By: Frank H.B. No. 4178

Substitute the following for H.B. No. 4178:

By: Klick C.S.H.B. No. 4178

A BILL TO BE ENTITLED

AN ACT

relating to the operation and administration of certain health and human services programs, 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 B, Chapter 531, Government Code, is amended by adding Section 531.02112 to read as follows:

Sec. 531.02112. POLICIES FOR IMPLEMENTING CHANGES TO PAYMENT RATES UNDER MEDICAID AND CHILD HEALTH PLAN PROGRAM. (a) The commission shall adopt policies related to the determination of fees, charges, and rates for payments under Medicaid and the child health plan program to ensure, to the greatest extent possible, that changes to a fee schedule are implemented in a way that minimizes administrative complexity, financial uncertainty, and retroactive adjustments for providers.

(b) In adopting policies under Subsection (a), the commission shall:

(1) develop a process for individuals and entities

that deliver services under the Medicaid managed care program to provide oral or written input on the proposed policies; and

(2) ensure that managed care organizations and the entity serving as the state's Medicaid claims administrator under the Medicaid fee-for-service delivery model are provided a period of not less than 45 days before the effective date of a final fee schedule change to make any necessary administrative or systems adjustments to implement the change.

(c) This section does not apply to changes to the fees, charges, or rates for payments made to a nursing facility or to capitation rates paid to a Medicaid managed care organization.

SECTION 3. Section 531.02118, Government Code, is amended by amending Subsection (c) and adding Subsections (e) and (f) to read as follows:

(c) In streamlining the Medicaid provider credentialing process under this section, the commission may designate a centralized credentialing entity and, if a centralized credentialing entity is designated, shall [~~may~~]:

(1) share information in the database established under Subchapter C, Chapter 32, Human Resources Code, with the centralized credentialing entity to reduce the submission of duplicative information or documents necessary for both Medicaid enrollment and credentialing; and

(2) require all Medicaid managed care organizations [~~contracting with the commission to provide health care services to Medicaid recipients under a managed care plan issued by the organization~~] to use the centralized credentialing entity as a hub

for the collection and sharing of information.

(e) To the extent permitted by federal law, the commission shall use available Medicare data to streamline the enrollment and credentialing of Medicaid providers by reducing the submission of duplicative information or documents.

(f) The commission shall develop and implement a process to expedite the Medicaid provider enrollment process for a health care provider who is providing health care services through a single case agreement to a Medicaid recipient with primary insurance coverage. The commission shall use a provider's national provider identifier number to enroll a provider under this subsection. In this subsection, "national provider identifier number" has the meaning assigned by Section 531.021182.

SECTION 4. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.021182 to read as follows:

Sec. 531.021182. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER. (a) In this section, "national provider identifier number" means the national provider identifier number required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The commission shall transition from using a state-issued provider identifier number to using only a national provider identifier number in accordance with this section.

(c) The commission shall implement a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid.

(d) The commission shall implement a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services.

SECTION 5. Section 531.024(b), Government Code, is amended to read as follows:

(b) The rules promulgated under Subsection (a)(7) must provide due process to an applicant for Medicaid services or programs and to a Medicaid recipient who seeks a Medicaid service, including a service that requires prior authorization. The rules must provide the protections for applicants and recipients required by 42 C.F.R. Part 431, Subpart E, including requiring that:

(1) the written notice to an individual of the individual's right to a hearing must:

(A) contain a clear [~~an~~] explanation of:

(i) the adverse determination and the circumstances under which Medicaid is continued if a hearing is requested; and

(ii) the fair hearing process, including the individual's ability to use an independent review process; and

(B) be mailed at least 10 days before the date the individual's Medicaid eligibility or service is scheduled to be terminated, suspended, or reduced, except as provided by 42 C.F.R. Section 431.213 or 431.214; and

(2) if a hearing is requested before the date a Medicaid recipient's service, including a service that requires prior authorization, is scheduled to be terminated, suspended, or

reduced, the agency may not take that proposed action before a decision is rendered after the hearing unless:

(A) it is determined at the hearing that the sole issue is one of federal or state law or policy; and

(B) the agency promptly informs the recipient in writing that services are to be terminated, suspended, or reduced pending the hearing decision.

SECTION 6. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024162, 531.024163, and 531.024164 to read as follows:

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

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

(2) for the recipient, a clear and easy-to-understand explanation of the reason for the denial; and

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

(b) The commission or a Medicaid managed care organization that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request shall issue a notice to the provider and the

Medicaid recipient on whose behalf the request was submitted. The notice issued under this subsection must:

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

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

(B) the applicable timeline, based on the requested service, for the provider to submit the documentation and a description of the reconsideration process described by Section 533.00284, if applicable; and

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

(2) be sent to the provider:

(A) using the provider's preferred method of contact most recently provided to the commission or the Medicaid managed care organization and using any alternative and known methods of contact; and

(B) as applicable, through an electronic notification on an Internet portal.

Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING MEDICAID PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the organization or entity maintains on the organization's or entity's

Internet website in an easily searchable and accessible format:

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

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

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

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

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

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

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

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

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

(1) adopt and maintain a process for a provider or

Medicaid recipient to contact the organization or entity to clarify prior authorization requirements or assist the provider or recipient in submitting a prior authorization request; and

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

Sec. 531.024164. INDEPENDENT REVIEW ORGANIZATIONS. (a) In this section, "independent review organization" means an organization certified under Chapter 4202, Insurance Code.

(b) The commission shall contract with an independent review organization to make review determinations with respect to:

(1) a Medicaid managed care organization's resolution of an internal appeal challenging a medical necessity determination;

(2) a denial by the commission of eligibility for a Medicaid program on the basis of the Medicaid recipient's or applicant's medical and functional needs; and

(3) an action, as defined by 42 C.F.R. Section 431.201, by the commission based on the recipient's medical and functional needs.

(c) The executive commissioner by rule shall determine:

(1) the manner in which an independent review organization is to settle the disputes;

(2) when, in the appeals process, an organization may be accessed; and

(3) the recourse available after the organization makes a review determination.

(d) The commission shall ensure that a contract entered into

under Subsection (b):

(1) requires an independent review organization to make a review determination in a timely manner;

(2) provides procedures to protect the confidentiality of medical records transmitted to the organization for use in conducting an independent review;

(3) sets minimum qualifications for and requires the independence of each physician or other health care provider making a review determination on behalf of the organization;

(4) specifies the procedures to be used by the organization in making review determinations;

(5) requires the timely notice to a Medicaid recipient of the results of an independent review, including the clinical basis for the review determination;

(6) requires that the organization report the following aggregate information to the commission in the form and manner and at the times prescribed by the commission:

(A) the number of requests for independent reviews received by the independent review organization;

(B) the number of independent reviews conducted;

(C) the number of review determinations made:

(i) in favor of a Medicaid managed care organization; and

(ii) in favor of a Medicaid recipient;

(D) the number of review determinations that resulted in a Medicaid managed care organization deciding to cover the service at issue;

(E) a summary of the disputes at issue in independent reviews;

(F) a summary of the services that were the subject of independent reviews; and

(G) the average time the organization took to complete an independent review and make a review determination; and

(7) requires that, in addition to the aggregate information required by Subdivision (6), the organization include in the report the information required by that subdivision categorized by Medicaid managed care organization.

(e) An independent review organization with which the commission contracts under this section shall:

(1) obtain all information relating to the internal appeal at issue, as applicable, from the Medicaid managed care organization and the provider in accordance with time frames prescribed by the commission;

(2) obtain all information relating to the denial or action at issue, as applicable, from the commission and provider in accordance with time frames prescribed by the commission;

(3) assign a physician or other health care provider with appropriate expertise as a reviewer to make a review determination;

(4) for each review, perform a check to ensure that the organization and the physician or other health care provider assigned to make a review determination do not have a conflict of interest, as defined in the contract entered into between the commission and the organization;

(5) communicate procedural rules, approved by the commission, and other information regarding the appeals process to all parties; and

(6) render a timely review determination, as determined by the commission.

(f) The commission shall ensure that the commission, the Medicaid managed care organization, the provider, and the Medicaid recipient involved in a dispute, as applicable, do not have a choice in the reviewer who is assigned to perform the review.

(g) In selecting an independent review organization with which to contract, the commission shall avoid conflicts of interest by considering and monitoring existing relationships between independent review organizations and Medicaid managed care organizations.

(h) The executive commissioner shall adopt rules necessary to implement this section.

SECTION 7. Section 531.02444, Government Code, is amended by amending Subsection (a) and adding Subsection (a-1) to read as follows:

(a) The executive commissioner shall develop and implement:

(1) to the extent permitted by a waiver sought by the commission under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315), a Medicaid buy-in program for persons with disabilities as authorized by the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the Balanced Budget Act of 1997 (Pub. L. No. 105-33); and

(2) subject to Subsection (a-1) as authorized by the

Deficit Reduction Act of 2005 (Pub. L. No. 109-171), a Medicaid buy-in program for children with disabilities that is described by 42 U.S.C. Section 1396a(cc)(1) whose family incomes do not exceed 300 percent of the applicable federal poverty level.

(a-1) The executive commissioner by rule shall increase the maximum family income prescribed by Subsection (a)(2) for determining eligibility for the buy-in program under that subdivision of a child who is eligible for the medically dependent children (MDCP) waiver program and is on the interest list for that program to the maximum family income amount allowable, considering available appropriations for that purpose.

SECTION 8. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024441, 531.0319, 531.03191, and 531.0602 to read as follows:

Sec. 531.024441. MEDICAID BUY-IN FOR CHILDREN PROGRAM DISABILITY DETERMINATION ASSESSMENT. (a) The commission shall, at the request of a child's legally authorized representative, conduct a disability determination assessment of the child to determine the child's eligibility for the Medicaid buy-in for children program implemented under Section 531.02444.

(b) The commission may seek a waiver to the state Medicaid plan under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to implement this section.

Sec. 531.0319. PROCESS FOR ADOPTING AND AMENDING POLICIES APPLICABLE TO MEDICAID MEDICAL BENEFITS. The commission shall develop and implement a process for adopting and amending policies applicable to Medicaid medical benefits under the Medicaid managed

care delivery model. The commission shall seek input from the state Medicaid managed care advisory committee in developing and implementing the process.

Sec. 531.03191. MEDICAID MEDICAL BENEFITS POLICY MANUAL. (a) To the greatest extent possible, the commission shall consolidate policy manuals, handbooks, and other informational documents into one Medicaid medical benefits policy manual to clarify and provide guidance on the policies under the Medicaid managed care delivery model.

(b) The commission shall periodically update the Medicaid medical benefits policy manual described by this section to reflect policies adopted or amended using the process under Section 531.0319.

Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM REASSESSMENTS. (a) To the extent allowed by federal law, the commission shall streamline the annual reassessment for making a medical necessity determination for a recipient participating in the medically dependent children (MDCP) waiver program. The annual reassessment should focus on significant changes in function that may affect medical necessity.

(b) The commission shall ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program provides the results of the reassessment to the parent or legally authorized representative of a recipient described by Subsection (a) for review. The commission shall ensure the provision of the results does not delay the determination of the services to be provided to the recipient or the

ability to authorize and initiate services.

(c) The commission shall require the parent's or representative's signature to verify the parent or representative received the results of the reassessment from the care coordinator under Subsection (b). A Medicaid managed care organization may not delay the delivery of care pending the signature.

(d) The commission shall provide a parent or representative who disagrees with the results of the reassessment an opportunity to dispute the reassessment with the commission through a peer-to-peer review with the treating physician of choice.

(e) This section does not affect any rights of a recipient to appeal a reassessment determination through the Medicaid managed care organization's internal appeal process or through the Medicaid fair hearing process.

SECTION 9. Section 531.072(c), Government Code, is amended to read as follows:

(c) In making a decision regarding the placement of a drug on each of the preferred drug lists, the commission shall consider:

(1) the recommendations of the Drug Utilization Review Board under Section 531.0736;

(2) the clinical efficacy of the drug;

(3) the price of competing drugs after deducting any federal and state rebate amounts; [~~and~~]

(4) the impact on recipient health outcomes and continuity of care; and

(5) program benefit offerings solely or in conjunction with rebates and other pricing information.

SECTION 10. Section 531.0736(c), Government Code, is amended to read as follows:

(c) The executive commissioner shall determine the composition of the board, which must:

(1) comply with applicable federal law, including 42 C.F.R. Section 456.716;

(2) include five [~~two~~] representatives of managed care organizations to represent each managed care product, no more than two of whom are voting members and at least [~~as nonvoting members,~~] one of whom must be a physician and one of whom must be a pharmacist;

(3) include at least 17 physicians and pharmacists who:

(A) provide services across the entire population of Medicaid recipients and represent different specialties, including at least one of each of the following types of physicians:

(i) a pediatrician;

(ii) a primary care physician;

(iii) an obstetrician and gynecologist;

(iv) a child and adolescent psychiatrist; and

(v) an adult psychiatrist; and

(B) have experience in either developing or practicing under a preferred drug list; and

(4) include not less than two [~~a~~] consumer advocates [~~advocate~~] who represent [~~represents~~] Medicaid recipients, at least one of whom is a nonvoting member.

SECTION 11. Section 531.0737, Government Code, is amended to read as follows:

Sec. 531.0737. DRUG UTILIZATION REVIEW BOARD: CONFLICTS OF INTEREST. (a) A voting member of the Drug Utilization Review Board must disclose any [~~may not have a~~] contractual relationship, ownership interest, or other conflict of interest with a pharmacy benefit manager, Medicaid managed care organization, or pharmaceutical manufacturer or labeler or with an entity engaged by the commission to assist in the development of the preferred drug lists or in the administration of the Medicaid Drug Utilization Review Program.

(b) The executive commissioner may adopt [~~implement this section by adopting~~] rules that identify prohibited relationships and conflicts or require [~~requiring~~] the board to develop a conflict-of-interest policy that applies to the board.

SECTION 12. Section 533.00253(a)(1), Government Code, is amended to read as follows:

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee described by [~~established under~~] Section 533.00254.

SECTION 13. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00254, 533.00282, 533.00283, and 533.00284 to read as follows:

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

(1) advise the commission on the operation of the STAR

Kids managed care program under Section 533.00253; and

(2) make recommendations for improvements to that program.

(b) On September 1, 2023:

(1) the advisory committee is abolished; and

(2) this section expires.

Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. (a) Section 4201.304, Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization.

(b) In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must require that:

(1) before issuing an adverse determination on a prior authorization request, the organization provide the physician requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted;

(2) the organization review and issue determinations on prior authorization requests according to the following time frames:

(A) with respect to a recipient who is hospitalized at the time of the request:

(i) within one business day after receiving the request, except as provided by Subparagraphs (ii) and (iii);

(ii) within 72 hours after receiving the request if the request is submitted by a provider of acute care inpatient services for services or equipment necessary to discharge the recipient from an inpatient facility; or

(iii) within one hour after receiving the request if the request is related to poststabilization care or a life-threatening condition; or

(B) with respect to a recipient who is not hospitalized at the time of the request:

(i) within three business days after receiving the request; or

(ii) if the period prescribed by Subparagraph (i) is not appropriate, within the time appropriate to the circumstances relating to the delivery of the services to the recipient and to the recipient's condition, provided that, when issuing a determination related to poststabilization care after emergency treatment as requested by a treating physician or other health care provider, the agent shall issue the determination to the treating physician or other health care provider not later than one hour after the time of the request; and

(3) the organization:

(A) have appropriate personnel reasonably available at a toll-free telephone number to respond to a prior authorization request between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9

a.m. and noon central time on Saturday, Sunday, and legal holidays;

(B) have a telephone system capable of receiving and recording incoming telephone calls for prior authorization requests after 6 p.m. central time Monday through Friday and after noon central time on Saturday, Sunday, and legal holidays; and

(C) have appropriate personnel to respond to each 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 request that resulted solely from the submission of insufficient or inadequate documentation.

(b) The process for reconsidering an adverse determination on a prior authorization request under this section must:

(1) allow a provider to, not later than the seventh business day following the date of the determination, submit any documentation that was identified as insufficient or inadequate in the notice provided under Section 531.024162;

(2) allow the provider requesting the prior authorization to discuss the request with another provider who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and

(3) require the Medicaid managed care organization to, not later than the first business day following the date the provider submits sufficient and adequate documentation under Subdivision (1), amend the determination to approve the prior authorization request.

(c) An adverse determination on a prior authorization

request is considered a denial of services in an evaluation of the Medicaid managed care organization only if the determination is not amended under Subsection (b)(3).

(d) The process for reconsidering an adverse determination on a prior authorization request under this section does not affect:

(1) any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an independent review organization; or

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

SECTION 14. Section 533.0071, Government Code, is amended to read as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission shall make every effort to improve the administration of contracts with Medicaid managed care organizations. To improve the administration of these contracts, the commission shall:

(1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program;

(2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program or is covered by another liable third party insurer;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and

other payments made to managed care organizations with respect to enrollees who leave the managed care program;

(4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by:

(A) where possible, decreasing the duplication of administrative reporting and process requirements for the managed care organizations and providers, such as requirements for 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) ensure that the commission's fair hearing process and [~~reserve the right to amend~~] the managed care organization's process for resolving recipient and provider appeals of denials based on medical necessity [~~to~~] include an independent review process established by the commission for final determination of these disputes.

SECTION 15. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.038 and 533.039 to read as follows:

Sec. 533.038. COORDINATION OF BENEFITS. (a) In this section, "Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient with both Medicaid and primary health benefit plan coverage when the recipient has exceeded the primary health benefit plan coverage limit or when the service is not covered by the primary health benefit plan issuer.

(b) The commission, in consultation with Medicaid managed care organizations and the state Medicaid managed care advisory committee, shall develop and implement a policy that ensures the coordinated and timely delivery of Medicaid wrap-around benefits to recipients. In developing and implementing the policy under this subsection, the commission shall consider:

(1) streamlining a Medicaid managed care organization's prior approval of services that are not traditionally covered by primary health benefit plan coverage;

(2) including the cost of providing a Medicaid wrap-around benefit in a Medicaid managed care organization's financial reports and in computing capitation rates, if the Medicaid managed care organization provides the wrap-around benefit in good faith and follows commission policies;

(3) reducing health care provider and recipient abrasion resulting from the recovery process when a recipient's primary health benefit plan issuer should have been the primary payor of a claim;

(4) efficiently providing Medicaid reimbursement for services ordered, referred, prescribed, or delivered by a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage;

(5) allowing a recipient with complex medical needs who has established a relationship with a specialty provider in an area outside of the recipient's Medicaid managed care organization's service delivery area to continue receiving care from that provider; and

(6) allowing a recipient using a prescription drug previously paid for under the recipient's primary health benefit plan coverage to continue receiving the prescription drug without requiring additional prior authorization.

(c) The executive commissioner may seek a waiver from the federal government as needed to:

(1) address federal policies related to coordination of benefits, third-party liability, and provider enrollment relating to Medicaid wrap-around benefits; and

(2) maximize federal financial participation for recipients with both primary health benefit plan coverage and Medicaid coverage.

(d) The commission shall ensure that the Medicaid managed care eligibility files indicate whether a recipient has primary health benefit plan coverage or health insurance premium payment coverage. For a recipient who has that coverage, the files may include the following up-to-date, accurate information related to primary health benefit plan coverage to the extent the information has been made available to the commission by the primary health benefit plan issuer:

(1) the health benefit plan issuer's name and address and the recipient's policy number;

(2) the primary health benefit plan coverage start and end dates;

(3) the primary health benefit plan coverage benefits, limits, copayment, and coinsurance information; and

(4) any additional information that would be useful to ensure the coordination of benefits.

Sec. 533.039. COORDINATION OF BENEFITS FOR PERSONS DUALLY ELIGIBLE UNDER MEDICAID AND MEDICARE. (a) In this section, "Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient with both Medicaid and Medicare coverage when the recipient has exceeded the Medicare coverage limit or when the service is not covered by Medicare.

(b) The commission, in consultation with Medicaid managed

care organizations and the state Medicaid managed care advisory committee, shall implement a policy that ensures the coordinated and timely delivery of Medicaid wrap-around benefits. The policy must:

(1) include a benefits equivalency crosswalk or other method for mapping equivalent benefits under Medicaid and Medicare; and

(2) in a manner that is consistent with federal and state law, require sharing of information concerning third-party sources of coverage and reimbursement.

SECTION 16. Section 62.152, Health and Safety Code, is amended to read as follows:

Sec. 62.152. APPLICATION OF INSURANCE LAW. (a) To provide the flexibility necessary to satisfy the requirements of Title XXI of the Social Security Act (42 U.S.C. Section 1397aa et seq.), as amended, and any other applicable law or regulations, the child health plan is not subject to a law that requires:

(1) coverage or the offer of coverage of a health care service or benefit;

(2) coverage or the offer of coverage for the provision of services by a particular health care services provider, except as provided by Section 62.155(b); or

(3) the use of a particular policy or contract form or of particular language in a policy or contract form.

(b) Section 4201.304, Insurance Code, does not apply to a health plan provider or the provider's utilization review agent.

SECTION 17. The policies for implementing changes to

payment rates required by Section 531.02112, Government Code, as added by this Act, apply only to a change to a fee, charge, or rate that takes effect on or after January 1, 2021.

SECTION 18. The Health and Human Services Commission shall implement:

(1) the Medicaid provider management and enrollment system required by Section 531.021182(c), Government Code, as added by this Act, not later than September 1, 2020; and

(2) the modernized claims processing system required by Section 531.021182(d), Government Code, as added by this Act, not later than September 1, 2023.

SECTION 19. Not later than December 31, 2019, the Health and Human Services Commission shall develop, implement, and publish on the commission's Internet website the process required under Section 531.0319, Government Code, as added by this Act.

SECTION 20. Section 531.0602, Government Code, as added by this Act, applies only to a reassessment of a child's eligibility for the medically dependent children (MDCP) waiver program made on or after December 1, 2019.

SECTION 21. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement the changes in law made by this Act.

SECTION 22. (a) Sections 533.00282 and 533.00284, Government Code, as added by this Act, apply only to a contract between the Health and Human Services Commission and a Medicaid managed care organization under Chapter 533, Government Code, that

is entered into or renewed on or after the effective date of this Act.

(b) The Health and Human Services Commission shall seek to amend contracts entered into with Medicaid managed care organizations under Chapter 533, Government Code, before the effective date of this Act to include the provisions required by Sections 533.00282 and 533.00284, Government Code, as added by this Act.

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

SECTION 24. This Act takes effect September 1, 2019.