By: Davis of Harris, Zerwas, Krause, Bonnen of Galveston, Turner of Tarrant, et al.

H.B. No. 2453

Substitute the following for H.B. No. 2453:

By: Clardy

C.S.H.B. No. 2453

A BILL TO BE ENTITLED

AN ACT

relating to the operation and administration of Medicaid, including the Medicaid managed care program.

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

SECTION 1. Section 531.001, Government Code, is amended by adding Subdivision (4-c) to read as follows:

(4-c) "Medicaid managed care organization" means a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients.

SECTION 2. Subchapter A, Chapter 531, Government Code, is amended by adding Section 531.0172 to read as follows:

Sec. 531.0172. OMBUDSMAN FOR MEDICAID PROVIDERS. (a) In this section, "office" means the office of ombudsman for Medicaid providers.

(b) The office of ombudsman for Medicaid providers is established within the commission's Medicaid and CHIP services division to support Medicaid providers in resolving disputes, complaints, or other issues between the provider and the commission or a Medicaid managed care organization under a Medicaid managed care or fee-for-service delivery model.

(c) The commission shall consider disputes, complaints, and other issues reported to the office in renewing a contract with a Medicaid managed care organization.

1 (d) The office shall report issues regarding the Medicaid
2 managed care program to the Medicaid director with timely
3 information.
4 (e) The office shall provide feedback to a person who files
5 a grievance with the office, such as feedback concerning any
6 investigation resulting from and the outcome of the grievance, in
7 accordance with the no-wrong-door system established under Section
8 533.027.
9 (f) Data collected by the office must be collected and
10 reported by provider type and population served. The office shall
11 use the data to develop and make to the commission's Medicaid and
12 CHIP services division recommendations for reforming providers'
13 experiences with Medicaid, including Medicaid managed care.
14 (g) The commission shall align the office's data collection
15 practices with the data collection practices used by the
16 commission's office of the ombudsman to facilitate comparisons.
17 (h) The executive commissioner shall adopt rules as
18 necessary to implement this section.
19 SECTION 3. Subchapter B, Chapter 531, Government Code, is
20 amended by adding Section 531.02133 to read as follows:
21 Sec. 531.02133. REQUESTING INFORMATION IN STAR HEALTH
22 PROGRAM. The Department of Family and Protective Services shall
23 provide clear guidance on the process for requesting and responding
24 to requests for documents relating to and medical records of a
25 recipient under the STAR Health program to:
26 (1) a Medicaid managed care organization that provides
27 health care services under that program; and

(2) attorneys ad litem representing recipients under that program.

SECTION 4. Section 531.02141, Government Code, is amended by adding Subsection (f) to read as follows:

(f) For each hearing officer that conducts Medicaid fair hearings, the commission or the external medical reviewer described by Section 533.00715 annually shall collect data regarding the officer's decisions and rates of upholding or reversing decisions on appeal. The commission shall analyze the data to identify outliers. The commission shall provide corrective education to hearing officers whose decisions or rates are outliers. The commission shall document the outliers identified and the corrective education provided.

SECTION 5. Section 531.02411, Government Code, is amended to read as follows:

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. (a) The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in Medicaid and shall use technology and efficient business practices to decrease those burdens. In addition, the commission shall make every effort to improve the business practices associated with the administration of Medicaid by any method the commission determines is cost-effective, including:

(1) expanding the utilization of the electronic claims payment system;

(2) developing an Internet portal system for prior

1 authorization requests;
2 (3) encouraging Medicaid providers to submit their
3 program participation applications electronically;
4 (4) ensuring that the Medicaid provider application is
5 easy to locate on the Internet so that providers may conveniently
6 apply to the program;
7 (5) working with federal partners to take advantage of
8 every opportunity to maximize additional federal funding for
9 technology in Medicaid; and
10 (6) encouraging the increased use of medical
11 technology by providers, including increasing their use of:
12 (A) electronic communications between patients
13 and their physicians or other health care providers;
14 (B) electronic prescribing tools that provide
15 up-to-date payer formulary information at the time a physician or
16 other health care practitioner writes a prescription and that
17 support the electronic transmission of a prescription;
18 (C) ambulatory computerized order entry systems
19 that facilitate physician and other health care practitioner orders
20 at the point of care for medications and laboratory and
21 radiological tests;
22 (D) inpatient computerized order entry systems
23 to reduce errors, improve health care quality, and lower costs in a
24 hospital setting;
25 (E) regional data-sharing to coordinate patient
26 care across a community for patients who are treated by multiple
27 providers; and

1 (F) electronic intensive care unit technology to
2 allow physicians to fully monitor hospital patients remotely.
3 (b) The commission shall adopt and implement policies that
4 encourage the use of electronic transactions in Medicaid. The
5 policies must:
6 (1) promote electronic payment systems for Medicaid
7 providers, including electronic funds transfer or other electronic
8 payment remittance and electronic payment status reports; and
9 (2) encourage providers through the use of incentives
10 to submit claims and prior authorization requests electronically to
11 help promote faster response times and reduce the administrative
12 costs related to paper claims processing.
13 SECTION 6. Subchapter B, Chapter 531, Government Code, is
14 amended by adding Sections 531.024162 and 531.024163 to read as
15 follows:
16 Sec. 531.024162. NOTICE REQUIREMENTS REGARDING MEDICAID
17 COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS.
18 (a) The commission shall ensure that notice sent by the commission
19 or a Medicaid managed care organization to a Medicaid recipient or
20 provider regarding the denial of coverage or prior authorization
21 for a service includes:
22 (1) information required by federal and state law;
23 (2) for the recipient, a clear and easy-to-understand
24 explanation of the reason for the denial; and
25 (3) for the provider, a thorough and detailed clinical
26 explanation of the reason for the denial, including, as applicable,
27 information required under Subsection (b).

1 (b) The commission or a Medicaid managed care organization
2 that receives from a provider a coverage or prior authorization
3 request that contains insufficient or inadequate documentation to
4 approve the request shall issue a notice to the provider and the
5 Medicaid recipient on whose behalf the request was submitted. The
6 notice issued under this subsection must:
7 (1) include a section specifically for the provider
8 that contains:
9 (A) a clear and specific list and description of
10 the documentation necessary for the commission or organization to
11 make a final determination on the request;
12 (B) the applicable timeline, based on the
13 requested service, for the provider to submit the documentation and
14 a description of the reconsideration process described by Section
15 533.00284, if applicable; and
16 (C) information on the manner through which a
17 provider may contact a Medicaid managed care organization or other
18 entity as required by Section 531.024163; and
19 (2) be sent to the provider:
20 (A) using the provider's preferred method of
21 contact most recently provided to the commission or the Medicaid
22 managed care organization and using any alternative and known
23 methods of contact; and
24 (B) as applicable, through an electronic
25 notification on an Internet portal.
26 Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING
27 MEDICAID PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive

1 commissioner by rule shall require each Medicaid managed care
2 organization or other entity responsible for authorizing coverage
3 for health care services under Medicaid to ensure that the
4 organization or entity maintains on the organization's or entity's
5 Internet website in an easily searchable and accessible format:
6 (1) the applicable timelines for prior authorization
7 requirements, including:
8 (A) the time within which the organization or
9 entity must make a determination on a prior authorization request;
10 (B) a description of the communications the
11 organization or entity provides to a provider and Medicaid
12 recipient regarding the documentation required to complete a
13 determination on a prior authorization request; and
14 (C) the deadline by which the organization or
15 entity is required to submit the communications described by
16 Paragraph (B); and
17 (2) an accurate and up-to-date catalogue of coverage
18 criteria and prior authorization requirements, including:
19 (A) for a prior authorization requirement first
20 imposed on or after September 1, 2019, the effective date of the
21 requirement;
22 (B) a list or description of any necessary or
23 supporting documentation necessary to obtain prior authorization
24 for a specified service; and
25 (C) the date and results of each review of the
26 prior authorization requirement conducted under Section 533.00283,
27 if applicable.

1 (b) The executive commissioner by rule shall require each
2 Medicaid managed care organization or other entity responsible for
3 authorizing coverage for health care services under Medicaid to:
4 (1) adopt and maintain a process for a provider or
5 Medicaid recipient to contact the organization or entity to clarify
6 prior authorization requirements or assist the provider or
7 recipient in submitting a prior authorization request; and
8 (2) ensure that the process described by Subdivision
9 (1) is not arduous or overly burdensome to a provider or recipient.
10 SECTION 7. Section 531.0317, Government Code, is amended by
11 adding Subsections (c-1) and (c-2) to read as follows:
12 (c-1) For the portion of the Internet site relating to
13 Medicaid, the commission shall:
14 (1) ensure the information is accessible and usable;
15 (2) publish Medicaid managed care organization
16 performance measures; and
17 (3) organize and maintain that portion of the Internet
18 site in a manner that serves Medicaid recipients, providers, and
19 managed care organizations, stakeholders, and the public.
20 (c-2) The commission shall establish and maintain an
21 interactive public portal on the Internet site that incorporates
22 data collected under Section 533.026 to allow Medicaid recipients
23 to compare Medicaid managed care organizations within a service
24 region.
25 SECTION 8. Section 531.073, Government Code, is amended by
26 adding Subsection (k) to read as follows:
27 (k) The commission, in consultation with physicians and

1 Medicaid managed care organizations, annually shall review prior
2 authorization requirements in the Medicaid vendor drug program and
3 determine whether to change, update, or delete any of the
4 requirements based on publicly available, up-to-date,
5 evidence-based, and peer-reviewed clinical criteria.
6 SECTION 9. Section 531.076, Government Code, is amended by
7 amending Subsection (b) and adding Subsections (c), (d), (e), (f),
8 (g), (h), (i), (j), (k), (l), and (m) to read as follows:
9 (b) The commission shall monitor Medicaid managed care
10 organizations to ensure that the organizations:
11 (1) are using prior authorization and utilization
12 review processes to reduce authorizations of unnecessary services
13 and inappropriate use of services; and
14 (2) are not using prior authorization to negatively
15 impact recipients' access to care.
16 (c) The commission shall monitor whether a Medicaid managed
17 care organization complies with applicable laws and rules in
18 establishing prior authorization requirements.
19 (d) The commission shall hold a Medicaid managed care
20 organization accountable for services and coordination the
21 organization is by contract required to provide.
22 (e) The commission annually shall review a Medicaid managed
23 care organization's prior authorization requirements and recommend
24 whether the organization should change, update, or delete any of
25 those requirements based on publicly available, up-to-date,
26 evidence-based, and peer-reviewed clinical criteria.
27 (f) To enable the commission to increase the commission's

1 utilization review resources with respect to Medicaid managed care
2 organization performance, the commission shall:
3 (1) increase the sample size and types of services
4 subject to utilization review to ensure an adequate and
5 representative sample;
6 (2) use a data-driven approach, including considering
7 data on provider grievances filed with the office of ombudsman for
8 Medicaid providers, to efficiently select cases for utilization
9 review that aligns with the commission's priorities for improved
10 outcomes; and
11 (3) use additional national measures the commission
12 considers appropriate.
13 (g) Before posting on the commission's Internet website the
14 findings of a Medicaid managed care organization's utilization
15 review performance or assessing liquidated damages related to that
16 performance, the commission shall allow the organization to review
17 and dispute the findings and discuss concerns with the commission.
18 The commission shall document comments from the organization not
19 later than the 60th day after the date the comments are received.
20 The commission shall post the comments along with the utilization
21 review findings.
22 (h) The commission shall request information regarding and
23 review the outcomes and timeliness of a Medicaid managed care
24 organization's prior authorizations to determine for particular
25 service requests:
26 (1) the number of service hours and units requested,
27 delivered, and billed;

1 (2) whether the organization denied, approved, or
2 amended the prior authorization request; and
3 (3) whether a denied prior authorization request
4 resulted in an internal appeal or a review by the external medical
5 reviewer described by Section 533.00715 and the final decision in
6 the appeal or review.
7 (i) The executive commissioner by rule shall determine the
8 frequency with which the commission may request information under
9 Subsection (h).
10 (j) The commission may:
11 (1) require an assessment of a Medicaid managed care
12 organization's employee who conducts utilization review to ensure
13 the employee's decisions and assessments are consistent with those
14 of other employees, clinical criteria, and guidelines;
15 (2) require the organization to provide a sample case
16 to:
17 (A) test how the organization conducts service
18 planning and utilization review; and
19 (B) determine whether the organization is
20 following the organization's utilization management policies and
21 procedures as expressed in the contract between the organization
22 and the commission, the organization's patient handbook, and other
23 publicly available written documents; and
24 (3) randomly select an employee to test how the
25 organization conducts service planning and utilization review,
26 particularly in the:
27 (A) STAR+PLUS Medicaid managed care program;

(B) STAR Kids managed care program; and

(C) STAR Health program.

(k) To the extent feasible, the commission shall give guidance on aligning treatments and conditions subject to prior authorization to create uniformity among Medicaid managed care plans. The commission, in consultation with physicians, other relevant providers, and Medicaid managed care organizations, shall take into account differences in the region and recipient populations, including ages of those populations, served under a plan and other relevant factors.

(l) The commission by rule shall require each Medicaid managed care organization to submit to the commission at least annually:

(1) a list of the conditions and treatments subject to prior authorization under the managed care plan offered by the organization;

(2) a specific description of the documentation the organization requires to approve a prior authorization request;

(3) the effective date of each prior authorization requirement;

(4) a description of the basis of each prior authorization requirement and the applicable medical screening criteria; and

(5) the dates of each previous prior authorization review conducted under Subsection (e) and the results and findings of those reviews.

(m) The commission shall develop a template for a Medicaid

1 managed care organization to use to post prior authorization
2 information on the organization's Internet website.
3 SECTION 10. Section 533.00253, Government Code, is amended
4 by adding Subsections (f), (g), and (h) to read as follows:
5 (f) The commission shall ensure that the care coordinator
6 for a Medicaid managed care organization under the STAR Kids
7 managed care program offers a recipient's parent or legally
8 authorized representative the opportunity to review the
9 recipient's completed care needs assessment. The commission shall
10 ensure the review does not delay the determination of the services
11 to be provided to the recipient or the ability to authorize and
12 initiate services. The commission shall require the parent's or
13 representative's signature to verify the parent or representative
14 received the opportunity to review the assessment with the care
15 coordinator. A Medicaid managed care organization may not delay
16 the delivery of care pending the signature. The commission shall
17 provide a parent or representative who disagrees with a care needs
18 assessment an opportunity to dispute the assessment with the
19 commission through a peer-to-peer review with the treating
20 physician of choice.
21 (g) The commission, in consultation with stakeholders,
22 shall redesign the care needs assessment used in the STAR Kids
23 managed care program to ensure the assessment collects useable and
24 actionable data pertinent to a child's physical, behavioral, and
25 long-term care needs. This subsection expires September 1, 2021.
26 (h) The advisory committee or a successor committee shall
27 provide recommendations to the commission for the redesign of the

private duty nursing assessment tools used in the STAR Kids managed care program based on observations from other states to be more comprehensive and allow for the streamlining of the documentation for prior authorization of private duty nursing. This subsection expires September 1, 2021.

SECTION 11. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.002533, 533.00271, 533.00282, 533.00283, and 533.00284 to read as follows:

Sec. 533.002533. CONTINUATION OF STAR KIDS MANAGED CARE ADVISORY COMMITTEE. The commission shall periodically evaluate whether to continue the STAR Kids Managed Care Advisory Committee established under Section 531.012 as a forum to identify and make recommendations for resolving eligibility, clinical, and administrative issues with the STAR Kids managed care program.

Sec. 533.00271. EXTERNAL QUALITY REVIEW ORGANIZATION: EVALUATION OF MEDICAID MANAGED CARE GENERALLY. (a) The commission annually shall identify and study areas of Medicaid managed care organization services for which the commission needs additional information. The external quality review organization annually shall study and report to the commission on at least three measures related to the identified areas and other measures the commission considers appropriate, which may include measures in the core set of children's health care quality measures or core set of adults' health care quality measures published by the United States Department of Health and Human Services.

(b) The external quality review organization annually shall:

1 (1) individually compare not-for-profit and
2 for-profit managed care plans offered by Medicaid managed care
3 organizations; and
4 (2) report to the commission the comparison between
5 those plans on the following under the plans:
6 (A) rates of:
7 (i) inquiries and complaints about access
8 to a provider in an enrollee's local area;
9 (ii) grievances, as defined by Section
10 533.027, received by the commission; and
11 (iii) service denials for Medicaid-covered
12 services;
13 (B) the number of Medicaid providers within a
14 specific provider type in an enrollee's local area;
15 (C) outcomes of internal appeals and external
16 medical reviews, including the number of appeals reversed;
17 (D) outcomes of fair hearing requests;
18 (E) constituent complaints brought to the
19 Medicaid managed care organization's attention by an individual or
20 entity, including a state legislator or the commission;
21 (F) provider opinions of the Medicaid managed
22 care organization's quality; and
23 (G) differences in Medicaid managed care
24 business and operation practices that may contribute to differences
25 in recipient medical acuity.
26 (c) The commission shall require each Medicaid managed care
27 organization to submit quarterly the information necessary to make

1 the comparison described by Subsection (b).
2 (d) The external quality review organization shall review
3 aggregate denial data categorized by Medicaid managed care plan to
4 identify trends and determine whether a Medicaid managed care
5 organization is disproportionately denying prior authorization
6 requests from a single provider or set of providers.
7 (e) The external quality review organization shall conduct
8 a study to determine whether Medicaid managed care organizations
9 could provide care coordination remotely through technology,
10 including synchronous audio-visual interaction. Not later than
11 September 1, 2020, the external quality review organization shall
12 prepare and submit a written report of the results of the study to
13 the commission. This subsection expires September 1, 2021.
14 Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION
15 PROCEDURES. In addition to the requirements of Section 533.005, a
16 contract between a Medicaid managed care organization and the
17 commission must require that:
18 (1) before issuing an adverse determination on a prior
19 authorization request, the organization provide the physician
20 requesting the prior authorization with a reasonable opportunity to
21 discuss the request with another physician who practices in the
22 same or a similar specialty, but not necessarily the same
23 subspecialty, and has experience in treating the same category of
24 population as the recipient on whose behalf the request is
25 submitted;
26 (2) the organization review and issue determinations
27 on prior authorization requests according to the following time

1 frames:
2 (A) with respect to a recipient who is
3 hospitalized at the time of the request:
4 (i) within one business day after receiving
5 the request, except as provided by Subparagraphs (ii) and (iii);
6 (ii) within 72 hours after receiving the
7 request if the request is submitted by a provider of acute care
8 inpatient services for services or equipment necessary to discharge
9 the recipient from an inpatient facility; or
10 (iii) within one hour after receiving the
11 request if the request is related to poststabilization care or a
12 life-threatening condition; or
13 (B) with respect to a recipient who is not
14 hospitalized at the time of the request, within three business days
15 after receiving the request; and
16 (3) the organization:
17 (A) have appropriate personnel reasonably
18 available at a toll-free telephone number to respond to a prior
19 authorization request between 6 a.m. and 6 p.m. central time Monday
20 through Friday on each day that is not a legal holiday and between 9
21 a.m. and noon central time on Saturday, Sunday, and legal holidays;
22 (B) have a telephone system capable of receiving
23 and recording incoming telephone calls for prior authorization
24 requests after 6 p.m. central time Monday through Friday and after
25 noon central time on Saturday, Sunday, and legal holidays; and
26 (C) have appropriate personnel to respond to each
27 call described by Paragraph (B) not later than 24 hours after

receiving the call.

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed care organization shall 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 for the vendor drug program. In conducting a review, the organization must:

(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) A Medicaid managed care organization may not impose 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.

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must include a requirement that the organization establish a process for reconsidering an adverse determination on a prior authorization

1 request that resulted solely from the submission of insufficient or
2 inadequate documentation.
3 (b) The process for reconsidering an adverse determination
4 on a prior authorization request under this section must:
5 (1) allow a provider to, not later than the seventh
6 business day following the date of the determination, submit any
7 documentation that was identified as insufficient or inadequate in
8 the notice provided under Section 531.024162;
9 (2) allow the physician requesting the prior
10 authorization to discuss the request with another physician who
11 practices in the same or a similar specialty, but not necessarily
12 the same subspecialty, and has experience in treating the same
13 category of population as the recipient on whose behalf the request
14 is submitted; and
15 (3) require the Medicaid managed care organization to,
16 not later than the first business day following the date the
17 provider submits sufficient and adequate documentation under
18 Subdivision (1), amend the determination to approve the prior
19 authorization request.
20 (c) An adverse determination on a prior authorization
21 request is considered a denial of services in an evaluation of the
22 Medicaid managed care organization only if the determination is not
23 amended under Subsection (b)(3).
24 (d) The process for reconsidering an adverse determination
25 on a prior authorization request under this section does not
26 affect:
27 (1) any related timelines, including the timeline for

an internal appeal, an external medical review, or a Medicaid fair hearing; or

(2) any rights of a recipient to appeal a determination on a prior authorization request.

SECTION 12. Section 533.005, Government Code, is amended by amending Subsection (a) and adding Subsection (g) to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of

educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan on any claim for payment after receiving the claim and [~~that is received with~~] documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

(8) a requirement that the commission, on the date of a

recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in

1 the organization's provider network; and
2 (B) treat advanced practice registered nurses
3 and physician assistants in the same manner as primary care
4 physicians with regard to:
5 (i) selection and assignment as primary
6 care providers;
7 (ii) inclusion as primary care providers in
8 the organization's provider network; and
9 (iii) inclusion as primary care providers
10 in any provider network directory maintained by the organization;
11 (14) a requirement that the managed care organization
12 reimburse a federally qualified health center or rural health
13 clinic for health care services provided to a recipient outside of
14 regular business hours, including on a weekend day or holiday, at a
15 rate that is equal to the allowable rate for those services as
16 determined under Section 32.028, Human Resources Code, if the
17 recipient does not have a referral from the recipient's primary
18 care physician;
19 (15) a requirement that the managed care organization
20 develop, implement, and maintain a system for tracking and
21 resolving all provider appeals related to claims payment, including
22 a process that will require:
23 (A) a tracking mechanism to document the status
24 and final disposition of each provider's claims payment appeal;
25 (B) the contracting with physicians who are not
26 network providers and who are of the same or related specialty as
27 the appealing physician to resolve claims disputes related to

1 denial on the basis of medical necessity that remain unresolved
2 subsequent to a provider appeal;
3 (C) the determination of the physician resolving
4 the dispute to be binding on the managed care organization and
5 provider; and
6 (D) the managed care organization to allow a
7 provider with a claim that has not been paid before the time
8 prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that
9 claim;
10 (16) a requirement that a medical director who is
11 authorized to make medical necessity determinations is available to
12 the region where the managed care organization provides health care
13 services;
14 (17) a requirement that the managed care organization
15 ensure that a medical director and patient care coordinators and
16 provider and recipient support services personnel are located in
17 the South Texas service region, if the managed care organization
18 provides a managed care plan in that region;
19 (18) a requirement that the managed care organization
20 provide special programs and materials for recipients with limited
21 English proficiency or low literacy skills;
22 (19) a requirement that the managed care organization
23 develop and establish a process for responding to provider appeals
24 in the region where the organization provides health care services;
25 (20) a requirement that the managed care organization:
26 (A) develop and submit to the commission, before
27 the organization begins to provide health care services to

recipients, a comprehensive plan that describes how the organization's provider network complies with the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a-1) [~~533.0061(a)~~] and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a

1 request for prior authorization for the care or service and the date
2 the care or service is initiated;
3 (21) a requirement that the managed care organization
4 demonstrate to the commission, before the organization begins to
5 provide health care services to recipients, that, subject to the
6 provider access standards established under Section 533.0061:
7 (A) the organization's provider network has the
8 capacity to serve the number of recipients expected to enroll in a
9 managed care plan offered by the organization;
10 (B) the organization's provider network
11 includes:
12 (i) a sufficient number of primary care
13 providers;
14 (ii) a sufficient variety of provider
15 types;
16 (iii) a sufficient number of providers of
17 long-term services and supports and specialty pediatric care
18 providers of home and community-based services; and
19 (iv) providers located throughout the
20 region where the organization will provide health care services;
21 and
22 (C) health care services will be accessible to
23 recipients through the organization's provider network to a
24 comparable extent that health care services would be available to
25 recipients under a fee-for-service or primary care case management
26 model of Medicaid managed care;
27 (22) a requirement that the managed care organization

develop a monitoring program for measuring the quality of the [~~health care~~] services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures <u>or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability</u>;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under Medicaid;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

(G) that allows the managed care organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code; and

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) to place a drug on a maximum allowable cost list, must ensure that:

(a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(b) the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

1 (ii) must provide to a network pharmacy
2 provider, at the time a contract is entered into or renewed with the
3 network pharmacy provider, the sources used to determine the
4 maximum allowable cost pricing for the maximum allowable cost list
5 specific to that provider;
6 (iii) must review and update maximum
7 allowable cost price information at least once every seven days to
8 reflect any modification of maximum allowable cost pricing;
9 (iv) must, in formulating the maximum
10 allowable cost price for a drug, use only the price of the drug and
11 drugs listed as therapeutically equivalent in the most recent
12 version of the United States Food and Drug Administration's
13 Approved Drug Products with Therapeutic Equivalence Evaluations,
14 also known as the Orange Book;
15 (v) must establish a process for
16 eliminating products from the maximum allowable cost list or
17 modifying maximum allowable cost prices in a timely manner to
18 remain consistent with pricing changes and product availability in
19 the marketplace;
20 (vi) must:
21 (a) provide a procedure under which a
22 network pharmacy provider may challenge a listed maximum allowable
23 cost price for a drug;
24 (b) respond to a challenge not later
25 than the 15th day after the date the challenge is made;
26 (c) if the challenge is successful,
27 make an adjustment in the drug price effective on the date the

1 challenge is resolved[,] and make the adjustment applicable to all
2 similarly situated network pharmacy providers, as determined by the
3 managed care organization or pharmacy benefit manager, as
4 appropriate;
5 (d) if the challenge is denied,
6 provide the reason for the denial; and
7 (e) report to the commission every 90
8 days the total number of challenges that were made and denied in the
9 preceding 90-day period for each maximum allowable cost list drug
10 for which a challenge was denied during the period;
11 (vii) must notify the commission not later
12 than the 21st day after implementing a practice of using a maximum
13 allowable cost list for drugs dispensed at retail but not by mail;
14 and
15 (viii) must provide a process for each of
16 its network pharmacy providers to readily access the maximum
17 allowable cost list specific to that provider;
18 (24) a requirement that the managed care organization
19 and any entity with which the managed care organization contracts
20 for the performance of services under a managed care plan disclose,
21 at no cost, to the commission and, on request, the office of the
22 attorney general all discounts, incentives, rebates, fees, free
23 goods, bundling arrangements, and other agreements affecting the
24 net cost of goods or services provided under the plan;
25 (25) a requirement that the managed care organization
26 not implement significant, nonnegotiated, across-the-board
27 provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reductions [~~reduction~~]; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; [~~and~~]

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes;

(27) a requirement that the managed care organization:

(A) not deny a reasonable prior authorization request or claim for a technical or minimal error; and

(B) not abuse the appeals or external medical review process to deter a recipient or provider from requesting health care services;

(28) a requirement that the managed care organization:

(A) automatically, without a request from a recipient or program, continue to provide the pre-reduction or pre-denial level of services to the recipient during an internal appeal or a review by the external medical reviewer described by Section 533.00715 of a reduction in or denial of services, unless the recipient or the recipient's parent on behalf of the recipient opts out of the automatic continuation of services; and

(B) provide the commission and the recipient with a notice of continuing services;

(29) a requirement that the managed care organization comply with the external medical review procedure established under

1 Section 533.00715 and comply with the external medical reviewer's
2 determination; and
3 (30) a requirement that the managed care organization
4 pay liquidated damages for each substantiated failure to adhere to
5 contractual requirements.
6 (g) The commission shall provide guidance and additional
7 education to managed care organizations regarding requirements
8 under federal law and Subsection (a)(28) to continue to provide
9 services during an internal appeal, an external medical review, and
10 a Medicaid fair hearing.
11 SECTION 13. Section 533.0051, Government Code, is amended
12 by adding Subsection (h) to read as follows:
13 (h) To monitor performance measures, the commission shall
14 develop a data-sharing platform that enables divisions within the
15 commission to electronically view data and access data analysis in
16 a single location.
17 SECTION 14. Subchapter A, Chapter 533, Government Code, is
18 amended by adding Section 533.0058 to read as follows:
19 Sec. 533.0058. INITIAL THERAPY EVALUATION IN CERTAIN
20 MANAGED CARE PROGRAMS. A Medicaid managed care organization that
21 provides health care services under the STAR Health program or the
22 STAR Kids managed care program may require prior authorization for
23 an initial therapy evaluation for a recipient only if the
24 requirement aligns with clinical criteria.
25 SECTION 15. The heading to Section 533.0061, Government
26 Code, is amended to read as follows:
27 Sec. 533.0061. PROVIDER ACCESS STANDARDS AND NETWORK

1 ADEQUACY; REPORT.

2 SECTION 16. Section 533.0061, Government Code, is amended
3 by amending Subsection (a) and adding Subsections (a-1), (b-1),
4 (b-2), (b-3), (b-4), (d), and (e) to read as follows:

5 (a) In this section:

6 (1) "Access to care" means access to care and services
7 available under Medicaid at least to the same extent that similar
8 care and services are available to the general population in the
9 recipient's geographic area.

10 (2) "Network adequacy" means the adequacy of a
11 Medicaid managed care organization's provider network determined
12 according to standards established by federal law.

13 (a-1) The commission shall establish minimum provider
14 access standards for the provider network of a managed care
15 organization that contracts with the commission to provide health
16 care services to recipients. The access standards must ensure that
17 a Medicaid managed care organization provides recipients
18 sufficient access to:

19 (1) preventive care;

20 (2) primary care;

21 (3) specialty care;

22 (4) after-hours urgent care;

23 (5) chronic care;

24 (6) long-term services and supports;

25 (7) nursing services;

26 (8) therapy services, including services provided in a
27 clinical setting or in a home or community-based setting; and

1 (9) any other services identified by the commission.
2 (b-1) Except as provided by Subsection (b-4), the
3 commission shall use travel time and distance standards to measure
4 network adequacy.
5 (b-2) In determining network adequacy, the commission shall
6 use automated data validation and calculation tools to decrease
7 processing time and resources required for calculating provider
8 distance and travel time. The commission shall use Medicaid
9 managed care organization contract data to validate network
10 adequacy determinations.
11 (b-3) The commission shall integrate access to care data
12 with network adequacy data to evaluate and monitor provider network
13 adequacy based on both provider location and availability.
14 (b-4) To account for differences in recipient population
15 and provider entity size, the commission shall establish provider
16 network adequacy standards, other than travel time and distance
17 standards, applicable in assessing the network adequacy for
18 personal care attendants and licensed providers of home and
19 community-based services in the home who travel to a recipient to
20 provide care. The commission shall develop and implement a process
21 to assist Medicaid managed care organizations in implementing the
22 network adequacy standards. The external quality review
23 organization shall periodically evaluate and report to the
24 commission on personal care attendant network adequacy.
25 (d) The executive commissioner by rule shall ensure that an
26 evaluation of a Medicaid managed care organization's provider
27 network adequacy conducted by the commission or the external

quality review organization with information obtained from a managed care organization's provider network directory is based on the total number of providers listed in the directory. The commission or external quality review organization must consider a provider with incorrect contact information or who is no longer participating in Medicaid as having no appointment availability for purposes of the evaluation.

(e) The external quality review organization shall use existing encounter data to monitor a Medicaid managed care organization's network adequacy and the accuracy of the organization's provider directories.

SECTION 17. Section 533.0063, Government Code, is amended by adding Subsections (d) and (e) to read as follows:

(d) The commission shall use the commission's master file of Medicaid providers to validate the provider network directory of a managed care organization described by Subsection (a). The commission shall establish a procedure to ensure the commission's master file of Medicaid providers is accurate and up-to-date.

(e) The commission shall prepare and submit to the legislature not later than December 1, 2020, a report describing the procedure required by Subsection (d) and how the procedure improves the current method of verifying and updating provider lists and the master file described by that subsection. This subsection expires September 1, 2021.

SECTION 18. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00661 to read as follows:

Sec. 533.00661. PROVIDER INCENTIVES: SELECTIVE PRIOR

1 AUTHORIZATION REQUIREMENTS. (a) The commission may implement
2 quality-based incentives designed to reduce the administrative
3 burdens and number of prior authorization requirements for
4 providers who are providing appropriate, quality care. The
5 commission may include incentives under which Medicaid managed care
6 organizations selectively require prior authorization for services
7 ordered by providers based on provider performance on quality
8 measures and adherence to evidence-based medicine or other
9 contractual agreements, such as risk-sharing arrangements.
10 (b) Criteria for selectively requiring prior authorization
11 described by Subsection (a) may include ordering or prescribing
12 patterns that align with evidence-based guidelines or historically
13 high prior authorization request approval rates.
14 (c) As part of the incentives under this section, the
15 commission may encourage Medicaid managed care organizations to:
16 (1) use programs that selectively require prior
17 authorization based on classifications of provider performance and
18 adherence to evidence-based medicine;
19 (2) develop criteria, with the input of the providers
20 or provider organizations, for the selection of providers to
21 participate in the selective prior authorization programs and for
22 their continued participation in the programs;
23 (3) make the criteria described by Subdivision (2)
24 transparent and easily accessible to providers; and
25 (4) make appropriate adjustments to prior
26 authorization requirements for providers participating in
27 risk-based payment contracts.

1 SECTION 19. Section 533.0071, Government Code, is amended
2 to read as follows:
3 Sec. 533.0071. ADMINISTRATION OF CONTRACTS. (a) The
4 commission shall make every effort to improve the administration of
5 contracts with Medicaid managed care organizations. To improve the
6 administration of these contracts, the commission shall:
7 (1) ensure that the commission has appropriate
8 expertise and qualified staff to effectively manage contracts with
9 managed care organizations under the Medicaid managed care program;
10 (2) evaluate options for Medicaid payment recovery
11 from managed care organizations if the enrollee dies or is
12 incarcerated or if an enrollee is enrolled in more than one state
13 program or is covered by another liable third party insurer;
14 (3) maximize Medicaid payment recovery options by
15 contracting with private vendors to assist in the recovery of
16 capitation payments, payments from other liable third parties, and
17 other payments made to managed care organizations with respect to
18 enrollees who leave the managed care program; and
19 (4) decrease the administrative burdens of managed
20 care for the state, the managed care organizations, and the
21 providers under managed care networks to the extent that those
22 changes are compatible with state law and existing Medicaid managed
23 care contracts, including decreasing those burdens by:
24 (A) where possible, decreasing the duplication
25 of administrative reporting and process requirements for the
26 managed care organizations and providers, such as requirements for
27 the submission of encounter data, quality reports, historically

underutilized business reports, and claims payment summary reports;

(B) allowing managed care organizations to provide updated address information directly to the commission for correction in the state system;

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to the preauthorization process, lengths of hospital stays, filing deadlines, levels of care, and case management services;

(D) reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications; and

(E) providing a portal through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims[~~; and~~

[~~(5) reserve the right to amend the managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process established by the commission for final determination of these disputes~~].

(b) For a contract described by Subsection (a), the commission shall:

(1) automate the process for receiving and tracking

1 contract amendment requests and incorporating an amendment into a
2 contract;
3 (2) make the most recent contract amendment
4 information readily available among divisions within the
5 commission; and
6 (3) provide technical assistance and education to help
7 a commission employee determine whether a requested contract
8 amendment is necessary or whether the issue could be resolved
9 through the uniform managed care manual, a memorandum, or guidance.
10 (c) The commission shall create a summary compliance
11 framework that summarizes contract provisions to help Medicaid
12 managed care organizations comply with those provisions.
13 (d) The commission shall annually review and assess
14 contract deliverables and eliminate unnecessary deliverables for
15 Medicaid managed care contracts. The commission may identify
16 measures to strengthen the contract deliverables and implement
17 those measures as needed.
18 SECTION 20. Subchapter A, Chapter 533, Government Code, is
19 amended by adding Section 533.00715 to read as follows:
20 Sec. 533.00715. EXTERNAL MEDICAL REVIEW. (a) In this
21 section, "external medical reviewer" and "reviewer" mean a
22 third-party medical review organization that provides objective,
23 unbiased medical necessity determinations conducted by clinical
24 staff with education and practice in the same or similar practice
25 area as the procedure for which an independent determination of
26 medical necessity is sought in accordance with applicable state law
27 and rules.

(b) The commission shall contract with an independent external medical reviewer to conduct external medical reviews and review:

(1) the resolution of a 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 the commission of eligibility for a Medicaid program in which eligibility is based on a recipient's medical and functional needs.

(c) A Medicaid managed care organization may not have a financial relationship with or ownership interest in the external medical reviewer with which the commission contracts.

(d) The external medical reviewer with which the commission contracts must:

(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) The commission shall establish a common procedure for reviews. The procedure must provide that a service ordered by a health care provider is presumed medically necessary and the Medicaid managed care organization bears the burden of proof to show the service is not medically necessary. Medical necessity must be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. The reviewer shall conduct the review within a period specified by the commission. The

1 commission shall also establish a procedure for expedited reviews
2 that allows the reviewer to identify an appeal that requires an
3 expedited resolution.
4 (f) An external medical review described by Subsection
5 (b)(1) occurs after the internal Medicaid managed care organization
6 appeal and before the Medicaid fair hearing and is granted when a
7 recipient contests the internal appeal decision of the Medicaid
8 managed care organization. An external medical review described by
9 Subsection (b)(2) occurs after the eligibility denial and before
10 the Medicaid fair hearing. The recipient or applicant, or the
11 recipient's or applicant's parent or legally authorized
12 representative, must affirmatively opt out of the external medical
13 review to proceed to a Medicaid fair hearing without first
14 participating in the external medical review.
15 (g) The external medical reviewer's determination of
16 medical necessity establishes the minimum level of services a
17 recipient must receive.
18 (h) The external medical reviewer shall require a Medicaid
19 managed care organization, in an external medical review relating
20 to a reduction in services, to submit a detailed reason for the
21 reduction and supporting documents.
22 (i) The external medical reviewer shall establish and
23 maintain an Internet portal through which a recipient may track the
24 status and final disposition of a review.
25 (j) The external medical reviewer shall educate recipients
26 and employees of Medicaid managed care organizations regarding
27 appeal and review processes, options, and proper and improper

1 denials of services on the basis of medical necessity.
2 SECTION 21. The heading to Section 533.0072, Government
3 Code, is amended to read as follows:
4 Sec. 533.0072. CORRECTIVE ACTION PLANS AND [~~INTERNET~~
5 ~~POSTING OF~~] SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS.
6 SECTION 22. Section 533.0072, Government Code, is amended
7 by amending Subsections (a), (b), and (c) and adding Subsections
8 (b-1) and (b-2) to read as follows:
9 (a) The commission shall prepare and maintain a record of
10 each enforcement action initiated by the commission [~~that results~~
11 ~~in a sanction, including a penalty, being imposed~~] against a
12 managed care organization for failure to comply with the terms of a
13 contract to provide health care services to recipients through a
14 managed care plan issued by the organization, including:
15 (1) an enforcement action that results in a sanction,
16 including a penalty;
17 (2) the imposition of a corrective action plan;
18 (3) the imposition of liquidated damages;
19 (4) the suspension of default enrollment; and
20 (5) the termination of the organization's contract.
21 (b) The record must include:
22 (1) the name and address of the organization;
23 (2) a description of the contractual obligation the
24 organization failed to meet;
25 (3) the date of determination of noncompliance;
26 (4) the date the sanction was imposed, if applicable;
27 (5) the maximum sanction that may be imposed under the

contract for the violation, if applicable; and

(6) the actual sanction imposed against the organization, if applicable.

(b-1) In assessing liquidated damages against a Medicaid managed care organization, the commission shall:

(1) include in the record prepared under Subsection (a):

(A) each step taken in the process of recommending and assessing liquidated damages; and

(B) the reason for any reduction of liquidated damages from the recommended amount;

(2) assess liquidated damages in an amount that is sufficient to ensure compliance with the uniform managed care contract and is a reasonable forecast of the damages caused by the noncompliance; and

(3) apply liquidated damages and other enforcement actions consistently among Medicaid managed care organizations for similar violations.

(b-2) If the commission reduces the sanction or penalty in an enforcement action, the commission shall include in the record prepared under Subsection (a) the reason for the reduction.

(c) The commission shall post and maintain the records required by this section on the commission's Internet website in English and Spanish. The commission's office of inspector general shall post and maintain the records relating to corrective action plans required by this section on the office's Internet website. The records must be posted in a format that is readily accessible to

1 and understandable by a member of the public. The commission and
2 the office shall update the list of records on the website at least
3 quarterly.
4 SECTION 23. Section 533.0075, Government Code, is amended
5 to read as follows:
6 Sec. 533.0075. RECIPIENT ENROLLMENT. (a) The commission
7 shall:
8 (1) encourage recipients to choose appropriate
9 managed care plans and primary health care providers by:
10 (A) providing initial information to recipients
11 and providers in a region about the need for recipients to choose
12 plans and providers not later than the 90th day before the date on
13 which a managed care organization plans to begin to provide health
14 care services to recipients in that region through managed care;
15 (B) providing follow-up information before
16 assignment of plans and providers and after assignment, if
17 necessary, to recipients who delay in choosing plans and providers;
18 and
19 (C) allowing plans and providers to provide
20 information to recipients or engage in marketing activities under
21 marketing guidelines established by the commission under Section
22 533.008 after the commission approves the information or
23 activities;
24 (2) consider the following factors in assigning
25 managed care plans and primary health care providers to recipients
26 who fail to choose plans and providers:
27 (A) the importance of maintaining existing

provider-patient and physician-patient relationships, including relationships with specialists, public health clinics, and community health centers;

(B) to the extent possible, the need to assign family members to the same providers and plans; [~~and~~]

(C) geographic convenience of plans and providers for recipients;

(D) a recipient's previous plan assignment;

(E) the Medicaid managed care organization's performance on quality assurance and improvement;

(F) enforcement actions, including liquidated damages, imposed against the managed care organization;

(G) corrective action plans the commission has required the managed care organization to implement; and

(H) other reasonable factors that support the objectives of the managed care program;

(3) retain responsibility for enrollment and disenrollment of recipients in managed care plans, except that the commission may delegate the responsibility to an independent contractor who receives no form of payment from, and has no financial ties to, any managed care organization;

(4) develop and implement an expedited process for determining eligibility for and enrolling pregnant women and newborn infants in managed care plans; and

(5) ensure immediate access to prenatal services and newborn care for pregnant women and newborn infants enrolled in managed care plans, including ensuring that a pregnant woman may

obtain an appointment with an obstetrical care provider for an initial maternity evaluation not later than the 30th day after the date the woman applies for Medicaid.

(b) To help new recipients easily compare managed care plans with regard to quality and patient satisfaction measures, the commission shall incorporate information the commission determines is relevant in Medicaid managed care report cards, including:

(1) feedback from recipient complaints;

(2) a Medicaid managed care organization's rate of denials of Medicaid-covered services, appeals, and external medical reviews;

(3) outcomes of internal appeals and external medical reviews; and

(4) information for each organization related to external medical reviews under Section 533.00715.

(c) After enrolling a recipient in the medically dependent children (MDCP) waiver program or the STAR+PLUS Medicaid managed care program, the commission shall require the recipient's or legally authorized representative's signature to verify the recipient received the recipient handbook.

(d) The commission shall:

(1) survey a select sample of recipients receiving benefits under the medically dependent children (MDCP) waiver program or the STAR+PLUS Medicaid managed care program to determine whether the recipients:

(A) received the recipient handbook required by contract to be provided within the required period; and

1 (B) understand the information in the recipient
2 handbook; and
3 (2) provide a sample recipient handbook to Medicaid
4 managed care organizations.
5 SECTION 24. Subchapter A, Chapter 533, Government Code, is
6 amended by adding Section 533.0095 to read as follows:
7 Sec. 533.0095. CERTAIN PRIOR AUTHORIZATION EXTENSIONS. (a)
8 The commission shall establish a list of health care services and
9 prescription drugs for which a Medicaid managed care organization
10 must grant extended prior authorization periods or amounts, as
11 applicable, without requiring additional proof or documentation.
12 The commission shall also establish a list of disabilities, chronic
13 health conditions, and mental health conditions the treatments for
14 which a Medicaid managed care organization must grant extended
15 prior authorization periods without requiring additional proof or
16 documentation. The commission shall establish the extended periods
17 and amounts.
18 (b) The commission shall establish the lists in
19 consultation with clinical experts, physicians, hospitals, patient
20 advocacy groups, and Medicaid managed care organizations. The
21 commission shall also consult with stakeholders through the
22 Medicaid managed care advisory committee.
23 (c) The commission's medical director shall solicit and
24 receive provider feedback regarding extended prior authorization
25 periods, including feedback related to which health care services,
26 prescription drugs, and disabilities and health and mental health
27 conditions should be subject to extended prior authorization

periods.

(d) The commission shall update the lists every two years with input from the medical care advisory committee established under Section 32.022, Human Resources Code.

SECTION 25. The heading to Section 533.015, Government Code, is amended to read as follows:

Sec. 533.015. [~~COORDINATION OF~~] EXTERNAL OVERSIGHT ACTIVITIES.

SECTION 26. Section 533.015, Government Code, is amended by adding Subsections (d) and (e) to read as follows:

(d) In overseeing Medicaid managed care organizations, the commission's office of inspector general shall use a program integrity methodology appropriate for managed care. The office may explore different options to measure program integrity efforts, including:

(1) quantifying and validating cost avoidance in a managed care context; and

(2) adapting existing program integrity tools within the office to permit the office to address specific risks and incentives related to risk-based and value-based arrangements.

(e) The commission's office of inspector general shall apply standards established in a contract between a Medicaid managed care organization and a provider to the extent the contract is allowed by a contract between the commission and a Medicaid managed care organization or state or federal law, rules, or policy.

SECTION 27. Subchapter A, Chapter 533, Government Code, is

amended by adding Sections 533.026, 533.027, 533.028, 533.031, and 533.032 to read as follows:

Sec. 533.026. ENHANCED DATA COLLECTION AND REPORTING OF ADMINISTRATIVE COSTS; CONTRACT OVERSIGHT. (a) The commission shall collect accurate, consistent, and verifiable data from Medicaid managed care organizations, including line-item data for administrative costs.

(b) The commission shall use data collected from a Medicaid managed care organization under this section to:

(1) identify grievances, as defined by Section 533.027;

(2) monitor contract compliance;

(3) identify other programmatic issues; and

(4) identify whether the organization is:

(A) unnecessarily denying, reducing, or otherwise failing to provide health care services to recipients;

(B) delaying or denying provider claims due to technical or minimal errors; or

(C) otherwise engaging in behavior that merits an enforcement action.

(c) A Medicaid managed care organization shall report administrative costs in the organization's financial statistical report and shall report those costs to the commission at least annually. The commission shall report information provided under this subsection annually to the lieutenant governor, the speaker of the house, and each standing committee of the legislature with jurisdiction over financing, operating, and overseeing Medicaid.

1 (d) The commission shall use data from grievances collected
2 under Section 533.027 for contract oversight and to determine
3 contract risk.
4 (e) The commission shall:
5 (1) provide financial subject matter expertise for
6 Medicaid managed care contract review and compliance oversight
7 among divisions within the commission;
8 (2) conduct extensive validation of Medicaid managed
9 care financial data; and
10 (3) analyze the ultimate underlying cause of an issue
11 to resolve that cause and prevent similar issues from arising in the
12 future within Medicaid managed care.
13 (f) The commission's office of inspector general shall
14 assist the commission in implementing this section.
15 Sec. 533.027. MANAGED CARE GRIEVANCES: PROCESSES AND
16 TRACKING. (a) In this section:
17 (1) "Comprehensive long-term services and supports
18 provider" means a provider of long-term services and supports under
19 Chapter 534 that ensures the coordinated, seamless delivery of the
20 full range of services in a recipient's program plan. The term
21 includes:
22 (A) a provider under the ICF-IID program, as
23 defined by Section 534.001; and
24 (B) a provider under a Medicaid waiver program,
25 as defined by Section 534.001.
26 (2) "Grievance" means any expression of
27 dissatisfaction or dispute, other than a denial, expressing

1 dissatisfaction with any aspect of a Medicaid managed care
2 organization's operations, activities, or behavior. The term
3 includes a complaint about access to a provider in a recipient's
4 local area, a formal complaint, a request for an internal appeal, a
5 request for an external medical review, a request for a fair
6 hearing, and a complaint brought by an individual or entity,
7 including a legislator or the commission, submitted to or received
8 by:
9 (A) a commission employee;
10 (B) a Medicaid managed care organization;
11 (C) a comprehensive long-term services and
12 supports provider;
13 (D) the commission's office of inspector
14 general;
15 (E) the commission's office of the ombudsman;
16 (F) the office of ombudsman for Medicaid
17 providers; or
18 (G) the Department of Family and Protective
19 Services.
20 (b) The commission shall:
21 (1) provide education and training to commission
22 employees on the correct issue resolution processes for Medicaid
23 managed care grievances; and
24 (2) require those employees to promptly report
25 grievances into the commission's grievance tracking system to
26 enable employees to track and timely resolve grievances.
27 (c) To ensure all grievances are managed consistently, the

1 commission shall ensure the definition of a grievance is consistent
2 among:
3 (1) commission employees and divisions within the
4 commission;
5 (2) Medicaid managed care organizations;
6 (3) comprehensive long-term services and supports
7 providers;
8 (4) the commission's office of inspector general;
9 (5) the commission's office of the ombudsman;
10 (6) the office of ombudsman for Medicaid providers;
11 and
12 (7) the Department of Family and Protective Services.
13 (d) The commission shall enhance the Medicaid managed care
14 grievance-tracking system's reporting capabilities and standardize
15 data reporting among divisions within the commission.
16 (e) In coordination with the executive commissioner's
17 duties under Section 531.0171, the commission shall implement a
18 no-wrong-door system for Medicaid managed care grievances reported
19 to the commission. The commission shall ensure that commission
20 employees, Medicaid managed care organizations, comprehensive
21 long-term services and supports providers, the commission's office
22 of inspector general, the commission's office of the ombudsman, the
23 office of ombudsman for Medicaid providers, and the Department of
24 Family and Protective Services use common practices and policies
25 and provide consistent resolutions for Medicaid managed care
26 grievances.
27 (f) The commission shall:

1 (1) implement a data analytics program to aggregate
2 rates of inquiries, complaints, calls, and denials; and
3 (2) include in each Medicaid managed care
4 organization's quality rating:
5 (A) the aggregate rating and data analysis; and
6 (B) fair hearing requests and outcomes data.
7 (g) The commission's office of inspector general shall
8 review the commission's duties under Subsection (f).
9 (h) The commission shall ensure that a comprehensive
10 long-term services and supports provider may submit a grievance on
11 behalf of a recipient.
12 Sec. 533.028. CARE COORDINATION AND CARE COORDINATORS. (a)
13 In this section, "care coordination" means assisting recipients to
14 develop a plan of care, including a service plan, that meets the
15 recipient's needs and coordinating the provision of Medicaid
16 benefits in a manner that is consistent with the plan of care. The
17 term is synonymous with "service coordination" and "service
18 management."
19 (b) The commission shall ensure a person who is engaged by a
20 Medicaid managed care organization to provide care coordination
21 benefits is consistently referred to as a "care coordinator"
22 throughout divisions within the commission and across all Medicaid
23 programs and services for recipients receiving benefits under a
24 managed care delivery model.
25 (c) The commission shall expeditiously develop materials
26 explaining the role of care coordinators by Medicaid managed care
27 product line. The commission shall establish clear expectations

that the care coordinator communicate with a recipient's health care providers with the goal of ensuring coordinated, effective, and efficient care delivery.

(d) The commission shall collect data on care coordination touchpoints with recipients.

(e) The commission shall provide to each Medicaid managed care organization information regarding best practices for care coordination services for the organization to incorporate into providing care.

(f) The executive commissioner by rule shall determine which providers are eligible to have a Medicaid managed care organization's care coordinator on-site or available through virtual means at the provider's practice. The commission shall ensure a care coordinator is reimbursed for care coordination services provided on-site or virtually and encourage managed care organizations to place care coordinators on-site or make the care coordinators available through virtual means.

(g) The commission shall ensure that care coordinators coordinate with physicians and other health care providers in compiling documentation to satisfy Medicaid managed care organization requirements, including prior authorization requirements.

(h) In this subsection, "potentially preventable admission" and "potentially preventable readmission" have the meanings assigned by Section 536.001. The commission shall change the methodology for calculating potentially preventable admissions and potentially preventable readmissions to exclude from those

1 admission and readmission rates hospitalizations in which a
2 Medicaid managed care organization did not adequately coordinate
3 the patient's care. The methodology must apply to physical and
4 behavioral health conditions. The change in methodology must be
5 clinical in nature.
6 (i) The executive commissioner shall include a provision
7 establishing key performance metrics for care coordination in a
8 contract between a managed care organization and the commission for
9 the organization to provide health care services to recipients
10 receiving home and community-based services under the:
11 (1) STAR+PLUS Medicaid managed care program;
12 (2) STAR Kids managed care program; or
13 (3) STAR Health program.
14 (j) The commission shall establish for Medicaid managed
15 care organizations and ensure compliance with metrics for the
16 following:
17 (1) a dedicated toll-free care coordination telephone
18 number;
19 (2) the time frame for the return of telephone calls;
20 (3) notice of the name and telephone number of a
21 recipient's care coordinator for a recipient that has an assigned
22 care coordinator;
23 (4) notice of changes in the name or telephone number
24 of a recipient's care coordinator for a recipient that has an
25 assigned care coordinator;
26 (5) initiation of assessments and reassessments;
27 (6) establishment and regular updating of

1 comprehensive, person-centered individual service plans;
2 (7) number of face-to-face and telephonic contacts for
3 each care coordination level;
4 (8) care coordinator turnover rates; and
5 (9) follow-up after hospitalization.
6 Sec. 533.031. COORDINATION OF BENEFITS UNDER MEDICALLY
7 DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM. The commission shall
8 prohibit a Medicaid managed care organization providing health care
9 services under the medically dependent children (MDCP) waiver
10 program from requiring additional authorization from an enrolled
11 child's health care provider for a service if the child's
12 third-party health benefit plan issuer authorizes the service,
13 except to minimize the opportunity for fraud, waste, abuse, gross
14 overuse, inappropriate or medically unnecessary care, or clinical
15 abuse or misuse.
16 Sec. 533.032. NOTICE OF CONTRACT AMENDMENT. (a) For
17 purposes of this section, "contract" includes a manual or document
18 that is incorporated by reference into a contract.
19 (b) Subject to Subsection (d), the commission must provide
20 notice of the commission's intent to amend a contract with a
21 Medicaid managed care organization to and allow for the receipt of
22 comments on the proposed amendment from:
23 (1) the Medicaid managed care organization;
24 (2) appropriate stakeholders, including organizations
25 representing each provider type that provides health care services
26 to recipients; and
27 (3) other interested parties.

1 (c) A contract amendment may not take effect before the 21st
2 day after the date the commission provides notice under this
3 section.
4 (d) The commission:
5 (1) shall provide the notice required by Subsection
6 (b) by:
7 (A) e-mail, if the commission has the e-mail
8 address of the person to whom the commission is required to send the
9 notice; and
10 (B) posting the notice on the commission's
11 Internet website;
12 (2) may provide the notice required by Subsection (b)
13 in any other format the commission determines appropriate; and
14 (3) shall include in the notice required by Subsection
15 (b):
16 (A) the proposed contract amendment;
17 (B) the method by which a person may comment on
18 the proposed contract amendment; and
19 (C) directions for providing comment.
20 (e) If the commission seeks to amend a contract in
21 accordance with a change in state or federal law, rule, policy, or
22 guideline, the commission shall make all reasonable efforts to
23 ensure that the effective date of the contract amendment, subject
24 to Subsections (b) and (c), is on or before the effective date of
25 the change in state or federal law, rule, policy, or guideline.
26 SECTION 28. Section 536.007, Government Code, is amended by
27 adding Subsection (b) to read as follows:

1 (b) The commission's medical director is responsible for
2 convening periodic meetings with Medicaid health care providers,
3 including hospitals, to analyze and evaluate all Medicaid managed
4 care and health care provider quality-based programs to ensure
5 feasibility and alignment among programs.
6 SECTION 29. As soon as practicable after the effective date
7 of this Act, the Health and Human Services Commission shall
8 implement the changes in law made by this Act.
9 SECTION 30. Section 533.005, Government Code, as amended by
10 this Act, applies only to a contract entered into or renewed on or
11 after the effective date of this Act. A contract entered into or
12 renewed before that date is governed by the law in effect on the
13 date the contract was entered into or renewed, and that law is
14 continued in effect for that purpose.
15 SECTION 31. If before implementing any provision of this
16 Act a state agency determines that a waiver or authorization from a
17 federal agency is necessary for implementation of that provision,
18 the agency affected by the provision shall request the waiver or
19 authorization and may delay implementing that provision until the
20 waiver or authorization is granted.
21 SECTION 32. If any provision of this Act or its application
22 to any person or circumstance is held invalid, the invalidity does
23 not affect other provisions or applications of this Act that can be
24 given effect without the invalid provision or application, and to
25 this end the provisions of this Act are declared to be severable.
26 SECTION 33. This Act takes effect September 1, 2019.