By: Perry, et al. S.B. No. 1207
(Krause, Parker, Leach, Davis of Harris)

Substitute the following for S.B. No. 1207:

By: Lucio III C.S.S.B. No. 1207

A BILL TO BE ENTITLED

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 531.02444, Government Code, is amended by amending Subsection (a) and adding Subsections (d) and (e) to read as follows:

(a) The executive commissioner shall develop and implement:

(1) a Medicaid buy-in program for persons with disabilities as authorized by the Ticket to Work and Work Incentives Improvement Act of 1999 (Pub. L. No. 106-170) or the Balanced Budget Act of 1997 (Pub. L. No. 105-33); and

(2) subject to Subsection (d) as authorized by the Deficit Reduction Act of 2005 (Pub. L. No. 109-171), a Medicaid buy-in program for children with disabilities that are [~~is~~] described by 42 U.S.C. Section 1396a(cc)(1) and whose family incomes do not exceed 300 percent of the applicable federal poverty

level.

(d) The executive commissioner by rule shall increase the maximum family income prescribed by Subsection (a)(2) for determining eligibility of children with disabilities for the buy-in program under that subdivision to the maximum family income amount for which federal matching funds are available, considering available appropriations for that purpose.

(e) The commission shall, at the request of a child's legally authorized representative, conduct a disability determination assessment of the child to determine the child's eligibility for the buy-in program under Subsection (a)(2). The commission shall directly conduct the disability determination assessment and may not contract with a Medicaid managed care organization or other entity to conduct the assessment.

SECTION 3. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024162, 531.024163, 531.024164, 531.0601, 531.0602, and 531.06021 to read as follows:

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

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

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

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

(b) The commission or a Medicaid managed care organization that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request shall issue a notice to the provider and the Medicaid recipient on whose behalf the request was submitted. The notice issued under this subsection must:

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

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

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

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

(2) be sent to the provider:

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

(B) as applicable, through an electronic

notification on an Internet portal.

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

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

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

(B) a description of the notice the organization or entity provides to a provider and Medicaid recipient 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. 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 for expedited reviews that allows the reviewer to identify an appeal that requires an expedited resolution.

(f) 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. An external medical review described by Subsection (b)(2) occurs after the eligibility denial

and before the Medicaid fair hearing. The Medicaid recipient or applicant, or the recipient's or applicant's parent or legally authorized representative, must affirmatively opt out of the external medical review to proceed to a Medicaid fair hearing without first participating in the external medical review.

(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.

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) 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 the options under this section for placing the child on an interest list.

Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM 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 annual medical necessity determination reassessment 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 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 reassessment an opportunity to dispute the reassessment 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 a reassessment determination through the Medicaid managed care organization's internal appeal process or through the Medicaid fair hearing process.

Sec. 531.06021. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM QUALITY MONITORING; REPORT. (a) The commission, through the state's external quality review organization, shall:

(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) as frequently as feasible but not less frequently than annually, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as the STAR Kids Screening and Assessment Instrument or the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures.

(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;

(4) use, requests to opt out, 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.

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 adding Subsections (c-1), (c-2), (f), (g), and (h) to read as follows:

(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 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 in navigating and resolving issues related to the STAR Kids managed care program; 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.

SECTION 6. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00254, 533.00282, 533.00283, 533.00284, 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 September 1, 2023:

(1) the advisory committee is abolished; and

(2) this section expires.

Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. (a) Section 4201.304(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) The commission shall establish a process consistent with 42 C.F.R. Section 438.210 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.

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) to approve the request.

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

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

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

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, 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) To further assist with the coordination of benefits and to the extent allowed under federal requirements for third-party liability, the commission, in coordination with Medicaid managed care organizations, shall develop and maintain a list of services that are not traditionally covered by primary health benefit plan coverage that a Medicaid managed care organization may approve without having to coordinate with the primary health benefit plan issuer and that can be resolved through third-party liability resolution processes. The commission shall periodically review and update the list.

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

(e) 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.

(f) 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.

(g) 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.

(h) 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.

(i) 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 531.02444(e), Government Code, as added by this Act, applies to a request for a disability determination assessment to determine eligibility for the Medicaid buy-in for children program made on or after the effective date of this Act.

(b) 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.

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

(d) 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.

(e) 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.

(f) 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.

(g) 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.