By: Raymond H.B. No. 2222

A BILL TO BE ENTITLED

AN ACT

relating to the administration and oversight of the Medicaid and child health plan programs.

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

SECTION 1. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1133 to read as follows:

Sec. 531.1133. PROVIDER NOT LIABLE FOR MANAGED CARE ORGANIZATION OVERPAYMENT OR DEBT. (a) If the commission's office of inspector general makes a determination to recoup an overpayment or debt from a managed care organization that contracts with the commission to provide health care services to Medicaid recipients, a provider that contracts with the managed care organization may not be held liable for the good faith provision of services under the provider's contract with the managed care organization that were provided with prior authorization.

(b) This section does not:

(1) limit the office of inspector general's authority to recoup an overpayment or debt from a provider that is owed by the provider as a result of the provider's failure to comply with applicable law or a contract provision, notwithstanding any prior authorization for a service provided; or

(2) apply to an action brought under Chapter 36, Human Resources Code.

SECTION 2. Section 533.00281, Government Code, is

redesignated as Section 533.0121, Government Code, and amended to read as follows:

Sec. 533.0121 [~~533.00281~~]. UTILIZATION REVIEW AND FINANCIAL AUDIT PROCESS FOR [~~STAR + PLUS~~] MEDICAID MANAGED CARE ORGANIZATIONS. (a) The commission's office responsible for [~~of~~] contract management shall establish an annual utilization review and financial audit process for managed care organizations participating in the [~~STAR + PLUS~~] Medicaid managed care program. The commission shall determine the topics to be examined in a [~~the~~] review [~~process~~], except that with respect to a managed care organization participating in the STAR+PLUS Medicaid managed care program, the review [~~process~~] must include a thorough investigation of the [~~each managed care~~] organization's procedures for determining whether a recipient should be enrolled in the STAR+PLUS [~~STAR + PLUS~~] home and community-based services and supports (HCBS) program, including the conduct of functional assessments for that purpose and records relating to those assessments.

(b) The commission's office responsible for [~~of~~] contract management shall use the utilization review and financial audit process established under this section to review each fiscal year:

(1) each managed care organization [~~every managed care organization~~] participating in the [~~STAR + PLUS~~] Medicaid managed care program in this state for that organization's first five years of participation; [~~or~~]

(2) each managed care organization providing health care services to a population of recipients new to receiving those services through a Medicaid [~~only the~~] managed care delivery model

for the first three years that the organization provides those services to that population; or

(3) managed care organizations that, using a risk-based assessment process and evaluation of prior history, the office determines have a higher likelihood of contract or financial noncompliance [~~inappropriate client placement in the STAR + PLUS home and community-based services and supports (HCBS) program~~].

(c) In addition to the reviews required by Subsection (b), the commission's office responsible for contract management shall use the utilization review and financial audit process established under this section to review each managed care organization participating in the Medicaid managed care program at least once every five years.

(d) In conjunction with the commission's office responsible for [~~of~~] contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over Medicaid not later than December 1 of each year. The report must:

(1) summarize the results of the [~~utilization~~] reviews conducted under this section during the preceding fiscal year;

(2) provide analysis of errors committed by each reviewed managed care organization; and

(3) extrapolate those findings and make recommendations for improving the efficiency of the Medicaid managed care program.

(e) If a [~~utilization~~] review conducted under this section results in a determination to recoup money from a managed care

organization, the provider protections from liability under Section 531.1133 apply [~~a service provider who contracts with the managed care organization may not be held liable for the good faith provision of services based on an authorization from the managed care organization~~].

SECTION 3. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0031 to read as follows:

Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) Notwithstanding Section 533.004 or any other law requiring the commission to contract with a managed care organization to provide health care services to recipients, the commission may contract with a managed care organization to provide those services only if the managed care plan offered by the organization is accredited by a nationally recognized accrediting entity.

(b) This section does not apply to a managed care organization that contracts with the commission to provide only dental or medical transportation services.

SECTION 4. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00611 to read as follows:

Sec. 533.00611. STANDARDS FOR DETERMINING MEDICAL NECESSITY. (a) Except as provided by Subsection (b), the commission shall establish standards that govern the processes, criteria, and guidelines under which managed care organizations determine the medical necessity of a health care service covered by Medicaid. In establishing standards under this section, the commission shall:

(1) ensure that each recipient has equal access in

scope and duration to the same covered health care services for which the recipient is eligible, regardless of the managed care organization with which the recipient is enrolled;

(2) provide managed care organizations with flexibility to approve covered medically necessary services for recipients that may not be within prescribed criteria and guidelines;

(3) require managed care organizations to make available to providers all criteria and guidelines used to determine medical necessity through an Internet portal accessible by the providers;

(4) ensure that managed care organizations consistently apply the same medical necessity criteria and guidelines for the approval of services and in retrospective utilization reviews; and

(5) ensure that managed care organizations include in any service or prior authorization denial specific information about the medical necessity criteria or guidelines that were not met.

(b) This section does not apply to or affect the commission's authority to:

(1) determine medical necessity for home and community-based services provided under the STAR+PLUS Medicaid managed care program; or

(2) conduct utilization reviews of those services.

SECTION 5. Section 533.0076, Government Code, is amended by amending Subsection (c) and adding Subsection (d) to read as

follows:

(c) The commission shall allow a recipient who is enrolled in a managed care plan under this chapter to disenroll from that plan and enroll in another managed care plan[~~:~~

[~~(1)~~] at any time for cause in accordance with federal law, including because:

(1) the recipient moves out of the managed care organization's service area;

(2) the plan does not, on the basis of moral or religious objections, cover the service the recipient seeks;

(3) the recipient needs related services to be performed at the same time, not all related services are available within the organization's provider network, and the recipient's primary care provider or another provider determines that receiving the services separately would subject the recipient to unnecessary risk;

(4) for recipients of long-term services or supports, the recipient would have to change the recipient's residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the managed care organization and, as a result, would experience a disruption in the recipient's residence or employment; or

(5) of another reason permitted under federal law, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the recipient's care needs[~~; and~~

[~~(2) once for any reason after the periods described by Subsections (a) and (b)~~].

(d) The commission shall implement a process by which the commission verifies that a recipient is permitted to disenroll from one managed care plan offered by a managed care organization and enroll in another managed care plan, including a plan offered by another managed care organization, before the disenrollment occurs.

SECTION 6. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0091 to read as follows:

Sec. 533.0091. CARE COORDINATION SERVICES. A managed care organization that contracts with the commission to provide health care services to recipients shall ensure that persons providing care coordination services through the organization coordinate with hospital discharge planners, who must notify the organization of an inpatient admission of a recipient, to facilitate the timely discharge of the recipient to the appropriate level of care and minimize potentially preventable readmissions, as defined by Section 536.001.

SECTION 7. Subchapter D, Chapter 62, Health and Safety Code, is amended by adding Section 62.1552 to read as follows:

Sec. 62.1552. MANAGED CARE PLAN ACCREDITATION. (a) Notwithstanding any other law requiring the commission to contract with a managed care organization to provide health benefits under the child health plan, the commission may contract with a managed care organization to provide those benefits only if the managed care plan offered by the organization is accredited by a nationally

recognized accrediting entity.

(b) This section does not apply to a managed care organization that contracts with the commission to provide only dental benefits.

SECTION 8. (a) The Health and Human Services Commission shall require that a managed care plan offered by a managed care organization with which the commission enters into or renews a contract under Chapter 533, Government Code, or Chapter 62, Health and Safety Code, as applicable, on or after the effective date of this Act complies with Section 533.0031, Government Code, as added by this Act, or Section 62.1552, Health and Safety Code, as added by this Act, as applicable, not later than September 1, 2022.

(b) Notwithstanding Section 533.0031, Government Code, as added by this Act, or Section 62.1552, Health and Safety Code, as added by this Act, a managed care organization may continue providing health care services or health benefits under a contract with the Health and Human Services Commission entered into under Chapter 533, Government Code, or Chapter 62, Health and Safety Code, as applicable, before the effective date of this Act, until the earlier of:

(1) the termination of the contract; or

(2) the third anniversary of the effective date of a contract amendment requiring accreditation of the managed care plan offered by the managed care organization.

(c) Not later than March 31, 2020, the Health and Human Services Commission shall seek to amend contracts described by Subsection (b) of this section to ensure those contracts comply

with Section 533.0031, Government Code, as added by this Act, or Section 62.1552, Health and Safety Code, as added by this Act, as applicable. To the extent of a conflict between Section 533.0031, Government Code, as added by this Act, or Section 62.1552, Health and Safety Code, as added by this Act, and a provision of a contract with a managed care organization entered into before the effective date of this Act, the contract provision prevails.

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 authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 10. This Act takes effect September 1, 2019.