar quarters.

Added by Acts 2015, 84th Leg., R.S., Ch. 1272 (S.B. 760), Sec. 5, eff. September 1, 2015.

Sec. 533.0063. PROVIDER NETWORK DIRECTORIES. (a) The commission shall ensure that a managed care organization that contracts with the commission to provide health care services to recipients:

(1) posts on the organization's Internet website:

(A) the organization's provider network directory; and

(B) a direct telephone number and e-mail address through which a recipient enrolled in the organization's managed care plan or the recipient's provider may contact the organization to receive assistance with:

(i) identifying in-network providers and services available to the recipient; and

(ii) scheduling an appointment for the recipient with an available in-network provider or to access available in-network services; and

(2) updates the online directory required under Subdivision (1)(A) at least monthly.

(b) A managed care organization is required to send a paper form of the organization's provider network directory for the program only to a recipient who requests to receive the directory in paper form.

(c) Repealed by Acts 2021, 87th Leg., R.S., Ch. 413 (S.B.

1829), Sec. 3, eff. June 7, 2021.

Added by Acts 2015, 84th Leg., R.S., Ch. 1272 (S.B. 760), Sec. 5, eff. September 1, 2015.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 413 (S.B. 1829), Sec. 2, eff. June 7, 2021.

Acts 2021, 87th Leg., R.S., Ch. 413 (S.B. 1829), Sec. 3, eff. June 7, 2021.

Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) In this section, "applicant provider" means a physician or other health care provider applying for expedited credentialing under this section.

(b) Notwithstanding any other law and subject to Subsection (c), a managed care organization that contracts with the commission to provide health services to recipients shall, in accordance with this section, establish and implement an expedited credentialing process that would allow applicant providers to provide services to recipients on a provisional basis.

(c) The commission shall identify the types of providers for which an expedited credentialing process must be established and implemented under this section.

(d) To qualify for expedited credentialing under this section and payment under Subsection (e), an applicant provider must:

(1) be a member of an established health care provider group that has a current contract in force with a managed care organization described by Subsection (b);

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described by Subdivision (1); and

(4) submit all documentation and other information required by the managed care organization as necessary to enable the organization to begin the credentialing process required by the organization to include a provider in the organization's provider network.

(e) On submission by the applicant provider of the

information required by the managed care organization under Subsection (d), and for Medicaid reimbursement purposes only, the organization shall treat the provider as if the provider were in the organization's provider network when the provider provides services to recipients, subject to Subsections (f) and (g).

(f) Except as provided by Subsection (g), if, on completion of the credentialing process, a managed care organization determines that the applicant provider does not meet the organization's credentialing requirements, the organization may recover from the provider the difference between payments for in-network benefits and out-of-network benefits.

(g) If a managed care organization determines on completion of the credentialing process that the applicant provider does not meet the organization's credentialing requirements and that the provider made fraudulent claims in the provider's application for credentialing, the organization may recover from the provider the entire amount of any payment paid to the provider.

Added by Acts 2015, 84th Leg., R.S., Ch. 1272 (S.B. 760), Sec. 5, eff. September 1, 2015.

Sec. 533.0065. FREQUENCY OF PROVIDER CREDENTIALING. A managed care organization that contracts with the commission to provide health care services to Medicaid recipients under a managed care plan issued by the organization shall formally recredential a physician or other provider with the frequency required by the single, consolidated Medicaid provider enrollment and credentialing process, if that process is created under Section 531.02118. The required frequency of recredentialing may be less frequent than once in any three-year period, notwithstanding any other law.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.21, eff. September 1, 2015.

Redesignated from Government Code, Section 533.0061 by Acts 2017, 85th Leg., R.S., Ch. 324 (S.B. 1488), Sec. 24.001(18), eff. September 1, 2017.

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. 533.0067. EYE HEALTH CARE SERVICE PROVIDERS. Subject to Section 32.047, Human Resources Code, but notwithstanding any other law, the commission shall require that each managed care organization that contracts with the commission under any Medicaid managed care model or arrangement to provide health care services to recipients in a region include in the organization's provider network each optometrist, therapeutic optometrist, and ophthalmologist described by Section 531.021191(b)(1)(A) or (B) and an institution of higher education described by Section 531.021191(a)(4) in the region who:

(1) agrees to comply with the terms and conditions of the organization;

(2) agrees to accept the prevailing provider contract rate of the organization;

(3) agrees to abide by the standards of care required by the organization; and

(4) is an enrolled provider under Medicaid.

Added by Acts 2017, 85th Leg., R.S., Ch. 901 (H.B. 3675), Sec. 3, eff. September 1, 2017.

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 managed care

organization plans to begin to provide health care services to recipients in that region through managed care. The implementation plan must include:

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

(2) specific time frames for demonstrating preparedness for implementation before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care.

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

(d) Each managed care organization that contracts with the commission to provide health care services to recipients in a region shall submit status reports on the implementation plan not later than the 60th day and the 30th day before the date on which the managed care organization plans to begin to provide health care services to recipients in that region through managed care and every 30th day after that date until the 180th day after that date.

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

(f) The commission may delay enrollment of recipients in a managed care plan issued by a managed care organization if the

review reveals that the managed care organization is not prepared to meet its contractual obligations. The commission shall notify a managed care organization of a decision to delay enrollment in a plan issued by that organization.

(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).

(l) The commission shall establish and implement a process for the direct monitoring of a managed care organization's provider network and providers in the network. The process:

(1) must be used to ensure compliance with contractual obligations related to:

(A) the number of providers accepting new patients under the Medicaid managed care program; and

(B) the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider;

(2) may use reasonable methods to ensure compliance with contractual obligations, including telephone calls made at random times without notice to assess the availability of providers and services to new and existing recipients; and

(3) may be implemented directly by the commission or through a contractor.

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.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.226, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 1272 (S.B. 760), Sec. 6, eff. September 1, 2015.

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 a managed care organization plans to begin to provide health care services to recipients in that region through managed care;

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

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

activities;

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

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

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

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

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

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

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

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.

Amended by:

Acts 2009, 81st Leg., R.S., Ch. 945 (H.B. 3231), Sec. 2, eff. June 19, 2009.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.227, eff. April 2, 2015.

Sec. 533.00751. RECIPIENT DIRECTORY. The commission shall

in accordance with a single source of truth design:

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

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

(B) e-mail address; and

(C) home and work addresses; and

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

Added by Acts 2021, 87th Leg., R.S., Ch. 413 (S.B. 1829), Sec. 1, eff. June 7, 2021.

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

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

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

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

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

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.22, eff. September 1, 2015.

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.

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

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

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 624 (H.B. 4), Sec. 5, eff. June 15, 2021.

Sec. 533.009. SPECIAL DISEASE MANAGEMENT. (a) The commission shall ensure that managed care organizations under contract with the commission to provide health care services to recipients develop and implement special disease management programs to manage a disease or other chronic health conditions, such as heart disease, chronic kidney disease and its medical complications, respiratory illness, including asthma, diabetes, end-stage renal disease, HIV infection, or AIDS, and with respect to which the commission identifies populations for which disease management would be cost-effective.

(b) A managed health care plan provided under this chapter must provide disease management services in the manner required by the commission, including:

(1) patient self-management education;

(2) provider education;

(3) evidence-based models and minimum standards of care;

(4) standardized protocols and participation criteria; and

(5) physician-directed or physician-supervised care.

(c) The executive commissioner, by rule, shall prescribe the minimum requirements that a managed care organization, in providing a disease management program, must meet to be eligible to receive a contract under this section. The managed care organization must, at a minimum, be required to:

(1) provide disease management services that have performance measures for particular diseases that are comparable to the relevant performance measures applicable to a provider of disease management services under Section 32.057, Human Resources Code;

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

(3) if a disease management program provided by the organization has low active participation rates, identify the reason for the low rates and develop an approach to increase active participation in disease management programs for high-risk recipients.

(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.

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.
Amended by:

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.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.228, eff. April 2, 2015.

Acts 2021, 87th Leg., R.S., Ch. 820 (H.B. 2658), Sec. 5, eff. September 1, 2021.

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 inspector general or the office of the attorney general, as applicable, shall review the information submitted under this section as appropriate in the investigation of fraud in the Medicaid managed care program.

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

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.

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.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.229, eff. April 2, 2015.

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

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

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

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

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

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

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

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

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

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

(b) In determining the maximum premium payment rates paid to a managed care organization that is licensed under Chapter 843, Insurance Code, the commission shall consider and adjust for the regional variation in costs of services under the traditional fee-for-service component of Medicaid, utilization patterns, and other factors that influence the potential for cost savings. For a

service area with a service area factor of.93 or less, or another appropriate service area factor, as determined by the commission, the commission may not discount premium payment rates in an amount that is more than the amount necessary to meet federal budget neutrality requirements for projected fee-for-service costs unless:

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

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

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

(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.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.230, eff. April 2, 2015.

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. 533.01315. REIMBURSEMENT FOR SERVICES PROVIDED OUTSIDE OF REGULAR BUSINESS HOURS. (a) This section applies only to a recipient receiving benefits through any Medicaid managed care model or arrangement.

(b) The commission shall ensure that a federally qualified health center, rural health clinic, or municipal health department's public clinic is reimbursed for health care services provided to a recipient outside of regular business hours, including on a weekend or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, regardless of whether the recipient has a referral from the recipient's primary care provider.

(c) The executive commissioner shall adopt rules regarding the days, times of days, and holidays that are considered to be outside of regular business hours for purposes of Subsection (b).

Added by Acts 2007, 80th Leg., R.S., Ch. 298 (H.B. 1579), Sec. 1, eff. September 1, 2007.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.231, eff. April 2, 2015.

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 executive commissioner shall adopt rules regarding the sharing of profits earned by a managed care organization through a managed care plan providing health care services under a contract with the commission under this chapter.

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

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

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.

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.232, eff. April 2, 2015.

Sec. 533.015. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. (a) To the extent possible, the commission shall coordinate all external oversight activities to minimize duplication of oversight of managed care plans under Medicaid and disruption of operations under those plans.

(b) The executive commissioner, after consulting with the commission's office of inspector general, shall by rule define the commission's and office's roles in and jurisdiction over, and frequency of, audits of managed care organizations participating in Medicaid that are conducted by the commission and the commission's office of inspector general.

Text of subsection as amended by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.23(a)

(c) In accordance with Section 531.102(q), the commission shall share with the commission's office of inspector general, at the request of the office, the results of any informal audit or onsite visit that could inform that office's risk assessment when determining whether to conduct, or the scope of, an audit of a

managed care organization participating in Medicaid.

Text of subsection as amended by Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 12

(c) In accordance with Section 531.102(w), the commission shall share with the commission's office of inspector general, at the request of the office, the results of any informal audit or on-site visit that could inform that office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

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 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.233, eff. April 2, 2015.

Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.23(a), eff. September 1, 2015.

Acts 2015, 84th Leg., R.S., Ch. 945 (S.B. 207), Sec. 12, eff. September 1, 2015.

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. 533.0161. 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.

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.

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 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.

Amended by:

Acts 2015, 84th Leg., R.S., Ch. 1 (S.B. 219), Sec. 2.234, eff. April 2, 2015.

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

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

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

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

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

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

(e) The commission may include in the Medicaid managed care

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

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

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

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

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

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

(h) If a recipient who has complex medical needs wants to continue to receive care from a specialty provider that is not in

the provider network of the Medicaid managed care organization offering the managed care plan in which the recipient is enrolled, the managed care organization shall develop a simple, timely, and efficient process to and shall make a good-faith effort to, negotiate a single-case agreement with the specialty provider. Until the Medicaid managed care organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rule, including 1 T.A.C. Section 353.4.

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

Added by Acts 2019, 86th Leg., R.S., Ch. 623 (S.B. 1207), Sec. 6, eff. September 1, 2019.

Amended by:

Acts 2021, 87th Leg., R.S., Ch. 954 (S.B. 1648), Sec. 4, eff. September 1, 2021.

Acts 2021, 87th Leg., R.S., Ch. 954 (S.B. 1648), Sec. 5, eff. September 1, 2021.

Sec. 533.039. DELIVERY OF BENEFITS USING TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY. (a) The commission shall establish policies and procedures to improve access to care under the Medicaid managed care program by encouraging the use of telehealth services, telemedicine medical services, home telemonitoring services, and other telecommunications or information technology under the program.

(b) To the extent permitted by federal law, the executive commissioner by rule shall establish policies and procedures that allow a Medicaid managed care organization to conduct assessments and provide care coordination services using telecommunications or information technology. In establishing the policies and procedures, the executive commissioner shall consider:

(1) the extent to which a managed care organization determines using the telecommunications or information technology

is appropriate;

(2) whether the recipient requests that the assessment or service be provided using telecommunications or information technology;

(3) whether the recipient consents to receiving the assessment or service using telecommunications or information technology;

(4) whether conducting the assessment, including an assessment for an initial waiver eligibility determination, or providing the service in person is not feasible because of the existence of an emergency or state of disaster, including a public health emergency or natural disaster; and

(5) whether the commission determines using the telecommunications or information technology is appropriate under the circumstances.

(c) If a Medicaid managed care organization conducts an assessment of or provides care coordination services to a recipient using telecommunications or information technology, the managed care organization shall:

(1) monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse; and

(2) determine whether additional social services or supports are needed.

(d) To the extent permitted by federal law, the commission shall allow a recipient who is assessed or provided with care coordination services by a Medicaid managed care organization using telecommunications or information technology to provide consent or other authorizations to receive services verbally instead of in writing.

(e) The commission shall determine categories of recipients of home and community-based services who must receive in-person visits. Except during circumstances described by Subsection (b)(4), a Medicaid managed care organization shall, for a recipient of home and community-based services for which the commission requires in-person visits, conduct:

(1) at least one in-person visit with the recipient to make an initial waiver eligibility determination; and

(2) additional in-person visits with the recipient if necessary, as determined by the managed care organization.

(f) Notwithstanding the provisions of this section, the commission may, on a case-by-case basis, require a Medicaid managed care organization to discontinue the use of telecommunications or information technology for assessment or service coordination services if the commission determines that the discontinuation is in the best interest of the recipient.

Added by Acts 2021, 87th Leg., R.S., Ch. 624 (H.B. 4), Sec. 6, eff. June 15, 2021.

SUBCHAPTER B. STRATEGY FOR MANAGING AUDIT RESOURCES

Sec. 533.051. DEFINITIONS.

In this subchapter:

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

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

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

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

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

Sec. 533.052. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER.

This subchapter does not apply to and may not be construed as affecting the conduct of audits by the commission's office of inspector general under the authority provided by Subchapter C, Chapter 531, including an audit of a managed care

organization conducted by the office after coordinating the office's audit and oversight activities with the commission as required by Section 531.102(q), as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015.

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

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

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

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

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

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

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

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

(1) establish a process to:

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

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

(2) establish and implement policies and procedures to:

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

organization based on a performance audit; and

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

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

Sec. 533.055. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS. To enhance the commission's use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, the commission shall:

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

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

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

Sec. 533.056. AUDITS OF PHARMACY BENEFIT MANAGERS. To obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, the commission shall:

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

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

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

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

the commission for audit-related services as required by contract.
Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

Sec. 533.058. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING. To strengthen the commission's process for collecting shared profits from managed care organizations, the commission shall develop, document, and implement monitoring processes in the Medicaid and CHIP services department of the commission to ensure that the commission:

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

(2) timely follows up on and resolves disputes over experience rebates claimed by managed care organizations.

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

Sec. 533.059. USE OF INFORMATION FROM EXTERNAL QUALITY REVIEWS. (a) To enhance the commission's monitoring of managed care organizations, the commission shall use the information provided by the external quality review organization, including:

(1) detailed data from results of surveys of Medicaid recipients and, if applicable, child health plan program enrollees, caregivers of those recipients and enrollees, and Medicaid and, as applicable, child health plan program providers; and

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

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

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

Sec. 533.060. SECURITY AND PROCESSING CONTROLS OVER INFORMATION TECHNOLOGY SYSTEMS. The commission shall:

(1) strengthen user access controls for the

commission's accounts receivable tracking system and network folders that the commission uses to manage the collection of experience rebates;

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

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

(B) the uniform statewide accounting system; and

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

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

(B) the authorization and testing of the changes described by Paragraph (A).

Added by Acts 2017, 85th Leg., R.S., Ch. 909 (S.B. 894), Sec. 4, eff. September 1, 2017.

SUBCHAPTER E. PILOT PROGRAM TO INCREASE INCENTIVE-BASED PROVIDER PAYMENTS

For expiration of this section, see Section 533.084.

Sec. 533.081. DEFINITION. In this subchapter, "pilot program" means the pilot program to increase incentive-based provider payments established under Section 533.082.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.25(a), eff. September 1, 2015.

For expiration of this section, see Section 533.084.

Sec. 533.082. PILOT PROGRAM TO INCREASE INCENTIVE-BASED PROVIDER PAYMENTS. The commission shall develop a pilot program to increase the use and effectiveness of incentive-based provider payments by managed care organizations providing services under the Medicaid managed care program. The commission and the managed care organizations providing those services in at least one managed care service delivery area shall work with health care providers and professional associations composed of health care providers to

develop common payment incentive methodologies for the pilot program that:

(1) are structured to reward appropriate, quality care;

(2) align outcomes of the pilot program with the commission's Medicaid managed care quality-based payment programs;

(3) are not intended to supplant existing incentive-based contracts between the managed care organizations and providers;

(4) are structured to encourage formal arrangements among providers to work together to provide better patient care;

(5) are adopted by all managed care organizations providing services under the Medicaid managed care program through the same managed care service delivery model so that similar incentive methodologies apply to all participating providers under the same model; and

(6) are voluntarily agreed to by the participating providers.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.25(a), eff. September 1, 2015.

Sec. 533.083. ASSESSMENT AND IMPLEMENTATION OF PILOT PROGRAM FINDINGS. Not later than September 1, 2018, and notwithstanding any other law, the commission shall:

(1) based on the results of the pilot program, identify which types of incentive-based provider payment goals and outcome measures are most appropriate for statewide implementation and the services that can be provided using those goals and outcome measures; and

(2) require that a managed care organization that has contracted with the commission to provide health care services to recipients implement the payment goals and outcome measures identified under Subdivision (1).

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.25(a), eff. September 1, 2015.

Sec. 533.084. EXPIRATION. Sections 533.081 and 533.082 and

this section expire September 1, 2018.

Added by Acts 2015, 84th Leg., R.S., Ch. 837 (S.B. 200), Sec. 2.25(a), eff. September 1, 2015.