AN ACT

relating to the operation and administration of Medicaid, including the Medicaid managed care program and the medically dependent children (MDCP) waiver 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. Section 531.024, Government Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) The rules promulgated under Subsection (a)(7) must provide due process to an applicant for Medicaid services 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 an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and

(B) be delivered by mail, and postmarked [~~mailed~~] at least 10 business 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.

(c) The commission shall develop a process to address a situation in which:

(1) an individual does not receive adequate notice as required by Subsection (b)(1); or

(2) the notice required by Subsection (b)(1) is delivered without a postmark.

SECTION 3. (a) To the extent of any conflict, Section 531.024162, Government Code, as added by this section, prevails over any provision of another Act of the 86th Legislature, Regular Session, 2019, relating to notice requirements regarding Medicaid coverage or prior authorization denials or incomplete requests, that becomes law.

(b) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024162, 531.024163, 531.024164, 531.0601, 531.0602, 531.06021, 531.0603, and 531.0604 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, partial denial, reduction, or termination of coverage or denial of prior authorization for a service includes:

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

(2) for the recipient:

(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;

(B) a copy of the information sent to the provider; and

(C) an educational component that includes a description of the recipient's rights, an explanation of the process related to appeals and Medicaid fair hearings, and a description of the role of an external medical review; and

(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, 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:

(A) to the provider:

(i) using the provider's preferred method of communication, to the extent practicable using existing resources; and

(ii) as applicable, through an electronic notification on an Internet portal; and

(B) to the recipient using the recipient's preferred method of communication, to the extent practicable using existing resources.

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 supporting or other 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 to assist the provider 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. EXTERNAL MEDICAL REVIEW. (a) In this section, "external medical reviewer" and "reviewer" mean a third-party medical review organization that provides objective, unbiased medical necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with applicable state law and rules.

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

(1) the resolution of a Medicaid recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program; or

(2) a denial by the commission of eligibility for a

Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs.

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

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

(1) be overseen by a medical director who is a physician licensed in this state; and

(2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.

(e) The commission shall establish a common procedure for reviews. To the greatest extent possible, the procedure must reduce administrative burdens on providers and the submission of duplicative information or documents. Medical necessity under the procedure must be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. The reviewer shall conduct the review within a period specified by the commission. The commission shall also establish a procedure and time frame for expedited reviews that allows the reviewer to:

(1) identify an appeal that requires an expedited resolution; and

(2) resolve the review of the appeal within a specified period.

(f) A Medicaid recipient or applicant, or the recipient's or applicant's parent or legally authorized representative, must

affirmatively request an external medical review. If requested:

(1) an external medical review described by Subsection (b)(1) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing and is granted when a Medicaid recipient contests the internal appeal decision of the Medicaid managed care organization; and

(2) an external medical review described by Subsection (b)(2) occurs after the eligibility denial and before the Medicaid fair hearing.

(g) The external medical reviewer's determination of medical necessity establishes the minimum level of services a Medicaid recipient must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

(h) The external medical reviewer shall require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

(i) To the extent money is appropriated for this purpose, the commission shall publish data regarding prior authorizations reviewed by the external medical reviewer, including the rate of prior authorization denials overturned by the external medical reviewer and additional information the commission and the external medical reviewer determine appropriate.

Sec. 531.0601. LONG-TERM CARE SERVICES WAIVER PROGRAM INTEREST LISTS. (a) This section applies only to a child who is enrolled in the medically dependent children (MDCP) waiver program

but becomes ineligible for services under the program because the child no longer meets:

(1) the level of care criteria for medical necessity for nursing facility care; or

(2) the age requirement for the program.

(b) A legally authorized representative of a child who is notified by the commission that the child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, may request that the commission:

(1) return the child to the interest list for the program unless the child is ineligible due to the child's age; or

(2) place the child on the interest list for another Section 1915(c) waiver program.

(c) At the time a child's legally authorized representative makes a request under Subsection (b), the commission shall:

(1) for a child who becomes ineligible for the reason described by Subsection (a)(1), place the child:

(A) on the interest list for the medically dependent children (MDCP) waiver program in the first position on the list; or

(B) except as provided by Subdivision (3), on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program;

(2) except as provided by Subdivision (3), for a child who becomes ineligible for the reason described by Subsection (a)(2), place the child on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program; or

(3) for a child who becomes ineligible for a reason described by Subsection (a) and who is already on an interest list for another Section 1915(c) waiver program, move the child to a position on the interest list relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program, if that date is earlier than the date the child was initially placed on the interest list for the other waiver program.

(d) Notwithstanding Subsection (c)(1)(B) or (c)(2), a child may be placed on an interest list for a Section 1915(c) waiver program in the position described by those subsections only if the child has previously been placed on the interest list for that waiver program.

(e) At the time the commission provides notice to a legally authorized representative that a child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, the commission shall inform the representative in writing about:

(1) the options under this section for placing the

child on an interest list; and

(2) the process for applying for the Medicaid buy-in program for children with disabilities implemented under Section 531.02444.

(f) This section expires December 1, 2021.

Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM ASSESSMENTS AND REASSESSMENTS. (a) 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 initial assessment or annual reassessment of medical necessity to the parent or legally authorized representative of a recipient receiving benefits under the medically dependent children (MDCP) waiver program 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.

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

(c) The commission shall provide a parent or representative who disagrees with the results of the initial assessment or reassessment an opportunity to request to dispute the results with the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice.

(d) This section does not affect any rights of a recipient to appeal an initial assessment or reassessment determination through the Medicaid managed care organization's internal appeal process, the Medicaid fair hearing process, or the external medical review process.

Sec. 531.06021. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM QUALITY MONITORING; REPORT. (a) The commission, based on the state's external quality review organization's initial report on the STAR Kids managed care program, shall determine whether the findings of the report necessitate additional data and research to improve the program. If the commission determines additional data and research are needed, the commission, through the external quality review organization, may:

(1) conduct annual surveys of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;

(2) conduct annual focus groups with recipients described by Subdivision (1) or their representatives on issues identified through:

(A) the Consumer Assessment of Healthcare Providers and Systems;

(B) other external quality review organization activities; or

(C) stakeholders, including the STAR Kids Managed Care Advisory Committee described by Section 533.00254; and

(3) in consultation with the STAR Kids Managed Care

Advisory Committee described by Section 533.00254 and as frequently as feasible, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as the collaborative innovation improvement network.

(b) Not later than the 30th day after the last day of each state fiscal quarter, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program:

(1) enrollment in the Medicaid buy-in for children program implemented under Section 531.02444;

(2) requests relating to interest list placements under Section 531.0601;

(3) use of the Medicaid escalation help line established under Section 533.00253, if the help line was operational during the applicable state fiscal quarter;

(4) use of, requests for, and outcomes of the external medical review procedure established under Section 531.024164; and

(5) complaints relating to the medically dependent children (MDCP) waiver program, categorized by disposition.

Sec. 531.0603. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN (MDCP) OR DEAF-BLIND WITH MULTIPLE DISABILITIES (DBMD) WAIVER PROGRAM. (a) Notwithstanding any

other law and to the extent allowed by federal law, in determining eligibility of a child for the medically dependent children (MDCP) waiver program, the deaf-blind with multiple disabilities (DBMD) waiver program, or a "Money Follows the Person" demonstration project, the commission shall consider whether the child:

(1) is diagnosed as having a condition included in the list of compassionate allowances conditions published by the United States Social Security Administration; or

(2) receives Medicaid hospice or palliative care services.

(b) If the commission determines a child is eligible for a waiver program under Subsection (a), the child's enrollment in the applicable program is contingent on the availability of a slot in the program. If a slot is not immediately available, the commission shall place the child in the first position on the interest list for the medically dependent children (MDCP) waiver program or deaf-blind with multiple disabilities (DBMD) waiver program, as applicable.

Sec. 531.0604. MEDICALLY DEPENDENT CHILDREN PROGRAM ELIGIBILITY REQUIREMENTS; NURSING FACILITY LEVEL OF CARE. To the extent allowed by federal law, the commission may not require that a child reside in a nursing facility for an extended period of time to meet the nursing facility level of care required for the child to be determined eligible for the medically dependent children (MDCP) waiver program.

SECTION 4. 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 5. Section 533.00253, Government Code, is amended by amending Subsection (c) and adding Subsections (c-1), (c-2), (f), (g), (h), (i), (j), (k), and (l) to read as follows:

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

(1) incorporate best practices, as determined by the commission;

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

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

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

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

(6) identify immediate interventions for transition of care;

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

(A) recipient quality of life;

(B) recipient satisfaction; and

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

(8) use innovations in the provision of services.

(c-1) To improve the care needs assessment tool used for purposes of a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, the commission in consultation and collaboration with the advisory committee shall consider changes that will:

(1) reduce the amount of time needed to complete the care needs assessment initially and at reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c-2) To the extent feasible and allowed by federal law, the commission shall streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity.

(f) The commission shall operate a Medicaid escalation help line through which Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program or the deaf-blind with multiple disabilities (DBMD) waiver program and their legally authorized representatives, parents, guardians, or

other representatives have access to assistance. The escalation help line must be:

(1) dedicated to assisting families of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program or the deaf-blind with multiple disabilities (DBMD) waiver program in navigating and resolving issues related to the STAR Kids managed care program, including complying with requirements related to the continuation of benefits during an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; and

(2) operational at all times, including evenings, weekends, and holidays.

(g) The commission shall ensure staff operating the Medicaid escalation help line:

(1) return a telephone call not later than two hours after receiving the call during standard business hours; and

(2) return a telephone call not later than four hours after receiving the call during evenings, weekends, and holidays.

(h) The commission shall require a Medicaid managed care organization participating in the STAR Kids managed care program to:

(1) designate an individual as a single point of contact for the Medicaid escalation help line; and

(2) authorize that individual to take action to resolve escalated issues.

(i) To the extent feasible, a Medicaid managed care organization shall provide information that will enable staff

operating the Medicaid escalation help line to assist recipients, such as information related to service coordination and prior authorization denials.

(j) Not later than September 1, 2020, the commission shall assess the utilization of the Medicaid escalation help line and determine the feasibility of expanding the help line to additional Medicaid programs that serve medically fragile children.

(k) Subsections (f), (g), (h), (i), and (j) and this subsection expire September 1, 2024.

(l) Not later than September 1, 2020, the commission shall evaluate risk-adjustment methods used for recipients under the STAR Kids managed care program, including recipients with private health benefit plan coverage, in the quality-based payment program under Chapter 536 to ensure that higher-volume providers are not unfairly penalized. This subsection expires January 1, 2021.

SECTION 6. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00254, 533.00282, 533.00283, 533.00284, 533.002841, and 533.038 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 December 31, 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(a)(2), 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; and

(2) the organization review and issue determinations on prior authorization requests with respect to a recipient who is not hospitalized at the time of the request according to the following time frames:

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

(B) within the time frame and following the process established by the commission if the organization receives a request for prior authorization that does not include sufficient or adequate documentation.

(c) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a process for use by a Medicaid managed care organization that receives a prior authorization request, with respect to a recipient who is not hospitalized at the time of the request, that does not include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(2)(A) within which a Medicaid managed care organization must issue a determination on a prior authorization request.

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed care organization, in consultation with the organization's provider advisory group required by contract, 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.

(c) The commission shall periodically review each Medicaid managed care organization to ensure the organization's compliance with this section.

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a uniform process and timeline for Medicaid managed care organizations to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. 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 implement the process and timeline.

(b) The process and timeline must:

(1) allow a provider to 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 amend the determination on the prior authorization request as necessary, considering the additional documentation.

(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) to approve the request.

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

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

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

Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. The time frames prescribed by the utilization review and prior authorization procedures described by Section 533.00282 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 533.00284 together may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care.

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 coordination with Medicaid managed care organizations and in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage. In developing the policy, the commission shall consider requiring a Medicaid managed care organization to allow, notwithstanding Sections 531.073 and 533.005(a)(23) or any other law, a recipient using a prescription drug for which the recipient's primary health benefit plan issuer previously provided coverage to continue receiving the prescription drug without requiring additional prior authorization.

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

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

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

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

(e) The commission may include in the Medicaid managed care eligibility files an indication of whether a recipient has primary health benefit plan coverage or is enrolled in a group health benefit plan for which the commission provides premium assistance under the health insurance premium payment program. For recipients with that coverage or for whom that premium assistance is provided, the files may include the following up-to-date, accurate information related to primary health benefit plan coverage to the extent the information is available to the commission:

(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; and

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

(f) To the extent allowed by federal law, the commission shall maintain processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed,

regardless of whether the provider is enrolled as a Medicaid provider. The commission shall allow a provider who is not enrolled as a Medicaid provider to order, refer, or prescribe services to a recipient based on the provider's national provider identifier number and may not require an additional state provider identifier number to receive reimbursement for the services. The commission may seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider.

SECTION 7. (a) Section 531.0601, Government Code, as added by this Act, applies only to a child who becomes ineligible for the medically dependent children (MDCP) waiver program on or after December 1, 2019.

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

(c) Notwithstanding Section 531.06021, Government Code, as added by this Act, the Health and Human Services Commission shall submit the first report required by that section not later than September 30, 2020, for the state fiscal quarter ending August 31, 2020.

(d) Not later than March 1, 2020, the Health and Human

Services Commission shall:

(1) develop a plan to improve the care needs assessment tool and the initial assessment and reassessment processes as required by Sections 533.00253(c-1) and (c-2), Government Code, as added by this Act; and

(2) post the plan on the commission's Internet website.

(e) 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.

(f) As soon as practicable after the effective date of this Act but not later than September 1, 2020, 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 8. 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 9. 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 10. 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 11. This Act takes effect September 1, 2019.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 1207 passed the Senate on April 17, 2019, by the following vote: Yeas 30, Nays 1; May 23, 2019, Senate refused to concur in House amendments and requested appointment of Conference Committee; May 23, 2019, House granted request of the Senate; May 26, 2019, Senate adopted Conference Committee Report by the following vote: Yeas 30, Nays 1.

Secretary of the Senate

I hereby certify that S.B. No. 1207 passed the House, with amendments, on May 20, 2019, by the following vote: Yeas 139, Nays 0, two present not voting; May 23, 2019, House granted request of the Senate for appointment of Conference Committee; May 26, 2019, House adopted Conference Committee Report by the following vote: Yeas 145, Nays 0, one present not voting.

Chief Clerk of the House

Approved:

Date

Governor