

BILL ANALYSIS

C.S.S.B. 1105
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has been suggested that the Medicaid process is encumbered with inefficiencies resulting in denied claims and payments, complexities for health care providers participating in the program, and certain barriers to care for some patients, including medically fragile children. C.S.S.B. 1105 seeks to address these issues by instituting certain reforms to the current Medicaid program, including with regard to changes in fees, charges, and rates for payments; ensuring efficiencies in provider enrollment; increasing public access to Medicaid data and health outcomes; and providing for a standardized process for complaints and for the procedures for prior authorizations for care.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 2 and 10 of this bill.

ANALYSIS

C.S.S.B. 1105 amends the Government Code to require the Health and Human Services Commission (HHSC) to adopt policies related to the determination of fees, charges, and rates for payments under Medicaid to ensure, to the greatest extent possible, that changes to a fee schedule are implemented in a way that minimizes administrative complexity, financial uncertainty, and retroactive adjustments for providers. The bill sets out certain required actions for HHSC in adopting the policies and establishes that these provisions do not apply to changes to the fees, charges, or rates for payments made to a nursing facility or to capitation rates paid to a Medicaid managed care organization (MCO). The adopted policies apply only to a change to a fee, charge, or rate that takes effect on or after January 1, 2021.

C.S.S.B. 1105 requires HHSC to do the following with respect to Medicaid provider identifier numbers:

- transition from using a state-issued provider identifier number to using only a national provider identifier number;
- implement, not later than September 1, 2020, a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid; and

- implement, not later than September 1, 2023, a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services.

C.S.S.B. 1105 requires HHSC to do the following with respect to grievances related to Medicaid:

- adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within HHSC to ensure all grievances are managed consistently;
- standardize Medicaid grievance data reporting and tracking among divisions within HHSC;
- implement a no-wrong-door system for Medicaid grievances reported to HHSC;
- establish a procedure for expedited resolution of a grievance that allows HHSC to identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution and to resolve the grievance within a specified period;
- verify grievance data reported by a Medicaid MCO;
- aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances; and
- make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider.

C.S.S.B. 1105 requires HHSC, to the extent permitted by federal law and in consultation and collaboration with the appropriate advisory committees related to Medicaid, to make available to the public on its website in an easy-to-read format data relating to the quality of health care received by Medicaid recipients and the health outcomes of those recipients. The bill requires the data made available to the public to be made available in a manner that does not identify or allow for the identification of individual recipients. The bill authorizes HHSC, in performing these duties, to collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data.

C.S.S.B. 1105 requires HHSC to ensure that notice sent by HHSC or a Medicaid MCO to a Medicaid recipient or provider regarding the denial of coverage or prior authorization for a service includes the following:

- information required by federal and state law and applicable regulations;
- for the recipient, a clear and easy-to-understand explanation of the reason for the denial; and
- for the provider, a thorough and detailed clinical explanation of the reason for the denial.

The bill requires HHSC or a Medicaid MCO that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request to issue a notice to the provider and the Medicaid recipient on whose behalf the request was submitted. The bill sets out requirements for the contents of that notice and the manner in which it is to be sent to the provider.

C.S.S.B. 1105 requires the executive commissioner of HHSC by rule to require each Medicaid MCO or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the MCO or entity maintains certain information related to Medicaid prior authorization requirements on the website of the MCO or entity, as applicable, in an easily searchable and accessible format. The bill requires the executive commissioner by rule to require each such MCO or entity to do the following:

- adopt and maintain a process for a provider or Medicaid recipient to contact the MCO or entity to clarify prior authorization requirements or assist the provider or recipient in submitting a prior authorization request; and
- ensure that the process is not arduous or overly burdensome to a provider or recipient.

C.S.S.B. 1105 requires HHSC, to the greatest extent possible, to consolidate policy manuals, handbooks, and other informational documents into one Medicaid medical benefits policy manual to clarify and provide guidance on the policies under the Medicaid managed care delivery model. The bill requires HHSC to periodically update the Medicaid medical benefits policy manual to reflect policies adopted or amended by HHSC.

C.S.S.B. 1105 requires a consumer direction model, including the consumer-directed service option, for the delivery of services under the medically dependent children Medicaid waiver program to allow for the delivery of all services and supports available under that program through consumer direction.

C.S.S.B. 1105 requires the executive commissioner, using existing resources and in consultation and collaboration with the STAR Kids Managed Care Advisory Committee, to determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an accountable care organization model in accordance with guidelines established by the federal Centers for Medicare and Medicaid Services (CMS) or an alternative model developed by or in collaboration with the CMS Innovation Center. The bill requires HHSC, not later than December 1, 2022, to prepare and submit a written report to the legislature of the executive commissioner's determination. These provisions expire September 1, 2023.

C.S.S.B. 1105 provides for an annual review of the prior authorization requirements of each Medicaid MCO, other than a prior authorization requirement prescribed by or implemented for the Medicaid vendor drug program, and for the inclusion in a Medicaid managed care contract of a requirement for the applicable MCO to establish a process for reconsidering an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. The bill sets out related provisions and requires HHSC to seek to amend a contract entered into before the bill's effective date to include the provisions establishing the reconsideration procedure.

C.S.S.B. 1105 exempts a Medicaid MCO or a utilization review agent who conducts utilization reviews for a Medicaid MCO from the application of Insurance Code provisions regulating the time within which a notice of an adverse determination is to be provided.

C.S.S.B. 1105 requires a managed care plan offered by a Medicaid MCO to be accredited by a nationally recognized accreditation organization. The bill authorizes HHSC to choose whether to require all managed care plans offered by Medicaid MCOs to be accredited by the same organization or to allow for accreditation by different organizations. The bill authorizes HHSC to use the data, scoring, and other information provided to or received from an accreditation organization in the contract oversight processes. The bill requires HHSC to require that a managed care plan offered by an MCO with which HHSC enters into or renews a Medicaid managed care contract on or after the bill's effective date comply with these provisions not later than September 1, 2022.

C.S.S.B. 1105 requires HHSC to issue a request for information to seek information and comments regarding contracting with an MCO to arrange for or provide a managed care plan under the STAR Kids managed care program throughout the state instead of on a regional basis.

C.S.S.B. 1105 requires HHSC, using available resources, to report available data on the 30-day limitation on reimbursement for inpatient hospital care provided to Medicaid recipients enrolled in the STAR+PLUS Medicaid managed care program. The bill requires HHSC, not later than

December 1, 2020, to submit the report containing the data to the governor, the legislature, and the Legislative Budget Board and authorizes the report to be combined with any other required report. The bill requires HHSC, to the extent data is available on the subject, to also report on the following:

- the number of Medicaid recipients affected by the limitation and their clinical outcomes; and
- the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days and any cost savings achieved by the limitation under Medicaid.

C.S.S.B. 1105 requires the executive commissioner to adopt rules necessary to implement the bill's changes. HHSC is required to implement a provision of the bill only if the legislature appropriates money specifically for that purpose. If the legislature does not make such a specific appropriation, HHSC may, but is not required to, implement a provision of the bill using other appropriations available for that purpose.

EFFECTIVE DATE

September 1, 2019.

COMPARISON OF SENATE ENGROSSED AND SUBSTITUTE

While C.S.S.B. 1105 may differ from the engrossed in minor or nonsubstantive ways, the following summarizes the substantial differences between the engrossed and committee substitute versions of the bill.

The substitute includes provisions relating to the following:

- the adoption of policies for implementing changes to fees, charges, and rates for payments under Medicaid;
- the issuance of a notice to a Medicaid provider from which HHSC receives a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request and to the applicable Medicaid recipient on whose behalf the request was submitted;
- the accessibility of information regarding Medicaid prior authorization requirements;
- the creation of a consolidated Medicaid medical benefits policy manual;
- an annual review of certain Medicaid MCO prior authorization requirements;
- an exemption from certain Insurance Code provisions for a Medicaid MCO or a utilization review agency who conducts utilization reviews for a Medicaid MCO; and
- reconsideration following adverse determinations on certain prior authorization requests.

The substitute revises provisions establishing requirements for the notice sent to a Medicaid recipient or provider regarding the denial of coverage or prior authorization for a service by:

- requiring the notice to also include information required by state law and applicable state and federal regulations; and
- requiring the clinical explanation given to the provider regarding the reason for the denial to be thorough and detailed.

The substitute does not include a provision authorizing HHSC to implement the immediately preceding notice requirements at the same time as other required or scheduled notice changes to ensure cost-effectiveness.

The substitute does not revise or set out additional provisions relating to a care needs assessment provided by a care management service.

The substitute does not include provisions requiring the STAR Kids Managed Care Advisory Committee to advise HHSC on the operation of the STAR Kids managed care program and make recommendations for improvements to that program.

The substitute includes additional procedural provisions establishing the applicability of certain provisions set out by the substitute and requiring HHSC to seek to amend certain Medicaid managed care contracts.

The substitute includes a procedural provision requiring the executive commissioner to adopt rules necessary to implement the bill's changes to law.