By: Kolkhorst, et al. (Frank, Klick) S.B. No. 1105

Substitute the following for S.B. No. 1105:

By: Miller C.S.S.B. No. 1105

A BILL TO BE ENTITLED

AN ACT

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

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 Sections 531.02112, 531.021182, 531.02131, 531.02142, 531.024162, 531.024163, 531.0319, and 531.0511 to read as follows:

Sec. 531.02112. POLICIES FOR IMPLEMENTING CHANGES TO PAYMENT RATES UNDER MEDICAID. (a) The commission shall adopt policies related to the determination of fees, charges, and rates for payments under Medicaid 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.

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.

Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) The commission shall adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within the commission to ensure all grievances are managed consistently.

(b) The commission shall standardize Medicaid grievance data reporting and tracking among divisions within the commission.

(c) The commission shall implement a no-wrong-door system for Medicaid grievances reported to the commission.

(d) The commission shall establish a procedure for expedited resolution of a grievance related to Medicaid that allows the commission to:

(1) identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution; and

(2) resolve the grievance within a specified period.

(e) The commission shall verify grievance data reported by a Medicaid managed care organization.

(f) The commission shall:

(1) aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances; and

(2) make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider.

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) To the extent permitted by federal law, the commission in

consultation and collaboration with the appropriate advisory committees related to Medicaid shall make available to the public on the commission's Internet website in an easy-to-read format data relating to the quality of health care received by Medicaid recipients and the health outcomes of those recipients. Data made available to the public under this section must be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) In performing its duties under this section, the commission may collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data.

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 on whose behalf the request was submitted 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. 531.0319. 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 by the commission.

Sec. 531.0511. MEDICALLY DEPENDENT CHILDREN WAIVER PROGRAM: CONSUMER DIRECTION OF SERVICES. Notwithstanding Sections 531.051(c)(1) and (d), a consumer direction model implemented under Section 531.051, including the consumer-directed service option, for the delivery of services under the medically dependent children (MDCP) waiver program must allow for the delivery of all services and supports available under that program through consumer direction.

SECTION 3. Section 533.00253(a)(1), Government Code, is amended to read as follows:

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee established by the executive commissioner under Section 531.012 [~~533.00254~~].

SECTION 4. Section 533.00253, Government Code, is amended by adding Subsections (f), (g), and (h) to read as follows:

(f) Using existing resources, the executive commissioner in consultation and collaboration with the advisory committee shall determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under:

(1) an accountable care organization model in accordance with guidelines established by the Centers for Medicare and Medicaid Services; or

(2) an alternative model developed by or in collaboration with the Centers for Medicare and Medicaid Services Innovation Center.

(g) Not later than December 1, 2022, the commission shall prepare and submit a written report to the legislature of the executive commissioner's determination under Subsection (f).

(h) Subsections (f) and (g) and this subsection expire September 1, 2023.

SECTION 5. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00282, 533.00283, 533.00284, and 533.0031 to read as follows:

Sec. 533.00282. UTILIZATION REVIEW PROCEDURES. 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.

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;

(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 on the prior authorization request, as necessary, considering the additional documentation; and

(4) comply with 42 C.F.R. Section 438.210.

(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 or a Medicaid fair hearing; or

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

Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A managed care plan offered by a Medicaid managed care organization must be accredited by a nationally recognized accreditation organization. The commission may choose whether to require all managed care plans offered by Medicaid managed care organizations to be accredited by the same organization or to allow for accreditation by different organizations.

(b) The commission may use the data, scoring, and other information provided to or received from an accreditation organization in the commission's contract oversight processes.

SECTION 6. The Health and Human Services Commission shall issue a request for information to seek information and comments regarding contracting with a managed care organization to arrange for or provide a managed care plan under the STAR Kids managed care program established under Section 533.00253, Government Code, throughout the state instead of on a regional basis.

SECTION 7. (a) Using available resources, the Health and Human Services Commission shall report available data on the 30-day limitation on reimbursement for inpatient hospital care provided to Medicaid recipients enrolled in the STAR+PLUS Medicaid managed care program under 1 T.A.C. Section 354.1072(a)(1) and other applicable law. To the extent data is available on the subject, the commission shall also report on:

(1) the number of Medicaid recipients affected by the limitation and their clinical outcomes; and

(2) the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days and any cost savings achieved by the limitation under Medicaid.

(b) Not later than December 1, 2020, the Health and Human Services Commission shall submit the report containing the data described by Subsection (a) of this section to the governor, the legislature, and the Legislative Budget Board. The report required under this subsection may be combined with any other report required by this Act or other law.

SECTION 8. 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 9. 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 10. 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 11. (a) Section 533.00284, Government Code, as added by this Act, applies 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 Section 533.00284, Government Code, as added by this Act.

SECTION 12. The Health and Human Services Commission shall require that a managed care plan offered by a managed care organization with which the commission enters into or renews a contract under Chapter 533, Government Code, on or after the effective date of this Act comply with Section 533.0031, Government Code, as added by this Act, not later than September 1, 2022.

SECTION 13. 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 14. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement a

provision of this Act using other appropriations available for that purpose.

SECTION 15. This Act takes effect September 1, 2019.