

By: Kolkhorst

S.B. No. 1105

A BILL TO BE ENTITLED

AN ACT

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

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

SECTION 1. Section 531.02118, Government Code, is amended by adding Subsections (e) and (f) to read as follows:

(e) The commission shall enroll a provider as a Medicaid provider, without requiring the provider to separately apply for enrollment through the entity serving as the state's Medicaid claims administrator, if the provider is:

(1) credentialed by a managed care organization that contracts with the commission under Chapter 533; or

(2) enrolled as a Medicare provider.

(f) The commission and the entity serving as the state's Medicaid claims administrator shall use a provider's national provider identifier number issued by the Centers for Medicare and Medicaid Services to identify an enrolled provider and may not issue a separate state provider identifier number.

SECTION 2. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.02131, 531.02142, and 531.0511 to read as follows:

Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) To ensure all grievances are managed consistently, the commission shall ensure the definition of a grievance related to Medicaid is

1 consistent among divisions within the commission.

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

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

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

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

12 (2) resolve the grievance within a specified period.

13 (e) The commission shall verify grievance data reported by a  
14 managed care organization that contracts with the commission under  
15 Chapter 533 to provide health care services to Medicaid recipients.

16 (f) The commission shall:

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

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

23 Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA.

24 (a) To the extent permitted by federal law, the commission shall  
25 make available to the public on its Internet website in an  
26 easy-to-read format data relating to the quality of health care  
27 received by Medicaid recipients and the health outcomes of those

1 recipients. Data made available to the public under this section  
2 must be made available in a manner that does not identify or allow  
3 for the identification of individual recipients.

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

8 Sec. 531.0511. MEDICALLY DEPENDENT CHILDREN WAIVER  
9 PROGRAM: CONSUMER DIRECTION OF SERVICES. Notwithstanding Sections  
10 531.051(c)(1) and (d), a consumer direction model implemented under  
11 Section 531.051, including the consumer-directed service option,  
12 for the delivery of services under the medically dependent children  
13 (MDCP) waiver program must allow for the delivery of all services  
14 and supports available under that program through consumer  
15 direction.

16 SECTION 3. Section 531.073, Government Code, is amended by  
17 adding Subsection (i) to read as follows:

18 (i) Notwithstanding Subsection (a), prior authorization may  
19 not be required under the Medicaid vendor drug program for low-cost  
20 generic drugs. The executive commissioner shall adopt rules  
21 defining "low-cost" for purposes of this subsection.

22 SECTION 4. Section 533.00253, Government Code, is amended  
23 by amending Subsection (c) and adding Subsections (c-1), (f), (g),  
24 (h), and (i) to read as follows:

25 (c) The commission may require that care management  
26 services made available as provided by Subsection (b)(7):

27 (1) incorporate best practices, as determined by the

1 commission;

2 (2) integrate with a nurse advice line to ensure  
3 appropriate redirection rates;

4 (3) use an identification and stratification  
5 methodology that identifies recipients who have the greatest need  
6 for services;

7 (4) provide a care needs assessment for a recipient  
8 ~~[that is comprehensive, holistic, consumer-directed,~~  
9 ~~evidence-based, and takes into consideration social and medical~~  
10 ~~issues, for purposes of prioritizing the recipient's needs that~~  
11 ~~threaten independent living];~~

12 (5) are delivered through multidisciplinary care  
13 teams located in different geographic areas of this state that use  
14 in-person contact with recipients and their caregivers;

15 (6) identify immediate interventions for transition  
16 of care;

17 (7) include monitoring and reporting outcomes that, at  
18 a minimum, include:

19 (A) recipient quality of life;

20 (B) recipient satisfaction; and

21 (C) other financial and clinical metrics  
22 determined appropriate by the commission; and

23 (8) use innovations in the provision of services.

24 (c-1) A care needs assessment provided as a component of  
25 care management services made available as provided by Subsection  
26 (b)(7) may be conducted using any nationally recognized screening  
27 tool the assessor chooses to use.

1       (f) A STAR Kids managed care organization shall, after  
2 conducting a care needs assessment for a recipient, report to the  
3 commission any significant change in condition the recipient  
4 experiences, including a change in condition resulting in the  
5 recipient no longer meeting an institutional level of care  
6 requirement. After receiving the report, the commission shall  
7 redetermine the recipient's eligibility for the STAR Kids managed  
8 care program.

9       (g) The executive commissioner shall develop and implement  
10 a pilot program through which Medicaid benefits are provided to  
11 children enrolled in the STAR Kids managed care program under an  
12 accountable care organization model in accordance with guidelines  
13 established by the Centers for Medicare and Medicaid Services. A  
14 child's participation in the pilot program is optional.

15       (h) Not later than December 1, 2022, the commission shall  
16 prepare and submit a written report to the legislature evaluating  
17 the outcomes of the pilot program and recommending whether the  
18 pilot program should be continued, expanded, or terminated.

19       (i) Subsections (g) and (h) and this subsection expire  
20 September 1, 2023.

21       SECTION 5. Subchapter A, Chapter 533, Government Code, is  
22 amended by adding Sections 533.0031, 533.029, and 533.030 to read  
23 as follows:

24       Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION.

25       (a) Notwithstanding Section 533.004 or any other law requiring the  
26 commission to contract with a managed care organization to provide  
27 health care services to recipients, the commission may contract

1 with a managed care organization to provide those services only if  
2 the managed care plan offered by the organization is accredited by a  
3 nationally recognized accrediting entity.

4 (b) As required by 42 C.F.R. Section 438.360, the commission  
5 shall provide information from the accrediting entity's review of a  
6 managed care plan offered by a managed care organization that  
7 contracts with the commission under this chapter to the external  
8 quality review organization, as defined by Section 533.051.

9 Sec. 533.029. HEALTH INSURANCE PREMIUM PAYMENT  
10 REIMBURSEMENT PROGRAM PROCEDURES. (a) The commission shall adopt  
11 uniform policies and procedures applicable to a managed care  
12 organization that contracts with the commission to provide health  
13 care services to a recipient who is also enrolled in a group health  
14 benefit plan as provided by Section 32.0422, Human Resources Code,  
15 that require the managed care organization to pay any deductible,  
16 copayment, coinsurance, or other cost-sharing obligation imposed  
17 on the recipient for a benefit covered under the group health  
18 benefit plan without requiring prior authorization.

19 (b) The policies and procedures must also include a process  
20 to streamline the Medicaid enrollment of a provider who:

21 (1) treats a recipient described by Subsection (a);  
22 and

23 (2) is enrolled as a provider in the group health  
24 benefit plan in which the recipient is enrolled as provided by  
25 Section 32.0422, Human Resources Code.

26 Sec. 533.030. STATEWIDE MANAGED CARE PLANS. (a) The  
27 commission shall contract with a managed care organization to

1 arrange for or provide managed care plans to recipients in certain  
2 Medicaid managed care programs throughout the state instead of on a  
3 regional basis. The executive commissioner shall determine the  
4 managed care programs or categories of recipients for which to  
5 arrange for or provide statewide managed care plans. In  
6 contracting with a managed care organization under this section,  
7 the commission shall consider:

8 (1) regional variations in the cost of and access to  
9 health care services;

10 (2) recipient access to and choice of providers;

11 (3) the potential impact on providers, including  
12 safety net providers; and

13 (4) public input.

14 (b) Not later than December 1, 2022, the commission shall  
15 prepare and submit a written report to the legislature evaluating  
16 the outcomes of the statewide managed care plans and recommending  
17 whether offering the plans on a statewide basis should be  
18 continued, expanded, or terminated.

19 (c) Subsection (b) and this subsection expire September 1,  
20 2023.

21 SECTION 6. (a) Using available resources, the Health and  
22 Human Services Commission shall conduct a study to evaluate the  
23 30-day limitation on reimbursement for inpatient hospital care  
24 provided to Medicaid recipients enrolled in the STAR+PLUS Medicaid  
25 managed care program under 1 T.A.C. Section 354.1072(a)(1) and  
26 other applicable law. In evaluating the limitation and to the  
27 extent data is available on the subject, the commission shall

1 consider:

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

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

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

13 SECTION 7. Section 533.0031, Government Code, as added by  
14 this Act, applies to a contract entered into or renewed on or after  
15 the effective date of this Act. A contract entered into or renewed  
16 before that date is governed by the law in effect immediately before  
17 the effective date of this Act, and that law is continued in effect  
18 for that purpose.

19 SECTION 8. If before implementing any provision of this Act  
20 a state agency determines that a waiver or authorization from a  
21 federal agency is necessary for implementation of that provision,  
22 the agency affected by the provision shall request the waiver or  
23 authorization and may delay implementing that provision until the  
24 waiver or authorization is granted.

25 SECTION 9. This Act takes effect September 1, 2019.