

BILL ANALYSIS

Senate Research Center

S.B. 1207
By: Perry
Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Many children enrolled in the Medically Dependent Child Program (MDCP) are also covered by commercial primary insurance or another primary insurance, meaning the Medicaid managed care program provides secondary coverage. In these situations, Medicaid is always the payer of last resort.

Before a managed care organization (MCO) will act on a claim or an authorization, it must first be acted upon by the commercial primary if there is one. This can create significant delay between the determination on the part of the primary, notification to the provider, re-submittal by the provider to the MCO, and the time the MCO processes the claim. Many times these authorizations are time-sensitive, and children have had major surgeries cancelled, critical medications denied, and medically necessary services or equipment significantly delayed, resulting in the child's condition deteriorating and causing further complications or increased ER visits.

S.B. 1207 will put in place parameters and framework to remove some of the barriers that are causing delays, conflicts, and lack of coordination, and will require the agency and managed care organizations to implement policies and procedures that will (1) allow maximum utilization of commercial insurance coverage, thus increasing cost-effectiveness; and (2) reduce unnecessary delays and conflicts in processing the child's Medicaid claims under the managed care program. (Original Author's/Sponsor's Statement of Intent)

S.B. 1207 amends current law relating to the operation and administration of Medicaid, including the Medicaid managed care program and the medically dependent children (MDCP) waiver program.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commissioner) in SECTION 3 and 8 (Section 531.024163, Government Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTION 2 (Section 531.024, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.001, Government Code, by adding Subdivision (4-c) to define "Medicaid managed care organization."

SECTION 2. Amends Section 531.024, Government Code, by amending Subsection (b) and adding Subsection (c), as follows:

(b) Requires the fair hearing rules for Medicaid-funded services promulgated by the executive commissioner of the Health and Human Services Commission (executive commissioner; HHSC) to provide certain protections, including requiring that the written notice to an individual of the individual's right to a hearing to be delivered by mail, and

postmarked at least 10 business days before a certain date, rather than be mailed at least 10 days before a certain date.

(c) Requires HHSC to develop a process to address a situation in which an individual does not receive adequate notice as required by Subsection (b)(1) or the notice required by Subsection (b)(1) is delivered without a postmark.

SECTION 3. (a) Provides that, to the extent of any conflict, Section 531.024162, Government Code, as added by this section, prevails over any provision of another Act of the 86th Legislature, Regular Session, 2019, relating to notice requirements regarding Medicaid coverage or prior authorization denials or incomplete requests, that becomes law.

(b) Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.024162, 531.024163, 531.024164, 531.0601, 531.0602, 531.06021, 531.0603, and 531.0604, as follows:

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING MEDICAID COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS. (a) Requires HHSC to ensure that notice sent by HHSC or a Medicaid managed care organization to a Medicaid recipient or provider regarding the denial, partial denial, reduction, or termination of coverage or denial of prior authorization for a service includes:

(1) information required by federal and state law and applicable regulations;

(2) for the recipient:

(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;

(B) a copy of the information sent to the provider; and

(C) an educational component that includes a description of the recipient's rights, an explanation of the process related to appeals and Medicaid fair hearings, and a description of the role of an external medical review; and

(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, including, as applicable, information required under Subsection (b).

(b) Requires HHSC or a Medicaid managed care organization 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. Requires the notice issued under this subsection to:

(1) include a section specifically for the provider that contains:

(A) a clear and specific list and description of the documentation necessary for HHSC or the organization to make a final determination on the request;

(B) the applicable timeline, based on the requested service, for the provider to submit the documentation and a

description of the reconsideration process described by Section 533.00284, if applicable; and

(C) information on the manner through which a provider may contact a Medicaid managed care organization or other entity as required by Section 531.024163; and

(2) be sent:

(A) to the provider:

(i) using the provider's preferred method of communication, to the extent practicable using existing resources; and

(ii) as applicable, through an electronic notification on an Internet portal; and

(B) to the recipient using the recipient's preferred method of communication, to the extent practicable using existing resources.

Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING MEDICAID PRIOR AUTHORIZATION REQUIREMENTS. (a) Requires the executive commissioner by rule to require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the organization or entity maintains on the organization's or entity's Internet website in an easily searchable and accessible format:

(1) the applicable timelines for prior authorization requirements, including:

(A) the time within which the organization or entity is required to make a determination on a prior authorization request;

(B) a description of the notice the organization or entity provides to a provider and Medicaid recipient on whose behalf the request was submitted regarding the documentation required to complete a determination on a prior authorization request; and

(C) the deadline by which the organization or entity is required to submit the notice described by Paragraph (B); and

(2) an accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, including:

(A) for a prior authorization requirement first imposed on or after September 1, 2019, the effective date of the requirement;

(B) a list or description of any supporting or other documentation necessary to obtain prior authorization for a specified service; and

(C) the date and results of each review of the prior authorization requirement conducted under Section 533.00283, if applicable.

(b) Requires the executive commissioner by rule to require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to:

(1) adopt and maintain a process for a provider or Medicaid recipient to contact the organization or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request; and

(2) ensure that the process described by Subdivision (1) is not arduous or overly burdensome to a provider or recipient.

Sec. 531.024164. EXTERNAL MEDICAL REVIEW. (a) Provides that, in this section, "external medical reviewer" and "reviewer" mean a third-party medical review organization that provides objective, unbiased medical necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with applicable state law and rules.

(b) Requires HHSC to contract with an independent external medical reviewer to conduct external medical reviews and review:

(1) the resolution of a Medicaid recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program; or

(2) a denial by HHSC of eligibility for a Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs.

(c) Prohibits a Medicaid managed care organization from having a financial relationship with or ownership interest in the external medical reviewer with which HHSC contracts.

(d) Requires the external medical reviewer with which HHSC contracts to:

(1) be overseen by a medical director who is a physician licensed in this state; and

(2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.

(e) Requires HHSC to establish a common procedure for reviews. Requires the procedure, to the greatest extent possible, to reduce administrative burdens on providers and the submission of duplicative information or documents. Requires medical necessity under the procedure to be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. Requires the reviewer to conduct the review within a period specified by HHSC. Requires HHSC to also establish a procedure and time frame for expedited reviews that allows the reviewer to identify an appeal that requires an expedited resolution and to resolve the review of the appeal within a specified period.

(f) Requires a Medicaid recipient or applicant, or the recipient's or applicant's parent or legally authorized representative, to affirmatively request an external medical review. Provides that, if requested:

(1) an external medical review described by Subsection (b)(1) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing and is granted when a Medicaid recipient contests the internal appeal decision of the Medicaid managed care organization; and

(2) an external medical review described by Subsection (b)(2) occurs after the eligibility denial and before the Medicaid fair hearing.

(g) Provides that the external medical reviewer's determination of medical necessity establishes the minimum level of services a Medicaid recipient is required to receive, except that the level of services is prohibited from exceeding the level identified as medically necessary by the ordering health care provider.

(h) Requires the external medical reviewer to require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

(i) Requires HHSC, to the extent money is appropriated for this purpose, to publish data regarding prior authorizations reviewed by the external medical reviewer, including the rate of prior authorization denials overturned by the external medical reviewer and additional information HHSC and the external medical reviewer determine appropriate.

Sec. 531.0601. LONG-TERM CARE SERVICES WAIVER PROGRAM INTEREST LISTS. (a) Provides that this section applies only to a child who is enrolled in the medically dependent children (MDCP) waiver program but becomes ineligible for services under the program because the child no longer meets:

(1) the level of care criteria for medical necessity for nursing facility care; or

(2) the age requirement for the program.

(b) Authorizes a legally authorized representative of a child who is notified by HHSC that the child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, to request that HHSC return the child to the interest list for the program unless the child is ineligible due to the child's age or place the child on the interest list for another Section 1915(c) waiver program.

(c) Requires HHSC, at the time a child's legally authorized representative makes a request under Subsection (b), to:

(1) for a child who becomes ineligible for the reason described by Subsection (a)(1), place the child:

(A) on the interest list for the medically dependent children (MDCP) waiver program in the first position on the list; or

(B) except as provided by Subdivision (3), on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program;

(2) except as provided by Subdivision (3), for a child who becomes ineligible for the reason described by Subsection (a)(2), place the child on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program; or

(3) for a child who becomes ineligible for a reason described by Subsection (a) and who is already on an interest list for another Section 1915(c) waiver program, move the child to a position on the interest list relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program, if that date is earlier than the date the child was initially placed on the interest list for the other waiver program.

(d) Authorizes a child, notwithstanding Subsection (c)(1)(B) or (c)(2), to be placed on an interest list for a Section 1915(c) waiver program in the position described by those subsections only if the child has previously been placed on the interest list for that waiver program.

(e) Requires HHSC, at the time HHSC provides notice to a legally authorized representative that a child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, to inform the representative in writing about:

(1) the options under this section for placing the child on an interest list; and

(2) the process for applying for the Medicaid buy-in program for children with disabilities implemented under Section 531.02444 (Medicaid Buy-In Programs For Certain Persons With Disabilities).

(f) Provides that this section expires December 1, 2021.

Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM ASSESSMENTS AND REASSESSMENTS. (a) Requires HHSC to ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program provides the results of the initial assessment or annual reassessment of medical necessity to the parent or legally authorized representative of a recipient receiving benefits under the medically dependent children (MDCP) waiver program for review. Requires HHSC to ensure the provision of the results does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services.

(b) Requires HHSC to require the parent's or representative's signature to verify the parent or representative received the results of the initial assessment or reassessment from the care coordinator under Subsection (a). Prohibits a Medicaid managed care organization from delaying the delivery of care pending the signature.

(c) Requires HHSC to provide a parent or representative who disagrees with the results of the initial assessment or reassessment an opportunity to request to dispute the results with the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice.

(d) Provides that this section does not affect any rights of a recipient to appeal an initial assessment or reassessment determination through the Medicaid managed care organization's internal appeal process, the Medicaid fair hearing process, or the external medical review process.

Sec. 531.06021. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM QUALITY MONITORING; REPORT. (a) Requires HHSC, based on the state's external quality review organization's initial report on the STAR Kids managed care program, to determine whether the findings of the report necessitate additional data and research to improve the program. Authorizes HHSC, if HHSC determines additional data and research are needed, through the external quality review organization, to:

(1) conduct annual surveys of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;

(2) conduct annual focus groups with recipients described by Subdivision (1) or their representatives on issues identified through:

(A) the Consumer Assessment of Healthcare Providers and Systems;

(B) other external quality review organization activities; or

(C) stakeholders, including the STAR Kids Managed Care Advisory Committee described by Section 533.00254 (STAR Kids Managed Care Advisory Committee); and

(3) in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254 and as frequently as feasible, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as the collaborative innovation improvement network.

(b) Requires HHSC, not later than the 30th day after the last day of each state fiscal quarter, to submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program:

(1) enrollment in the Medicaid buy-in for children program implemented under Section 531.02444;

(2) requests relating to interest list placements under Section 531.0601;

(3) use of the Medicaid escalation help line established under Section 533.00253 (Star Kids Medicaid Managed Care Program),

if the help line was operational during the applicable state fiscal quarter;

(4) use of, requests for, and outcomes of the external medical review procedure established under Section 531.024164; and

(5) complaints relating to the medically dependent children (MDCP) waiver program, categorized by disposition.

Sec. 531.0603. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN (MDCP) OR DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM. (a) Requires HHSC, notwithstanding any other law and to the extent allowed by federal law, in determining eligibility of a child for the medically dependent children (MDCP) waiver program, the deaf-blind with multiple disabilities (DBMD) waiver program, or a "Money Follows the Person" demonstration project, to consider whether the child:

(1) is diagnosed as having a condition included in the list of compassionate allowances conditions published by the United States Social Security Administration; or

(2) receives Medicaid hospice or palliative care services.

(b) Provides that, if HHSC determines a child is eligible for a waiver program under Subsection (a), the child's enrollment in the applicable program is contingent on the availability of a slot in the program. Requires HHSC, if a slot is not immediately available, to place the child in the first position on the interest list for the medically dependent children (MDCP) waiver program or deaf-blind with multiple disabilities (DBMD) waiver program, as applicable.

Sec. 531.0604. MEDICALLY DEPENDENT CHILDREN PROGRAM ELIGIBILITY REQUIREMENTS; NURSING FACILITY LEVEL OF CARE. Prohibits HHSC, to the extent allowed by federal law, from requiring that a child reside in a nursing facility for an extended period of time to meet the nursing facility level of care required for the child to be determined eligible for the medically dependent children (MDCP) waiver program.

SECTION 4. Amends Section 533.00253(a)(1), Government Code, to define "advisory committee" as the STAR Kids Managed Care Advisory Committee described by established under Section 533.00254, rather than established under Section 533.00254.

SECTION 5. Amends Section 533.00253, Government Code, by amending Subsection (c) and adding Subsections (c-1), (c-2), (f), (g), (h), (i), (j), (k), and (l), as follows:

(c) Deletes existing text relating to a care needs assessment for a recipient that is comprehensive, holistic, consumer-directed, evidence-based, and takes into consideration social and medical issues, for purposes of prioritizing the recipient's needs that threaten independent living.

(c-1) Requires HHSC in consultation and collaboration with the advisory committee, 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, to 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) Requires HHSC, to the extent feasible and allowed by federal law, to 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.

(f) Requires HHSC to 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. Requires the escalation help line to 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) Requires HHSC to 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) Requires HHSC to 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) Requires a Medicaid managed care organization, to the extent feasible, to 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) Requires HHSC, not later than September 1, 2020, to 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) Provides that Subsections (f), (g), (h), (i), and (j) and this subsection expire September 1, 2024.

(l) Requires HHSC, not later than September 1, 2020, to evaluate risk-adjustment methods used for recipients under the STAR Kids managed care program, including recipients with private health benefit plan coverage, in the quality-based payment program under Chapter 536 (Medicaid and the Child Health Plan Program; Quality-Based Outcomes and Payments) to ensure that higher-volume providers are not unfairly penalized. Provides that this subsection expires January 1, 2021.

SECTION 6. Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.00254, 533.00282, 533.00283, 533.00284, 533.002841, and 533.038, as follows:

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

- (1) advise HHSC on the operation of the STAR Kids managed care program under Section 533.00253; and
- (2) make recommendations for improvements to that program.

(b) Provides that, on December 31, 2023, the advisory committee is abolished and this section expires.

Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. (a) Provides that Section 4201.304(a)(2) (relating to time for notice of adverse determination for a patient who is not hospitalized at the time of the determination), 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) Requires a contract between a Medicaid managed care organization and HHSC, in addition to the requirements of Section 533.005 (Required Contract Provisions), to 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 HHSC if the organization receives a request for prior authorization that does not include sufficient or adequate documentation.

(c) Requires HHSC, in consultation with the state Medicaid managed care advisory committee, to 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. Requires the process to provide a time frame within which a provider may submit the necessary documentation. Requires the time frame to be longer than the time frame specified by Subsection (b)(2)(A) within which a Medicaid managed care organization is required to issue a determination on a prior authorization request.

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Requires each Medicaid managed care organization, in consultation with the organization's provider advisory group required by contract, to 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 (Prior Authorization For Certain Prescription Drugs) for the vendor drug program. Requires the organization, in conducting a review, to:

(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) Prohibits a Medicaid managed care organization from imposing 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) Requires HHSC to periodically review each Medicaid managed care organization to ensure the organization's compliance with this section.

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) Requires HHSC, in consultation with the state Medicaid managed care advisory committee, to 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. Requires a contract between a Medicaid managed care organization and HHSC, in addition to the requirements of Section 533.005, to include a requirement that the organization implement the process and timeline.

(b) Requires the process and timeline to:

(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) Provides that 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) Provides that 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.

Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. Prohibits 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 from exceeding the time frame for a decision under federally prescribed time frames. Provides that 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.

Sec. 533.038. COORDINATION OF BENEFITS. (a) Provides that, 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) Requires HHSC, in coordination with Medicaid managed care organizations and in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254, to 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. Requires HHSC, in developing the policy, to consider requiring a Medicaid managed care organization to allow, notwithstanding Sections 531.073 and 533.005(a)(23) (relating to requiring managed care organizations to perform certain activities in regards to outpatient pharmacy benefit plans) 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) Requires the Medicaid managed care organization that paid the claim, if HHSC determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, to work with HHSC on the recovery process and make every attempt to reduce health care provider and recipient abrasion.

(d) Authorizes the executive commissioner to 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) Authorizes HHSC to 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 HHSC provides premium assistance under the health insurance premium payment program. Provides that, 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 HHSC:

- (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) Requires HHSC, to the extent allowed by federal law, to 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. Requires HHSC to 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 prohibits HHSC from requiring an additional state provider identifier number to receive reimbursement for the services. Authorizes HHSC to seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(g) Requires HHSC to 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.

SECTION 7. (a) Provides that Section 531.0601, Government Code, as added by this Act, applies only to a child who becomes ineligible for the medically dependent children (MDCP) waiver program on or after December 1, 2019.

(b) Provides that Section 531.0602, Government Code, as added by this Act, applies only to an assessment or reassessment of a child's eligibility for the medically dependent children (MDCP) waiver program made on or after December 1, 2019.

(c) Requires HHSC, notwithstanding Section 531.06021, Government Code, as added by this Act, to submit the first report required by that section not later than September 30, 2020, for the state fiscal quarter ending August 31, 2020.

(d) Requires HHSC, not later than March 1, 2020, to:

(1) develop a plan to improve the care needs assessment tool and the initial assessment and reassessment processes as required by Sections 533.00253(c-1) and (c-2), Government Code, as added by this Act; and

(2) post the plan on HHSC's Internet website.

(e) Provides that Sections 533.00282 and 533.00284, Government Code, as added by this Act, apply only to a contract between HHSC and a Medicaid managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act.

(f) Requires HHSC, as soon as practicable after the effective date of this Act but not later than September 1, 2020, to seek to amend contracts entered into with Medicaid managed care organizations under Chapter 533, Government Code, before the effective date of this Act to include the provisions required by Sections 533.00282 and 533.00284, Government Code, as added by this Act.

SECTION 8. Requires the executive commissioner, as soon as practicable after the effective date of this Act, to adopt rules necessary to implement the changes in law made by this Act.

SECTION 9. Requires a state agency affected by any provision of this Act, if before implementing the provision the agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, to request the waiver or authorization and authorizes the agency to delay implementing that provision until the waiver or authorization is granted.

SECTION 10. Provides that HHSC is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. Authorizes, but does not require,

HHSC, if the legislature does not appropriate money specifically for that purpose, to implement a provision of this Act using other appropriations available for that purpose.

SECTION 11. Effective date: September 1, 2019.