By: Kolkhorst S.B. No. 2239

A BILL TO BE ENTITLED

AN ACT

relating to the operation and administration of certain health and human services programs, including the Medicaid managed care 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. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02112 to read as follows:

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

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

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

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

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

(2) publish notice of the proposed change:

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

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

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

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

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

(4) provide managed care organizations and the entity

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

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

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

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

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

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

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

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

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

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

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

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

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

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) Beginning September 1, 2020, the commission:

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

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

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

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

(b) The rules promulgated under Subsection (a)(7) must provide due process to an applicant for Medicaid services or programs 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 a clear [~~an~~] explanation of:

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

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

(B) be mailed at least 10 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.

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

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING DENIAL OF COVERAGE OR PRIOR AUTHORIZATION. 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 law;

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

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

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

(1) be updated monthly, as necessary;

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

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

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

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

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

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

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

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

(2) the clinical efficacy of the drug;

(3) the price of competing drugs after deducting any federal and state rebate amounts; [~~and~~]

(4) the impact on recipient health outcomes and continuity of care; and

(5) program benefit offerings solely or in conjunction with rebates and other pricing information.

SECTION 8. Section 531.0736(c), Government Code, is amended to read as follows:

(c) The executive commissioner shall determine the composition of the board, which must:

(1) comply with applicable federal law, including 42 C.F.R. Section 456.716;

(2) include five [~~two~~] representatives of managed care organizations to represent each managed care product [~~as nonvoting members~~], at least one of whom must be a physician and one of whom must be a pharmacist;

(3) include at least 17 physicians and pharmacists who:

(A) provide services across the entire population of Medicaid recipients and represent different specialties, including at least one of each of the following types of physicians:

(i) a pediatrician;

(ii) a primary care physician;

(iii) an obstetrician and gynecologist;

(iv) a child and adolescent psychiatrist;

and

(v) an adult psychiatrist; and

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

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

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

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

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

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

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

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

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

(c) 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:

(1) coverage criteria and prior authorization requirements are:

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

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

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

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

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

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

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

(B) request a peer review regarding the prior

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

(2) a requirement that the organization:

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

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

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

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

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

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

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

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

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

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

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

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

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

notifications; and

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

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

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

(c) The commission shall allow a recipient who is enrolled in a managed care plan under this chapter to disenroll from that plan and enroll in another managed care plan[~~:~~

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

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

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

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.

(c) To further assist with the coordination of benefits, 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 review and update the list quarterly.

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

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

(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;

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

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

(i) The commission shall develop and implement 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, prescribed, or delivered, 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, prescribe, or deliver 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.

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

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

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

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

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

Sec. 533.039. COORDINATION OF BENEFITS FOR PERSONS DUALLY ELIGIBLE UNDER MEDICAID AND MEDICARE. (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 Medicare coverage when the recipient has exceeded the Medicare coverage limit or when the service is not covered by Medicare.

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

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

and

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

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

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

SECTION 14. 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.

SECTION 15. 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 16. (a) Section 533.00285, 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 533.00285, Government Code, as added by this Act.

SECTION 17. 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 18. This Act takes effect September 1, 2019.