S.B. No. 1648

AN ACT

relating to the provision of benefits under the Medicaid program, including to recipients with complex medical needs.

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.024165 to read as follows:

Sec. 531.024165. MEDICAL REVIEW OF MEDICAID SERVICE DENIALS FOR FOSTER CARE YOUTH. (a) Using existing resources, the commission shall coordinate with the Department of Family and Protective Services to develop and implement a process to review a denial of services under the Medicaid managed care program on the basis of medical necessity for foster care youth.

(b) Not later than December 31, 2022, the commission and the Department of Family and Protective Services shall submit a report to the legislature that includes a summary of the process developed and implemented under Subsection (a).

(c) This section expires September 1, 2023.

SECTION 2. Section 531.024172(d), Government Code, is amended to read as follows:

(d) In implementing the electronic visit verification system:

(1) subject to Subsection (e), the executive commissioner shall adopt compliance standards for health care providers; and

(2) the commission shall ensure that:

(A) the information required to be reported by health care providers is standardized across managed care organizations that contract with the commission to provide health care services to Medicaid recipients and across commission programs;

(B) processes required by managed care organizations to retrospectively correct data are standardized and publicly accessible to health care providers; [~~and~~]

(C) standardized processes are established for addressing the failure of a managed care organization to provide a timely authorization for delivering services necessary to ensure continuity of care; and

(D) a health care provider is allowed to enter a variable schedule into the electronic visit verification system.

SECTION 3. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.0501, 531.0512, and 531.0605 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 and the STAR Kids Managed Care Advisory Committee, 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 appropriate and cost-effective automated method for

1 determining the level of need of an individual seeking services
2 through a Medicaid waiver program.
3 (b) Not later than January 1, 2023, the commission shall
4 prepare and submit a report to the governor, the lieutenant
5 governor, the speaker of the house of representatives, and the
6 standing legislative committees with primary jurisdiction over
7 health and human services that summarizes the commission's findings
8 and conclusions from the study.
9 (c) Subsections (a) and (b) and this subsection expire
10 September 1, 2023.
11 (d) The commission shall develop a protocol in the office of
12 the ombudsman to improve the capture and updating of contact
13 information for an individual who contacts the office of the
14 ombudsman regarding Medicaid waiver programs or services.
15 Sec. 531.0512. NOTIFICATION REGARDING CONSUMER DIRECTION
16 MODEL. The commission shall:
17 (1) develop a procedure to:
18 (A) verify that a Medicaid recipient or the
19 recipient's parent or legal guardian is informed regarding the
20 consumer direction model and provided the option to choose to
21 receive care under that model; and
22 (B) if the individual declines to receive care
23 under the consumer direction model, document the declination; and
24 (2) ensure that each Medicaid managed care
25 organization implements the procedure.
26 Sec. 531.0605. ADVANCING CARE FOR EXCEPTIONAL KIDS PILOT
27 PROGRAM. (a) The commission shall collaborate with the STAR Kids

1 Managed Care Advisory Committee, Medicaid recipients, family
2 members of children with complex medical conditions, children's
3 health care advocates, Medicaid managed care organizations, and
4 other stakeholders to develop and implement a pilot program that is
5 substantially similar to the program described by Section 3,
6 Medicaid Services Investment and Accountability Act of 2019 (Pub.
7 L. No. 116-16), to provide coordinated care through a health home
8 to children with complex medical conditions.
9 (b) The commission shall seek guidance from the Centers for
10 Medicare and Medicaid Services and the United States Department of
11 Health and Human Services regarding the design of the program and,
12 based on the guidance, may actively seek and apply for federal
13 funding to implement the program.
14 (c) Not later than December 31, 2024, the commission shall
15 prepare and submit a report to the legislature that includes:
16 (1) a summary of the commission's implementation of
17 the pilot program; and
18 (2) if the pilot program has been operating for a
19 period sufficient to obtain necessary data, a summary of the
20 commission's evaluation of the effect of the pilot program on the
21 coordination of care for children with complex medical conditions
22 and a recommendation as to whether the pilot program should be
23 continued, expanded, or terminated.
24 (d) The pilot program terminates and this section expires
25 September 1, 2025.
26 SECTION 4. The heading to Section 533.038, Government Code,
27 is amended to read as follows:

Sec. 533.038. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS.

SECTION 5. Section 533.038, Government Code, is amended by amending Subsection (g) and adding Subsections (h) and (i) to read as follows:

(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.

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. Section 531.0601(f), Government Code, is repealed.

SECTION 8. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money to the commission specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement a provision of this Act using other appropriations that are available for that purpose.

SECTION 9. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or

1 authorization and may delay implementing that provision until the
2 waiver or authorization is granted.
3 SECTION 10. This Act takes effect September 1, 2021.

S.B. No. 1648

______________________________ ______________________________
President of the Senate Speaker of the House

I hereby certify that S.B. No. 1648 passed the Senate on May 12, 2021, by the following vote: Yeas 30, Nays 0; May 27, 2021, Senate refused to concur in House amendments and requested appointment of Conference Committee; May 28, 2021, House granted request of the Senate; May 30, 2021, Senate adopted Conference Committee Report by the following vote: Yeas 31, Nays 0.

____
Secretary of the Senate

I hereby certify that S.B. No. 1648 passed the House, with amendments, on May 24, 2021, by the following vote: Yeas 141, Nays 1, one present not voting; May 28, 2021, House granted request of the Senate for appointment of Conference Committee; May 30, 2021, House adopted Conference Committee Report by the following vote: Yeas 137, Nays 0, two present not voting.

____
Chief Clerk of the House

Approved:

____
Date

____
Governor