# BILL ANALYSIS

C.S.S.B. 1207
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Insurance
Committee Report (Substituted)

## BACKGROUND AND PURPOSE

It has been noted that many children enrolled in the state's medically dependent child program are also covered by commercial primary insurance or another primary insurance, meaning the Medicaid managed care program provides secondary coverage and is the payor of last resort. There are concerns that the practice of a managed care organization waiting for a claim or an authorization to first be acted on by the primary insurer, if there is one, before itself acting on the claim or authorization can create significant delay in processing claims or authorizations that are time sensitive. C.S.S.B. 1207 seeks to address these concerns by revising provisions relating to the operation and administration of Medicaid, including the Medicaid managed care program and the medically dependent children (MDCP) waiver program.

## 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, 3, and 8 of this bill.

## ANALYSIS

C.S.S.B. 1207 amends the Government Code to require the executive commissioner of the Health and Human Services Commission (HHSC) by rule to increase the maximum family income for determining eligibility for the Medicaid buy-in program for children with disabilities to the maximum family income amount for which federal matching funds are available, considering available appropriations for that purpose. The bill requires HHSC, at the request of a child's legally authorized representative, to conduct a disability determination assessment of the child to determine the child's eligibility for the buy-in program. The bill requires HHSC to directly conduct the disability determination assessment and prohibits HHSC from contracting with a Medicaid managed care organization (MCO) or other entity to conduct the assessment.

C.S.S.B. 1207 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 certain information. The bill requires HHSC or the 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 and sets out requirements for the notice. The bill requires the executive commissioner by rule to require the following:

- each Medicaid MCO or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the MCO or entity maintains specified

information on the MCO or entity's website in an easily searchable and accessible format; and

- each MCO or other entity responsible for authorizing coverage for health care services under Medicaid to adopt and maintain a process for a provider or Medicaid recipient to contact the MCO or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request and to ensure that the process is not arduous or overly burdensome to a provider or recipient.

C.S.S.B. 1207 requires HHSC to take the following actions with regard to an external medical review:

- contract with an independent external medical reviewer to conduct external medical reviews and review 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 a denial by HHSC of eligibility for a Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs;
- establish a common procedure for reviews; and
- establish a procedure for expedited reviews that allows the reviewer to identify an appeal that requires an expedited resolution.

The bill prohibits a Medicaid MCO from having a financial relationship with or ownership interest in the external medical reviewer with which HHSC contracts and sets out certain requirements for the reviews and the external medical reviewer. The bill provides for the periods in which reviews occur and the option for a Medicaid recipient or applicant, or the recipient's or applicant's parent or legally authorized representative, to affirmatively opt out of the external medical review to proceed to a Medicaid fair hearing without first participating in the external medical review. The bill establishes that the external medical reviewer's determination of medical necessity establishes the minimum level of services a Medicaid recipient must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider. The bill requires the external medical reviewer to require a Medicaid MCO, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

C.S.S.B. 1207, with regard to a child who is enrolled in the medically dependent children (MDCP) waiver program but becomes ineligible for services because the child no longer meets the level of care criteria for medical necessity for nursing facility care or the age requirement for the program, authorizes such a child's legally authorized representative who is notified by the HHSC of the ineligibility 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 specified waiver program.

The bill sets out requirements for HHSC regarding the placement of the child on an applicable waiver list. These provisions apply only to a child who becomes ineligible for the MDCP waiver program on or after December 1, 2019.

C.S.S.B. 1207 requires HHSC to ensure that the care coordinator for a Medicaid MCO under the STAR Kids managed care program provides the results of the annual medical necessity determination reassessment to the parent or legally authorized representative of a recipient receiving benefits under the MDCP waiver program for review and 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. The bill provides for the verification of receipt of reassessment results and a dispute of the reassessment through a peer-to-peer review. These provisions expressly do not affect any rights of a recipient to appeal a reassessment determination through the Medicaid MCO internal appeal process or through the Medicaid fair

hearing process. These provisions apply only to a reassessment of a child's eligibility for the MDCP waiver program made on or after December 1, 2019.

C.S.S.B. 1207 requires HHSC, through the state's external quality review organization, to do the following:

- conduct annual surveys of Medicaid recipients receiving benefits under the MDCP waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;
- conduct annual focus groups with recipients or their representatives on certain issues; and
- as frequently as feasible but not less frequently than annually, calculate Medicaid MCO performance on performance measures using available data sources such as the STAR Kids Screening and Assessment Instrument or the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures.

The bill 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, specified information and data related to access to care for Medicaid recipients receiving benefits under the MDCP waiver program. The bill requires HHSC to submit the first report not later than September 30, 2020, for the state fiscal quarter ending August 31, 2020.

C.S.S.B. 1207, with regard to STAR Kids Medicaid managed care program, requires HHSC to do the following:

- consider, for purposes of improving the care needs assessment tool and improving the initial assessment and reassessment processes and in consultation and collaboration with the advisory committee, changes that will:
    - reduce the amount of time needed to complete the care needs assessment initially and at reassessment; and
    - 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 MCOs and different service coordinators within the same MCO;
- streamline the STAR Kids managed care program annual care needs reassessment process, to the extent feasible and allowed by federal law, for a child who has not had a significant change in function that may affect medical necessity;
- operate a Medicaid escalation help line that meets certain requirements and through which Medicaid recipients receiving benefits under the MDCP waiver program and their legally authorized representatives, parents, guardians, or other representatives have access to assistance;
- require a Medicaid MCO participating in the STAR Kids managed care program to designate an individual as a single point of contact for the Medicaid escalation help line and authorize that individual to take action to resolve escalated issues; and
- develop, not later than March 1, 2020, a plan to improve the care needs assessment tool and the initial assessment and reassessment processes and to post the plan on the HHSC website.

C.S.S.B. 1207 requires 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. These provisions expire and the advisory committee is abolished on September 1, 2023.

C.S.S.B. 1207, with regard to utilization review and prior authorization procedures, exempts a Medicaid MCO and a utilization review agent who conducts utilization reviews for a Medicaid MCO from the requirement to provide certain timely notice of an adverse determination with respect to a patient who is not hospitalized at the time of the adverse determination. The bill sets out additional requirements for a contract between a Medicaid MCO and HHSC requiring HHSC to require that:

- 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
- 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 certain time frames.

The bill requires HHSC to establish a process consistent with federal regulations for use by a Medicaid MCO that receives a prior authorization request, with respect to a recipient who is not hospitalized at the time of the request, that does not include sufficient or adequate documentation. The bill requires the process to provide a time frame within which a provider may submit the necessary documentation.

C.S.S.B. 1207 requires each Medicaid MCO 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 for the vendor drug program. The bill sets out requirements for the Medicaid MCO in conducting a review. The bill prohibits a Medicaid MCO from imposing a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented for the vendor drug program, unless the MCO has reviewed the requirement during the most recent annual review.

C.S.S.B. 1207, with regard to reconsideration following an adverse determination on certain prior authorization requests, additionally requires a contract between a Medicaid MCO and HHSC to include a requirement that the organization establish a process for reconsidering such an adverse determination that resulted solely from the submission of insufficient or inadequate documentation. The bill sets out requirements for the reconsideration process. The bill establishes that an adverse determination on a prior authorization request is considered a denial of services in an evaluation of the Medicaid MCO only if the determination is not applicably amended to approve the request. The bill establishes that the reconsideration process does not affect any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an independent review organization or any rights of a recipient to appeal a determination on a prior authorization request.

C.S.S.B. 1207 requires HHSC, in coordination with a Medicaid MCO, to develop and adopt a clear policy for a Medicaid MCO to ensure the coordination and timely delivery for Medicaid recipients with both primary health benefit plan coverage and Medicaid coverage of Medicaid wrap-around benefits, defined as a Medicaid-covered service that is provided to such a recipient 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. The bill requires HHSC, in developing the policy, to consider requiring a Medicaid MCO to allow 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.S.S.B. 1207 requires a Medicaid MCO that in good faith and following HHSC policies provides coverage for a Medicaid wrap-around benefit to include the cost of providing the benefit in its financial reports and requires HHSC to include the reported costs in computing

capitation rates for the MCO. The bill establishes that, if HHSC determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, the MCO that paid the claim is required to work with HHSC on the recovery process and make every attempt to reduce health care provider and recipient abrasion.

C.S.S.B. 1207 requires HHSC, in coordination with Medicaid managed care organizations, in order to further assist with benefits coordination, and to the extent allowed under federal requirements for third-party liability, to develop, maintain, and periodically review and update a list of services that are not traditionally covered by primary health benefit plan coverage that an MCO may approve without having to coordinate with the plan issuer and that can be resolved through third-party liability resolution processes. The bill authorizes the executive commissioner to seek a waiver from the federal government as needed to address federal policies related to coordination of benefits and third-party liability and to maximize federal financial participation for Medicaid recipients with both primary health benefit plan coverage and Medicaid coverage.

C.S.S.B. 1207 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. The bill establishes that the files for such a recipient may include certain up-to-date, accurate information related to primary health benefit plan coverage to the extent the information is available to HHSC.

C.S.S.B. 1207 requires HHSC to take the following actions:

- to the extent allowed by federal law, maintain processes and policies to allow a health care provider who is primarily providing services to a Medicaid 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; and
- allow a provider who is not enrolled as a Medicaid provider to order, refer, or prescribe services to a Medicaid 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.

The bill authorizes HHSC to seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement these provisions.

C.S.S.B. 1207 requires HHSC to develop a clear and easy process, to be implement through a contract, that allows a Medicaid recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider.

C.S.S.B. 1207 establishes that HHSC is required to implement a provision of the bill only if the legislature appropriates money specifically for that purpose and that HHSC may, but is not required to, implement the bill's provisions using other appropriations available for that purpose if the legislature does not appropriate money specifically for that purpose. The bill requires the executive commissioner to adopt rules necessary to implement the bill's provisions. The bill requires HHSC to seek to amend contracts entered into with Medicaid MCO before the bill's effective date to include certain provisions required by the bill.

**EFFECTIVE DATE**

September 1, 2019.

**COMPARISON OF SENATE ENGROSSED AND SUBSTITUTE**

While C.S.S.B. 1207 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 the following provisions:

- a requirement for the executive commissioner to increase the maximum family income qualifications for a Medicaid buy-in program;
- a requirement for HHSC to conduct a disability determination assessment of a child to determine eligibility for the buy-in program and a prohibition against HHSC contracting with a Medicaid MCO to conduct the assessment;
- a requirement for HHSC to ensure that notice sent by HHSC or a Medicaid MCO to a recipient or provider regarding denial of Medicaid coverage or prior authorization for a service includes certain information;
- a requirement for HHSC or a Medicaid MCO that receives a prior authorization request that contains insufficient or inadequate documentation to issue a certain notice;
- a requirement for the executive commissioner to require each MCO or entity responsible for authorizing service under Medicaid to maintain on the organization's or entity's website certain information and to adopt and maintain a process for a provider or recipient to contact the MCO or entity to clarify prior authorization requirements;
- a requirement for HHSC to contract with an independent external medical reviewer to conduct certain reviews;
- a prohibition against an MCO having a financial relationship or ownership of an external medical reviewer;
- provisions relating to the external medical review;
- provisions relating to the MDCP waiver program, MDCP waiting list, and MDCP reassessments;
- requirements for HHSC to conduct certain surveys and focus groups and to submit a report to the governor, the lieutenant governor, the speaker of the house, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid;
- requirements for HHSC to improve the care needs assessment tool for the STAR Kids managed care program;
- a requirement for HHSC to streamline the STAR Kids managed care program;
- a requirement for HHSC to operate a Medicaid escalation help line;
- a requirement for the STAR Kids Managed Care Advisory Committee to advise HHSC on the operation of the STAR Kids managed care program and to make recommendations for improvements;
- certain additional requirements for a contract between an MCO and HHSC with regard to the STAR Kids managed care program;
- a requirement for each MCO to develop and implement a process to annually review the organization's prior authorization requirements and a prohibition against an MCO imposing a prior authorization requirement other than an implemented requirement for the drug vendor program;
- provisions relating to reconsideration following an adverse determination on certain prior authorization requests;
- provisions establishing the applicability date of certain bill provisions; and
- a requirement for the executive commissioner to adopt rules necessary to implement the bill's provisions.

The substitute revises the following provisions:

- a provision for the continued use of certain prescription drugs without requiring additional prior authorization;
- a requirement for HHSC to develop and maintain a list of services that are not traditionally covered by primary health benefit plan coverage that an MCO may approve without having to coordinate with the primary plan issuer;
- a requirement for HHSC 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; and
- a requirement for HHSC to develop a clear and easy process to allow a recipient with complex medical needs to continue receiving care from a certain provider.

The substitute changes the frequency in which HHSC is required to review and update the list from quarterly to periodically.

The substitute does not include the following:

- a provision establishing that a single-case agreement entered into by a provider outside of an MCO service and delivery area with the MCO is not considered an out-of-network agreement; and
- a requirement for HHSC to develop and implement processes concerning reimbursement to certain recipients and to capture encounter data for the wrap-around benefits provided by an MCO.