

By: Raymond

H.B. No. 2379

A BILL TO BE ENTITLED

AN ACT

relating to changes to and the setting of fees, charges, and rates under the Medicaid and child health plan programs.

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02112 to read as follows:

Sec. 531.02112. PROCEDURE FOR IMPLEMENTING CHANGES TO PAYMENT RATES UNDER MEDICAID AND CHILD HEALTH PLAN PROGRAM. (a) In adopting rules and standards related to the determination of fees, charges, and rates for payments under Medicaid and the child health plan program, the executive commissioner, in consultation with the advisory committee established under Subsection (b), shall adopt rules to ensure that changes to the fees, charges, and rates are implemented in accordance with this section and in a way that minimizes administrative complexity and financial uncertainty.

(b) The executive commissioner shall establish an advisory committee of nine members to provide input for the adoption of rules and standards that comply with this section. The advisory committee is composed of representatives from managed care organizations and providers, including physicians, under Medicaid and the child health plan program. The advisory committee is abolished on the date the rules that comply with this section are adopted. This subsection expires September 1, 2021.

(c) Before implementing a change to the fees, charges, and

1 rates for payments under Medicaid or the child health plan program,
2 the commission shall:

3 (1) before or at the time notice of the proposed change
4 is published under Subdivision (2), notify managed care
5 organizations and the entity serving as the state's Medicaid claims
6 administrator under the Medicaid fee-for-service delivery model of
7 the proposed change;

8 (2) publish notice of the proposed change:

9 (A) for public comment in the Texas Register for
10 a period of not less than 30 days; and

11 (B) on the commission's and state Medicaid claims
12 administrator's Internet websites during the period specified
13 under Paragraph (A);

14 (3) publish notice of a final determination to make
15 the proposed change:

16 (A) in the Texas Register for a period of not less
17 than 30 days before the change becomes effective; and

18 (B) on the commission's and state Medicaid claims
19 administrator's Internet websites during the period specified
20 under Paragraph (A); and

21 (4) provide managed care organizations and the entity
22 serving as the state's Medicaid claims administrator under the
23 Medicaid fee-for-service delivery model with a period of not less
24 than 30 days before the effective date of the final change to make
25 any necessary administrative or systems adjustments to implement
26 the change.

27 (d) If changes to the fees, charges, or rates for payments

under Medicaid or the child health plan program are mandated by the legislature or federal government on a date that does not fall within the time frame for the implementation of those changes described by this section, the commission shall:

(1) prorate the amount of the change over the fee, charge, or rate period; and

(2) publish the proration schedule described by Subdivision (1) in the Texas Register along with the notice provided under Subsection (c)(3).

(e) This section does not apply to changes to the fees, charges, or rates for payments made to a nursing facility.

SECTION 2. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0059 to read as follows:

Sec. 533.0059. RESTRICTIONS ON CERTAIN REIMBURSEMENT RATE REDUCTIONS. (a) In this section, "across-the-board provider reimbursement rate reduction" means a provider reimbursement rate reduction proposed by a managed care organization that the commission determines is likely to affect more than 50 percent of a particular type of provider participating in the organization's provider network during the 12-month period following implementation of the proposed reduction, regardless of whether:

(1) the organization limits the proposed reduction to specific service areas or provider types; or

(2) the affected providers are likely to experience differing percentages of rate reductions or amounts of lost revenue as a result of the proposed reduction.

(b) Except as provided by Subsection (e), a managed care

1 organization that contracts with the commission to provide health
2 care services to recipients may not implement a significant, as
3 determined by the commission, across-the-board provider
4 reimbursement rate reduction unless the organization:

5 (1) at least 90 days before the proposed rate
6 reduction is to take effect:

7 (A) provides the commission and affected
8 providers with written notice of the proposed rate reduction; and

9 (B) makes a good faith effort to negotiate the
10 reduction with the affected providers; and

11 (2) receives prior approval from the commission,
12 subject to Subsection (c).

13 (c) An across-the-board provider reimbursement rate
14 reduction is considered to have received the commission's prior
15 approval for purposes of Subsection (b)(2) unless the commission
16 issues a written statement of disapproval not later than the 45th
17 day after the date the commission receives notice of the proposed
18 rate reduction from the managed care organization under Subsection
19 (b)(1)(A).

20 (d) If a managed care organization proposes an
21 across-the-board provider reimbursement rate reduction in
22 accordance with this section and subsequently rejects alternative
23 rate reductions suggested by an affected provider, the organization
24 must provide the provider with written notice of that rejection,
25 including an explanation of the grounds for the rejection, before
26 implementing any rate reduction.

27 (e) This section does not apply to rate reductions that are

1 implemented because of reductions to the Medicaid fee schedule or
2 cost containment initiatives that are specifically directed by the
3 legislature and implemented by the commission.

4 SECTION 3. Section 2, Chapter 1117 (H.B. 3523), Acts of the
5 84th Legislature, Regular Session, 2015, which amended Section
6 533.00251(c), Government Code, effective September 1, 2021, is
7 repealed.

8 SECTION 4. Not later than December 31, 2019, the executive
9 commissioner of the Health and Human Services Commission shall
10 establish the advisory committee as required by Section
11 531.02112(b), Government Code, as added by this Act.

12 SECTION 5. (a) Not later than December 31, 2020, the
13 executive commissioner of the Health and Human Services Commission
14 shall adopt the rules required to implement Section 531.02112,
15 Government Code, as added by this Act.

16 (b) The procedure for implementing changes to payment rates
17 required by Section 531.02112, Government Code, as added by this
18 Act, applies only to a change to a fee, charge, or rate that takes
19 effect on or after January 1, 2021.

20 SECTION 6. If before implementing any provision of this Act
21 a state agency determines that a waiver or authorization from a
22 federal agency is necessary for implementation of that provision,
23 the agency affected by the provision shall request the waiver or
24 authorization and may delay implementing that provision until the
25 waiver or authorization is granted.

26 SECTION 7. This Act takes effect September 1, 2019.