H.B. No. 2658

AN ACT

relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.0501 and 531.0512 to read as follows:

Sec. 531.0501. MEDICAID WAIVER PROGRAMS: INTEREST LIST MANAGEMENT. (a) The commission, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053, shall study the feasibility of creating an online portal for individuals to request to be placed and check the individual's placement on a Medicaid waiver program interest list. As part of the study, the commission shall determine the most cost-effective automated method for determining the level of need of an individual seeking services through a Medicaid waiver program.

(b) Not later than January 1, 2023, the commission shall prepare and submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the standing legislative committees with primary jurisdiction over health and human services that summarizes the commission's findings and conclusions from the study.

(c) Subsections (a) and (b) and this subsection expire

1 September 1, 2023.

2 (d) The commission shall develop a protocol in the office of
3 the ombudsman to improve the capture and updating of contact
4 information for an individual who contacts the office of the
5 ombudsman regarding Medicaid waiver programs or services.

6 Sec. 531.0512. NOTIFICATION REGARDING CONSUMER DIRECTION
7 MODEL. The commission shall:

8 (1) develop a procedure to:

9 (A) verify that a Medicaid recipient or the
10 recipient's parent or legal guardian is informed regarding the
11 consumer direction model and provided the option to choose to
12 receive care under that model; and

13 (B) if the individual declines to receive care
14 under the consumer direction model, document the declination; and

15 (2) ensure that each Medicaid managed care
16 organization implements the procedure.

17 SECTION 2. Section 533.00251, Government Code, is amended
18 by adding Subsection (h) to read as follows:

19 (h) In addition to the minimum performance standards the
20 commission establishes for nursing facility providers seeking to
21 participate in the STAR+PLUS Medicaid managed care program, the
22 executive commissioner shall adopt rules establishing minimum
23 performance standards applicable to nursing facility providers
24 that participate in the program. The commission is responsible for
25 monitoring provider performance in accordance with the standards
26 and requiring corrective actions, as the commission determines
27 necessary, from providers that do not meet the standards. The

1 commission shall share data regarding the requirements of this
2 subsection with STAR+PLUS Medicaid managed care organizations as
3 appropriate.
4 SECTION 3. Section 533.005(a), Government Code, is amended
5 to read as follows:
6 (a) A contract between a managed care organization and the
7 commission for the organization to provide health care services to
8 recipients must contain:
9 (1) procedures to ensure accountability to the state
10 for the provision of health care services, including procedures for
11 financial reporting, quality assurance, utilization review, and
12 assurance of contract and subcontract compliance;
13 (2) capitation rates that:
14 (A) include acuity and risk adjustment
15 methodologies that consider the costs of providing acute care
16 services and long-term services and supports, including private
17 duty nursing services, provided under the plan; and
18 (B) ensure the cost-effective provision of
19 quality health care;
20 (3) a requirement that the managed care organization
21 provide ready access to a person who assists recipients in
22 resolving issues relating to enrollment, plan administration,
23 education and training, access to services, and grievance
24 procedures;
25 (4) a requirement that the managed care organization
26 provide ready access to a person who assists providers in resolving
27 issues relating to payment, plan administration, education and

1 training, and grievance procedures;

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

6 (6) procedures for recipient outreach and education;

7 (7) a requirement that the managed care organization
8 make payment to a physician or provider for health care services
9 rendered to a recipient under a managed care plan on any claim for
10 payment that is received with documentation reasonably necessary
11 for the managed care organization to process the claim:

12 (A) not later than:

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

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

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

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

25 (7-a) a requirement that the managed care organization
26 demonstrate to the commission that the organization pays claims
27 described by Subdivision (7)(A)(ii) on average not later than the

1 21st day after the date the claim is received by the organization;
2 (8) a requirement that the commission, on the date of a
3 recipient's enrollment in a managed care plan issued by the managed
4 care organization, inform the organization of the recipient's
5 Medicaid certification date;
6 (9) a requirement that the managed care organization
7 comply with Section 533.006 as a condition of contract retention
8 and renewal;
9 (10) a requirement that the managed care organization
10 provide the information required by Section 533.012 and otherwise
11 comply and cooperate with the commission's office of inspector
12 general and the office of the attorney general;
13 (11) a requirement that the managed care
14 organization's usages of out-of-network providers or groups of
15 out-of-network providers may not exceed limits for those usages
16 relating to total inpatient admissions, total outpatient services,
17 and emergency room admissions determined by the commission;
18 (12) if the commission finds that a managed care
19 organization has violated Subdivision (11), a requirement that the
20 managed care organization reimburse an out-of-network provider for
21 health care services at a rate that is equal to the allowable rate
22 for those services, as determined under Sections 32.028 and
23 32.0281, Human Resources Code;
24 (13) a requirement that, notwithstanding any other
25 law, including Sections 843.312 and 1301.052, Insurance Code, the
26 organization:
27 (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

1 network providers and who are of the same or related specialty as
2 the appealing physician to resolve claims disputes related to
3 denial on the basis of medical necessity that remain unresolved
4 subsequent to a provider appeal;

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

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

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

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

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

24 (19) a requirement that the managed care organization
25 develop and establish a process for responding to provider appeals
26 in the region where the organization provides health care services;

27 (20) a requirement that the managed care organization:

1 (A) develop and submit to the commission, before
2 the organization begins to provide health care services to
3 recipients, a comprehensive plan that describes how the
4 organization's provider network complies with the provider access
5 standards established under Section 533.0061;
6 (B) as a condition of contract retention and
7 renewal:
8 (i) continue to comply with the provider
9 access standards established under Section 533.0061; and
10 (ii) make substantial efforts, as
11 determined by the commission, to mitigate or remedy any
12 noncompliance with the provider access standards established under
13 Section 533.0061;
14 (C) pay liquidated damages for each failure, as
15 determined by the commission, to comply with the provider access
16 standards established under Section 533.0061 in amounts that are
17 reasonably related to the noncompliance; and
18 (D) regularly, as determined by the commission,
19 submit to the commission and make available to the public a report
20 containing data on the sufficiency of the organization's provider
21 network with regard to providing the care and services described
22 under Section 533.0061(a) and specific data with respect to access
23 to primary care, specialty care, long-term services and supports,
24 nursing services, and therapy services on the average length of
25 time between:
26 (i) the date a provider requests prior
27 authorization for the care or service and the date the organization

1 approves or denies the request; and
2 (ii) the date the organization approves a
3 request for prior authorization for the care or service and the date
4 the care or service is initiated;
5 (21) a requirement that the managed care organization
6 demonstrate to the commission, before the organization begins to
7 provide health care services to recipients, that, subject to the
8 provider access standards established under Section 533.0061:
9 (A) the organization's provider network has the
10 capacity to serve the number of recipients expected to enroll in a
11 managed care plan offered by the organization;
12 (B) the organization's provider network
13 includes:
14 (i) a sufficient number of primary care
15 providers;
16 (ii) a sufficient variety of provider
17 types;
18 (iii) a sufficient number of providers of
19 long-term services and supports and specialty pediatric care
20 providers of home and community-based services; and
21 (iv) providers located throughout the
22 region where the organization will provide health care services;
23 and
24 (C) health care services will be accessible to
25 recipients through the organization's provider network to a
26 comparable extent that health care services would be available to
27 recipients under a fee-for-service or primary care case management

1 model of Medicaid managed care;
2 (22) a requirement that the managed care organization
3 develop a monitoring program for measuring the quality of the
4 health care services provided by the organization's provider
5 network that:
6 (A) incorporates the National Committee for
7 Quality Assurance's Healthcare Effectiveness Data and Information
8 Set (HEDIS) measures or, as applicable, the national core
9 indicators adult consumer survey and the national core indicators
10 child family survey for individuals with an intellectual or
11 developmental disability;
12 (B) focuses on measuring outcomes; and
13 (C) includes the collection and analysis of
14 clinical data relating to prenatal care, preventive care, mental
15 health care, and the treatment of acute and chronic health
16 conditions and substance abuse;
17 (23) subject to Subsection (a-1), a requirement that
18 the managed care organization develop, implement, and maintain an
19 outpatient pharmacy benefit plan for its enrolled recipients:
20 (A) that, except as provided by Paragraph
21 (L)(ii), exclusively employs the vendor drug program formulary and
22 preserves the state's ability to reduce waste, fraud, and abuse
23 under Medicaid;
24 (B) that adheres to the applicable preferred drug
25 list adopted by the commission under Section 531.072;
26 (C) that, except as provided by Paragraph (L)(i),
27 includes the prior authorization procedures and requirements

1 prescribed by or implemented under Sections 531.073(b), (c), and
2 (g) for the vendor drug program;
3 (C-1) that does not require a clinical,
4 nonpreferred, or other prior authorization for any antiretroviral
5 drug, as defined by Section 531.073, or a step therapy or other
6 protocol, that could restrict or delay the dispensing of the drug
7 except to minimize fraud, waste, or abuse;
8 (D) for purposes of which the managed care
9 organization:
10 (i) may not negotiate or collect rebates
11 associated with pharmacy products on the vendor drug program
12 formulary; and
13 (ii) may not receive drug rebate or pricing
14 information that is confidential under Section 531.071;
15 (E) that complies with the prohibition under
16 Section 531.089;
17 (F) under which the managed care organization may
18 not prohibit, limit, or interfere with a recipient's selection of a
19 pharmacy or pharmacist of the recipient's choice for the provision
20 of pharmaceutical services under the plan through the imposition of
21 different copayments;
22 (G) that allows the managed care organization or
23 any subcontracted pharmacy benefit manager to contract with a
24 pharmacist or pharmacy providers separately for specialty pharmacy
25 services, except that:
26 (i) the managed care organization and
27 pharmacy benefit manager are prohibited from allowing exclusive

1 contracts with a specialty pharmacy owned wholly or partly by the
2 pharmacy benefit manager responsible for the administration of the
3 pharmacy benefit program; and
4 (ii) the managed care organization and
5 pharmacy benefit manager must adopt policies and procedures for
6 reclassifying prescription drugs from retail to specialty drugs,
7 and those policies and procedures must be consistent with rules
8 adopted by the executive commissioner and include notice to network
9 pharmacy providers from the managed care organization;
10 (H) under which the managed care organization may
11 not prevent a pharmacy or pharmacist from participating as a
12 provider if the pharmacy or pharmacist agrees to comply with the
13 financial terms and conditions of the contract as well as other
14 reasonable administrative and professional terms and conditions of
15 the contract;
16 (I) under which the managed care organization may
17 include mail-order pharmacies in its networks, but may not require
18 enrolled recipients to use those pharmacies, and may not charge an
19 enrolled recipient who opts to use this service a fee, including
20 postage and handling fees;
21 (J) under which the managed care organization or
22 pharmacy benefit manager, as applicable, must pay claims in
23 accordance with Section 843.339, Insurance Code;
24 (K) under which the managed care organization or
25 pharmacy benefit manager, as applicable:
26 (i) to place a drug on a maximum allowable
27 cost list, must ensure that:

1 (a) the drug is listed as "A" or "B"
2 rated in the most recent version of the United States Food and Drug
3 Administration's Approved Drug Products with Therapeutic
4 Equivalence Evaluations, also known as the Orange Book, has an "NR"
5 or "NA" rating or a similar rating by a nationally recognized
6 reference; and
7 (b) the drug is generally available
8 for purchase by pharmacies in the state from national or regional
9 wholesalers and is not obsolete;
10 (ii) must provide to a network pharmacy
11 provider, at the time a contract is entered into or renewed with the
12 network pharmacy provider, the sources used to determine the
13 maximum allowable cost pricing for the maximum allowable cost list
14 specific to that provider;
15 (iii) must review and update maximum
16 allowable cost price information at least once every seven days to
17 reflect any modification of maximum allowable cost pricing;
18 (iv) must, in formulating the maximum
19 allowable cost price for a drug, use only the price of the drug and
20 drugs listed as therapeutically equivalent in the most recent
21 version of the United States Food and Drug Administration's
22 Approved Drug Products with Therapeutic Equivalence Evaluations,
23 also known as the Orange Book;
24 (v) must establish a process for
25 eliminating products from the maximum allowable cost list or
26 modifying maximum allowable cost prices in a timely manner to
27 remain consistent with pricing changes and product availability in

1 the marketplace;
2 (vi) must:
3 (a) provide a procedure under which a
4 network pharmacy provider may challenge a listed maximum allowable
5 cost price for a drug;
6 (b) respond to a challenge not later
7 than the 15th day after the date the challenge is made;
8 (c) if the challenge is successful,
9 make an adjustment in the drug price effective on the date the
10 challenge is resolved and make the adjustment applicable to all
11 similarly situated network pharmacy providers, as determined by the
12 managed care organization or pharmacy benefit manager, as
13 appropriate;
14 (d) if the challenge is denied,
15 provide the reason for the denial; and
16 (e) report to the commission every 90
17 days the total number of challenges that were made and denied in the
18 preceding 90-day period for each maximum allowable cost list drug
19 for which a challenge was denied during the period;
20 (vii) must notify the commission not later
21 than the 21st day after implementing a practice of using a maximum
22 allowable cost list for drugs dispensed at retail but not by mail;
23 and
24 (viii) must provide a process for each of
25 its network pharmacy providers to readily access the maximum
26 allowable cost list specific to that provider; and
27 (L) under which the managed care organization or

1 pharmacy benefit manager, as applicable:
2 (i) may not require a prior authorization,
3 other than a clinical prior authorization or a prior authorization
4 imposed by the commission to minimize the opportunity for waste,
5 fraud, or abuse, for or impose any other barriers to a drug that is
6 prescribed to a child enrolled in the STAR Kids managed care program
7 for a particular disease or treatment and that is on the vendor drug
8 program formulary or require additional prior authorization for a
9 drug included in the preferred drug list adopted under Section
10 531.072;
11 (ii) must provide for continued access to a
12 drug prescribed to a child enrolled in the STAR Kids managed care
13 program, regardless of whether the drug is on the vendor drug
14 program formulary or, if applicable on or after August 31, 2023, the
15 managed care organization's formulary;
16 (iii) may not use a protocol that requires a
17 child enrolled in the STAR Kids managed care program to use a
18 prescription drug or sequence of prescription drugs other than the
19 drug that the child's physician recommends for the child's
20 treatment before the managed care organization provides coverage
21 for the recommended drug; and
22 (iv) must pay liquidated damages to the
23 commission for each failure, as determined by the commission, to
24 comply with this paragraph in an amount that is a reasonable
25 forecast of the damages caused by the noncompliance;
26 (24) a requirement that the managed care organization
27 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.

SECTION 4. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00515 to read as follows:

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.

SECTION 5. Section 533.009(c), Government Code, is amended to read as follows:

(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; [~~and~~]

(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.

SECTION 6. Section 32.054, Human Resources Code, is amended by adding Subsection (f) to read as follows:

(f) To prevent serious medical conditions and reduce emergency room visits necessitated by complications resulting from a lack of access to dental care, the commission shall provide medical assistance reimbursement for preventive dental services, including reimbursement for one preventive dental care visit per year, for an adult recipient with a disability who is enrolled in the STAR+PLUS Medicaid managed care program. This subsection does not apply to an adult recipient who is enrolled in the STAR+PLUS home and community-based services (HCBS) waiver program. This

subsection may not be construed to reduce dental services available to persons with disabilities that are otherwise reimbursable under the medical assistance program.

SECTION 7. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0317 to read as follows:

Sec. 32.0317. REIMBURSEMENT FOR SERVICES PROVIDED UNDER SCHOOL HEALTH AND RELATED SERVICES PROGRAM. The executive commissioner shall adopt rules requiring parental consent for services provided under the school health and related services program in order for a school district to receive reimbursement for the services. The rules must allow a school district to seek a waiver to receive reimbursement for services provided to a student who does not have a parent or legal guardian who can provide consent.

SECTION 8. Section 32.0261, Human Resources Code, is amended to read as follows:

Sec. 32.0261. CONTINUOUS ELIGIBILITY. (a) This section applies only to a child younger than 19 years of age who is determined eligible for medical assistance under this chapter.

(b) The executive commissioner shall adopt rules in accordance with 42 U.S.C. Section 1396a(e)(12), as amended, to provide for two consecutive periods of [~~a period of continuous~~] eligibility for a child between each certification and recertification of the child's eligibility, subject to Subsections (f) and (h) [~~under 19 years of age who is determined to be eligible for medical assistance under this chapter~~].

(c) The first of the two consecutive periods of eligibility

described by Subsection (b) must be continuous in accordance with Subsection (d). The second of the two consecutive periods of eligibility is not continuous and may be affected by changes in a child's household income, regardless of whether those changes occurred or whether the commission became aware of the changes during the first or second of the two consecutive periods of eligibility.

(d) A [~~The rules shall provide that the~~] child remains eligible for medical assistance during the first of the two consecutive periods of eligibility, without additional review by the commission and regardless of changes in the child's household [~~resources or~~] income, until [~~the earlier of:~~

[~~(1)~~] the end of the six-month period following the date on which the child's eligibility was determined, except as provided by Subsections (f)(1) and (h) [~~; or~~

[~~(2) the child's 19th birthday~~].

(e) During the sixth month following the date on which a child's eligibility for medical assistance is certified or recertified, the commission shall, in a manner that complies with federal law, including verification plan requirements under 42 C.F.R. Section 435.945(j), review the child's household income using electronic income data available to the commission. The commission may conduct this review only once during the child's two consecutive periods of eligibility. Based on the review:

(1) the commission shall, if the review indicates that the child's household income does not exceed the maximum income for eligibility for the medical assistance program, provide for a

second consecutive period of eligibility for the child until the child's required annual recertification, except as provided by Subsection (h) and subject to Subsection (c); or

(2) the commission may, if the review indicates that the child's household income exceeds the maximum income for eligibility for the medical assistance program, request additional documentation to verify the child's household income in a manner that complies with federal law.

(f) If, after reviewing a child's household income under Subsection (e), the commission determines that the household income exceeds the maximum income for eligibility for the medical assistance program, the commission shall continue to provide medical assistance to the child until:

(1) the commission provides the child's parent or guardian with a period of not less than 30 days to provide documentation demonstrating that the child's household income does not exceed the maximum income for eligibility; and

(2) the child's parent or guardian fails to provide the documentation during the period described by Subdivision (1).

(g) If a child's parent or guardian provides to the commission within the period described by Subsection (f) documentation demonstrating that the child's household income does not exceed the maximum income for eligibility for the medical assistance program, the commission shall provide for a second consecutive period of eligibility for the child until the child's required annual recertification, except as provided by Subsection (h) and subject to Subsection (c).

(h) Notwithstanding any other period prescribed by this section, a child's eligibility for medical assistance ends on the child's 19th birthday.

(i) The commission may not recertify a child's eligibility for medical assistance more frequently than every 12 months as required by federal law.

(j) If a child's parent or guardian fails to provide to the commission within the period described by Subsection (f) documentation demonstrating that the child's household income does not exceed the maximum income for eligibility for the medical assistance program, the commission shall provide the child's parent or guardian with written notice of termination following that period. The notice must include a statement that the child may be eligible for enrollment in the child health plan under Chapter 62, Health and Safety Code.

(k) In developing the notice, the commission shall consult with health care providers, children's health care advocates, family members of children enrolled in the medical assistance program, and other stakeholders to determine the most user-friendly method to provide the notice to a child's parent or guardian.

(l) The executive commissioner may adopt rules as necessary to implement this section.

SECTION 9. (a) In this section, "commission," "executive commissioner," and "Medicaid" have the meanings assigned by Section 531.001, Government Code.

(b) Using existing resources, the commission shall:

(1) review the commission's staff rate enhancement

programs to:

(A) identify and evaluate methods for improving administration of those programs to reduce administrative barriers that prevent an increase in direct care staffing and direct care wages and benefits in nursing homes; and

(B) develop recommendations for increasing participation in the programs;

(2) revise the commission's policies regarding the quality incentive payment program (QIPP) to require improvements to staff-to-patient ratios in nursing facilities participating in the program by January 1, 2025; and

(3) identify factors influencing active participation by Medicaid recipients in disease management programs by examining variations in:

(A) eligibility criteria for the programs; and

(B) participation rates by health plan, disease management program, and year.

(c) The executive commissioner may approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model.

SECTION 10. (a) In this section, "commission" and "Medicaid" have the meanings assigned by Section 531.001, Government Code.

(b) As soon as practicable after the effective date of this Act, the commission shall conduct a study to determine the cost-effectiveness and feasibility of providing to Medicaid recipients who have been diagnosed with diabetes, including Type 1

1 diabetes, Type 2 diabetes, and gestational diabetes:
2 (1) diabetes self-management education and support
3 services that follow the National Standards for Diabetes
4 Self-Management Education and Support and that may be delivered by
5 a certified diabetes educator; and
6 (2) medical nutrition therapy services.
7 (c) If the commission determines that providing one or both
8 of the types of services described by Subsection (b) of this section
9 would improve health outcomes for Medicaid recipients and lower
10 Medicaid costs, the commission shall, notwithstanding Section
11 32.057, Human Resources Code, or Section 533.009, Government Code,
12 and to the extent allowed by federal law develop a program to
13 provide the benefits and seek prior approval from the Legislative
14 Budget Board before implementing the program.
15 SECTION 11. (a) In this section, "commission" and
16 "Medicaid" have the meanings assigned by Section 531.001,
17 Government Code.
18 (b) As soon as practicable after the effective date of this
19 Act, the commission shall conduct a study to:
20 (1) identify benefits and services provided under
21 Medicaid that are not provided in this state under the Medicaid
22 managed care model; and
23 (2) evaluate the feasibility, cost-effectiveness, and
24 impact on Medicaid recipients of providing the benefits and
25 services identified under Subdivision (1) of this subsection
26 through the Medicaid managed care model.
27 (c) Not later than December 1, 2022, the commission shall

1 prepare and submit a report to the legislature that includes:
2 (1) a summary of the commission's evaluation under
3 Subsection (b)(2) of this section; and
4 (2) a recommendation as to whether the commission
5 should implement providing benefits and services identified under
6 Subsection (b)(1) of this section through the Medicaid managed care
7 model.
8 SECTION 12. (a) In this section:
9 (1) "Commission," "Medicaid," and "Medicaid managed
10 care organization" have the meanings assigned by Section 531.001,
11 Government Code.
12 (2) "Dually eligible individual" has the meaning
13 assigned by Section 531.0392, Government Code.
14 (b) The commission shall conduct a study regarding dually
15 eligible individuals who are enrolled in the Medicaid managed care
16 program. The study must include an evaluation of:
17 (1) Medicare cost-sharing requirements for those
18 individuals;
19 (2) the cost-effectiveness for a Medicaid managed care
20 organization to provide all Medicaid-eligible services not covered
21 under Medicare and require cost-sharing for those services; and
22 (3) the impact on dually eligible individuals and
23 Medicaid providers that would result from the implementation of
24 Subdivision (2) of this subsection.
25 (c) Not later than September 1, 2022, the commission shall
26 prepare and submit a report to the legislature that includes:
27 (1) a summary of the commission's findings from the

1 study conducted under Subsection (b) of this section; and
2 (2) a recommendation as to whether the commission
3 should implement Subsection (b)(2) of this section.
4 SECTION 13. (a) Using existing resources, the Health and
5 Human Services Commission shall conduct a study to assess the
6 impact of revising the capitation rate setting strategy used to
7 cover long-term care services and supports provided to recipients
8 under the STAR+PLUS Medicaid managed care program from a strategy
9 based on the setting in which services are provided to a strategy
10 based on a blended rate. The study must:
11 (1) assess the potential impact using a blended
12 capitation rate would have on recipients' choice of setting;
13 (2) include an actuarial analysis of the impact using
14 a blended capitation rate would have on program spending; and
15 (3) consider the experience of other states that use a
16 blended capitation rate to reimburse managed care organizations for
17 the provision of long-term care services and supports under
18 Medicaid.
19 (b) Not later than September 1, 2022, the Health and Human
20 Services Commission shall prepare and submit a report that
21 summarizes the findings of the study conducted under Subsection (a)
22 of this section to the governor, the lieutenant governor, the
23 speaker of the house of representatives, the House Human Services
24 Committee, and the Senate Health and Human Services Committee.
25 SECTION 14. Notwithstanding Section 2, Chapter 1117 (H.B.
26 3523), Acts of the 84th Legislature, Regular Session, 2015, Section
27 533.00251(c), Government Code, as amended by Section 2 of that Act,

1 takes effect September 1, 2023.
2 SECTION 15. (a) Section 533.005(a), Government Code, as
3 amended by this Act, applies only to a contract between the Health
4 and Human Services Commission and a managed care organization that
5 is entered into or renewed on or after the effective date of this
6 Act.
7 (b) To the extent permitted by the terms of the contract,
8 the Health and Human Services Commission shall seek to amend a
9 contract entered into before the effective date of this Act with a
10 managed care organization to comply with Section 533.005(a),
11 Government Code, as amended by this Act.
12 SECTION 16. As soon as practicable after the effective date
13 of this Act, the Health and Human Services Commission shall conduct
14 the study and make the determination required by Section
15 531.0501(a), Government Code, as added by this Act.
16 SECTION 17. If before implementing any provision of this
17 Act a state agency determines that a waiver or authorization from a
18 federal agency is necessary for implementation of that provision,
19 the agency affected by the provision shall request the waiver or
20 authorization and may delay implementing that provision until the
21 waiver or authorization is granted.
22 SECTION 18. The Health and Human Services Commission is
23 required to implement this Act only if the legislature appropriates
24 money specifically for that purpose. If the legislature does not
25 appropriate money specifically for that purpose, the commission
26 may, but is not required to, implement this Act using other
27 appropriations available for the purpose.

1 SECTION 19. This Act takes effect September 1, 2021.

______________________________ President of the Senate

______________________________ Speaker of the House

I certify that H.B. No. 2658 was passed by the House on April 21, 2021, by the following vote: Yeas 147, Nays 0, 2 present, not voting; that the House refused to concur in Senate amendments to H.B. No. 2658 on May 27, 2021, and requested the appointment of a conference committee to consider the differences between the two houses; and that the House adopted the conference committee report on H.B. No. 2658 on May 30, 2021, by the following vote: Yeas 135, Nays 0, 2 present, not voting.

______________________________ Chief Clerk of the House

H.B. No. 2658

I certify that H.B. No. 2658 was passed by the Senate, with amendments, on May 22, 2021, by the following vote: Yeas 31, Nays 0; at the request of the House, the Senate appointed a conference committee to consider the differences between the two houses; and that the Senate adopted the conference committee report on H.B. No. 2658 on May 30, 2021, by the following vote: Yeas 31, Nays 0.

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Secretary of the Senate

APPROVED: _____________________
Date

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Governor