

By: Frank

H.B. No. 4178

A BILL TO BE ENTITLED

1 AN ACT

2 relating to the operation and administration of certain health and
3 human services programs, including the Medicaid managed care
4 program.

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

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

8 (4-c) "Medicaid managed care organization" means a
9 managed care organization as defined by Section 533.001 that
10 contracts with the commission under Chapter 533 to provide health
11 care services to Medicaid recipients.

12 SECTION 2. Subchapter B, Chapter 531, Government Code, is
13 amended by adding Section 531.02112 to read as follows:

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

23 (b) The executive commissioner shall establish an advisory
24 committee to provide input for the adoption of rules and standards

1 that comply with this section. The advisory committee is composed
2 of representatives of managed care organizations and providers
3 under Medicaid and the child health plan program. The advisory
4 committee is abolished on the date the rules that comply with this
5 section are adopted. This subsection expires September 1, 2021.

6 (c) Before implementing a change to the fees, charges, and
7 rates for payments under Medicaid or the child health plan program,
8 the commission shall:

9 (1) before or at the time notice of the proposed change
10 is published under Subdivision (2), notify managed care
11 organizations and the entity serving as the state's Medicaid claims
12 administrator under the Medicaid fee-for-service delivery model of
13 the proposed change;

14 (2) publish notice of the proposed change:

15 (A) for public comment in the Texas Register for
16 a period of not less than 60 days; and

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

20 (3) publish notice of a final determination to make
21 the proposed change:

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

24 (B) on the commission's and state Medicaid claims
25 administrator's Internet websites during the period specified
26 under Paragraph (A); and

27 (4) provide managed care organizations and the entity

1 serving as the state's Medicaid claims administrator under the
2 Medicaid fee-for-service delivery model with a period of not less
3 than 30 days before the effective date of the final change to make
4 any necessary administrative or systems adjustments to implement
5 the change.

6 (d) If changes to the fees, charges, or rates for payments
7 under Medicaid or the child health plan program are mandated by the
8 legislature or federal government on a date that does not fall
9 within the time frame for the implementation of those changes
10 described by this section, the commission shall:

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

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

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

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

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

25 (1) share information in the database established
26 under Subchapter C, Chapter [32](#), Human Resources Code, with the
27 centralized credentialing entity to reduce the submission of

1 1 duplicative information or documents necessary for both Medicaid
2 enrollment and credentialing; and

3 (2) require all Medicaid managed care organizations
4 [~~contracting with the commission to provide health care services to~~
5 ~~Medicaid recipients under a managed care plan issued by the~~
6 ~~organization~~] to use the centralized credentialing entity as a hub
7 for the collection and sharing of information.

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

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

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

22 Sec. 531.021182. USE OF NATIONAL PROVIDER IDENTIFIER
23 NUMBER. (a) In this section, "national provider identifier
24 number" means the national provider identifier number required
25 under Section 1128J(e), Social Security Act (42 U.S.C. Section
26 1320a-7k(e)).

27 (b) Beginning September 1, 2020, the commission:

1 (1) may not use a state-issued provider identifier
2 number to identify a Medicaid provider;

3 (2) shall use only a national provider identifier
4 number to identify a Medicaid provider; and

5 (3) must allow a Medicaid provider to bill for
6 Medicaid services using the provider's national provider
7 identifier number.

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

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

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

18 (A) contain a clear ~~an~~ explanation of:

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

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

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

1 (2) if a hearing is requested before the date a
2 Medicaid recipient's service, including a service that requires
3 prior authorization, is scheduled to be terminated, suspended, or
4 reduced, the agency may not take that proposed action before a
5 decision is rendered after the hearing unless:

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

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

11 SECTION 6. Subchapter B, Chapter 531, Government Code, is
12 amended by adding Sections 531.024162, 531.0319, and 531.0602 to
13 read as follows:

14 Sec. 531.024162. NOTICE REQUIREMENTS REGARDING DENIAL OF
15 COVERAGE OR PRIOR AUTHORIZATION. The commission shall ensure that
16 notice sent by the commission or a Medicaid managed care
17 organization to a Medicaid recipient or provider regarding the
18 denial of coverage or prior authorization for a service includes:

19 (1) information required by federal law;

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

22 (3) a clinical explanation of the reason for the
23 denial for the provider.

24 Sec. 531.0319. MEDICAID MEDICAL POLICY MANUAL. (a) The
25 commission shall develop and publish on the commission's Internet
26 website a Medicaid medical policy manual. The manual must:

27 (1) be updated monthly, as necessary;

1 (2) primarily address the managed care delivery model
2 for Medicaid benefits;

3 (3) include a description of each service covered
4 under Medicaid, including the scope, duration, and amount of
5 coverage; and

6 (4) direct Medicaid providers to the Medicaid managed
7 care manual that applies to the provider for specific prior
8 authorization and billing policies.

9 (b) The commission shall publish the Medicaid medical
10 policy manual not later than January 1, 2020. Beginning on that
11 date, the commission may not use any prior Medicaid procedures
12 manual for providers. This subsection expires September 1, 2021.

13 Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER
14 PROGRAM REASSESSMENTS. To the extent allowed by federal law, the
15 commission shall require that a child participating in the
16 medically dependent children (MDCP) waiver program be reassessed to
17 determine whether the child meets the level of care criteria for
18 medical necessity for nursing facility care only if the child has a
19 significant change in function that may affect the medical
20 necessity for that level of care instead of requiring that the
21 reassessment be made annually.

22 SECTION 7. Section 531.072(c), Government Code, is amended
23 to read as follows:

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

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

- 1 (2) the clinical efficacy of the drug;
- 2 (3) the price of competing drugs after deducting any
- 3 federal and state rebate amounts; ~~and~~
- 4 (4) the impact on recipient health outcomes and
- 5 continuity of care; and
- 6 (5) program benefit offerings solely or in conjunction
- 7 with rebates and other pricing information.

8 SECTION 8. Section 531.0736(c), Government Code, is amended

9 to read as follows:

10 (c) The executive commissioner shall determine the

11 composition of the board, which must:

12 (1) comply with applicable federal law, including 42

13 C.F.R. Section 456.716;

14 (2) include five ~~two~~ representatives of managed care

15 organizations to represent each managed care product ~~[as nonvoting~~

16 ~~members]~~, at least one of whom must be a physician and one of whom

17 must be a pharmacist;

18 (3) include at least 17 physicians and pharmacists

19 who:

20 (A) provide services across the entire

21 population of Medicaid recipients and represent different

22 specialties, including at least one of each of the following types

23 of physicians:

- 24 (i) a pediatrician;
- 25 (ii) a primary care physician;
- 26 (iii) an obstetrician and gynecologist;
- 27 (iv) a child and adolescent psychiatrist;

1 and

2 (v) an adult psychiatrist; and

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

5 (4) include a consumer advocate who represents
6 Medicaid recipients.

7 SECTION 9. Subchapter A, Chapter 533, Government Code, is
8 amended by adding Sections 533.00284 and 533.00285 to read as
9 follows:

10 Sec. 533.00284. ADOPTION OF PRIOR AUTHORIZATION PRACTICE
11 GUIDELINES; ACCESSIBILITY. (a) In developing medical policies and
12 standards for making medical necessity determinations for prior
13 authorizations, each Medicaid managed care organization shall:

14 (1) in consultation with health care providers in the
15 organization's provider network, adopt practice guidelines that:

16 (A) are based on valid and reliable clinical
17 evidence or the medical consensus among health care professionals
18 who practice in the applicable field; and

19 (B) take into consideration the health care needs
20 of the recipients enrolled in a managed care plan offered by the
21 organization; and

22 (2) develop a written process describing the method
23 for periodically reviewing and amending utilization management
24 clinical review criteria.

25 (b) A Medicaid managed care organization shall annually
26 review and, as necessary, update the practice guidelines adopted
27 under Subsection (a)(1).

1 (c) 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 ensure that:

5 (1) coverage criteria and prior authorization
6 requirements are:

7 (A) made available to recipients and providers on
8 the organization's or entity's Internet website; and

9 (B) communicated in a clear, concise, and easily
10 understandable manner;

11 (2) any necessary or supporting documents needed to
12 obtain prior authorization are made available on a web page of the
13 organization's or entity's Internet website accessible through a
14 clearly marked link to the web page; and

15 (3) the process for contacting the organization or
16 entity for clarification or assistance in obtaining prior
17 authorization is not arduous or overly burdensome to a recipient or
18 provider.

19 Sec. 533.00285. PRIOR AUTHORIZATION PROCEDURES. In
20 addition to the requirements of Section 533.005, a contract between
21 a Medicaid managed care organization and the commission described
22 by that section must include:

23 (1) time frames for the prior authorization of health
24 care services that enable Medicaid providers to:

25 (A) deliver those services in a timely manner;
26 and

27 (B) request a peer review regarding the prior

1 authorization before the organization makes a final decision on the
2 prior authorization; and

3 (2) a requirement that the organization:

4 (A) has appropriate personnel reasonably
5 available at a toll-free telephone number to receive prior
6 authorization requests between 6 a.m. and 6 p.m. central time
7 Monday through Friday on each day that is not a legal holiday and
8 between 9 a.m. and noon central time on Saturday and Sunday; and

9 (B) has a telephone system capable of receiving
10 and recording incoming telephone calls for prior authorization
11 requests after 6 p.m. central time Monday through Friday and after
12 noon central time on Saturday and Sunday.

13 SECTION 10. Section 533.0071, Government Code, is amended
14 to read as follows:

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

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

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

26 (3) maximize Medicaid payment recovery options by
27 contracting with private vendors to assist in the recovery of

1 capitation payments, payments from other liable third parties, and
2 other payments made to managed care organizations with respect to
3 enrollees who leave the managed care program;

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

9 (A) where possible, decreasing the duplication
10 of administrative reporting and process requirements for the
11 managed care organizations and providers, such as requirements for
12 the submission of encounter data, quality reports, historically
13 underutilized business reports, and claims payment summary
14 reports;

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

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

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

1 notifications; and

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

5 (5) ensure that the commission's fair hearing process
6 and [~~reserve the right to amend~~] the managed care organization's
7 process for resolving recipient and provider appeals of denials
8 based on medical necessity [~~to~~] include an independent review
9 process established by the commission for final determination of
10 these disputes.

11 SECTION 11. Section 533.0076(c), Government Code, is
12 amended to read as follows:

13 (c) The commission shall allow a recipient who is enrolled
14 in a managed care plan under this chapter to disenroll from that
15 plan and enroll in another managed care plan[+]

16 [~~(1)~~] at any time for cause in accordance with federal
17 law[~~, and~~

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

20 SECTION 12. Subchapter A, Chapter 533, Government Code, is
21 amended by adding Sections 533.038 and 533.039 to read as follows:

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

1 primary health benefit plan issuer.

2 (b) The commission, in coordination with Medicaid managed
3 care organizations, shall develop and adopt a clear policy for a
4 Medicaid managed care organization to ensure the coordination and
5 timely delivery of Medicaid wrap-around benefits for recipients
6 with both primary health benefit plan coverage and Medicaid
7 coverage.

8 (c) To further assist with the coordination of benefits, the
9 commission, in coordination with Medicaid managed care
10 organizations, shall develop and maintain a list of services that
11 are not traditionally covered by primary health benefit plan
12 coverage that a Medicaid managed care organization may approve
13 without having to coordinate with the primary health benefit plan
14 issuer and that can be resolved through third-party liability
15 resolution processes. The commission shall review and update the
16 list quarterly.

17 (d) A Medicaid managed care organization that in good faith
18 and following commission policies provides coverage for a Medicaid
19 wrap-around benefit shall include the cost of providing the benefit
20 in the organization's financial reports. The commission shall
21 include the reported costs in computing capitation rates for the
22 managed care organization.

23 (e) If the commission determines that a recipient's primary
24 health benefit plan issuer should have been the primary payor of a
25 claim, the Medicaid managed care organization that paid the claim
26 shall work with the commission on the recovery process and make
27 every attempt to reduce health care provider and recipient

1 abrasion.

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

4 (1) address federal policies related to coordination
5 of benefits and third-party liability; and

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

9 (g) Notwithstanding Sections 531.073 and 533.005(a)(23) or
10 any other law, the commission shall ensure that a prescription drug
11 that is covered under the Medicaid vendor drug program or other
12 applicable formulary and is prescribed to a recipient with primary
13 health benefit plan coverage is not subject to any prior
14 authorization requirement if the primary health benefit plan issuer
15 will pay at least \$0.01 on the prescription drug claim. If the
16 primary insurer will pay nothing on a prescription drug claim, the
17 prescription drug is subject to any applicable Medicaid clinical or
18 nonpreferred prior authorization requirement.

19 (h) The commission shall ensure that the daily Medicaid
20 managed care eligibility files indicate whether a recipient has
21 primary health benefit plan coverage or health insurance premium
22 payment coverage. For a recipient who has that coverage, the files
23 must include the following up-to-date, accurate information
24 related to primary health benefit plan coverage:

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

27 (2) the primary health benefit plan coverage start and

1 end dates;

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

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

6 (i) The commission shall develop and implement processes
7 and policies to allow a health care provider who is primarily
8 providing services to a recipient through primary health benefit
9 plan coverage to receive Medicaid reimbursement for services
10 ordered, referred, prescribed, or delivered, regardless of whether
11 the provider is enrolled as a Medicaid provider. The commission
12 shall allow a provider who is not enrolled as a Medicaid provider to
13 order, refer, prescribe, or deliver services to a recipient based
14 on the provider's national provider identifier number and may not
15 require an additional state provider identifier number to receive
16 reimbursement for the services. The commission may seek a waiver of
17 Medicaid provider enrollment requirements for providers of
18 recipients with primary health benefit plan coverage to implement
19 this subsection.

20 (j) The commission shall develop and implement a clear and
21 easy process to allow a recipient with complex medical needs who has
22 established a relationship with a specialty provider in an area
23 outside of the recipient's Medicaid managed care organization's
24 service delivery area to continue receiving care from that provider
25 if the provider will enter into a single-case agreement with the
26 Medicaid managed care organization. A single-case agreement with a
27 provider outside of the organization's service delivery area in

1 accordance with this subsection is not considered an
2 out-of-network agreement and must be included in the organization's
3 network adequacy determination.

4 (k) The commission shall develop and implement processes
5 to:

6 (1) reimburse a recipient with primary health benefit
7 plan coverage who pays a copayment, coinsurance, or other
8 cost-sharing amount out of pocket because the primary health
9 benefit plan issuer refuses to enroll in Medicaid, enter into a
10 single-case agreement, or bill the recipient's Medicaid managed
11 care organization; and

12 (2) capture encounter data for the Medicaid
13 wrap-around benefits provided by the Medicaid managed care
14 organization under this subsection.

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

22 (b) The executive commissioner, in consultation with
23 Medicaid managed care organizations, by rule shall develop and
24 implement a policy that ensures the coordinated and timely delivery
25 of Medicaid wrap-around benefits. The policy must:

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

1 and

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

5 SECTION 13. (a) Not later than December 31, 2019, the
6 executive commissioner of the Health and Human Services Commission
7 shall establish the advisory committee as required by Section
8 531.02112(b), Government Code, as added by this Act.

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

13 SECTION 14. Section 531.0602, Government Code, as added by
14 this Act, applies only to a reassessment of a child's eligibility
15 for the medically dependent children (MDCP) waiver program made on
16 or after December 1, 2019.

17 SECTION 15. As soon as practicable after the effective date
18 of this Act, the executive commissioner of the Health and Human
19 Services Commission shall adopt rules necessary to implement the
20 changes in law made by this Act.

21 SECTION 16. (a) Section 533.00285, Government Code, as
22 added by this Act, applies only to a contract between the Health and
23 Human Services Commission and a Medicaid managed care organization
24 under Chapter 533, Government Code, that is entered into or renewed
25 on or after the effective date of this Act.

26 (b) The Health and Human Services Commission shall seek to
27 amend contracts entered into with Medicaid managed care

1 organizations under Chapter 533, Government Code, before the
2 effective date of this Act to include the provisions required by
3 Section 533.00285, Government Code, as added by this Act.

4 SECTION 17. If before implementing any provision of this
5 Act a state agency determines that a waiver or authorization from a
6 federal agency is necessary for implementation of that provision,
7 the agency affected by the provision shall request the waiver or
8 authorization and may delay implementing that provision until the
9 waiver or authorization is granted.

10 SECTION 18. This Act takes effect September 1, 2019.