SENATE AMENDMENTS

2nd Printing

By: Frank H.B. No. 2658

A BILL TO BE ENTITLED

AN ACT

relating to the operation and administration of the Medicaid managed care program, including requirements for and reimbursement of managed care organizations.

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

SECTION 1. Section 533.005(a), Government Code, is amended to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that:

(A) include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the plan; and

(B) ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration,

education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan on any claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days,

specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and

32.0281, Human Resources Code;

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician;

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and

resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal;

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider; and

(D) the managed care organization to allow a provider with a claim that has not been paid before the time prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that claim;

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited

English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals in the region where the organization provides health care services;

(20) a requirement that the managed care organization:

(A) develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a) and specific data with respect to access

to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated;

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that, subject to the provider access standards established under Section 533.0061:

(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types;

(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and

(iv) providers located throughout the region where the organization will provide health care services;

and

(C) health care services will be accessible to recipients through the organization's provider network to a comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that, except as provided by Paragraph (L)(ii), exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse

under Medicaid;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that, except as provided by Paragraph (L)(i), includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(C-1) that does not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, as defined by Section 531.073, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse;

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

(G) that allows the managed care organization or

any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in

accordance with Section 843.339, Insurance Code;

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) to place a drug on a maximum allowable cost list, must ensure that:

(a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(b) the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(ii) must provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(iii) must review and update maximum allowable cost price information at least once every seven days to reflect any modification of maximum allowable cost pricing;

(iv) must, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations,

also known as the Orange Book;

(v) must establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(vi) must:

(a) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

(b) respond to a challenge not later than the 15th day after the date the challenge is made;

(c) if the challenge is successful, make an adjustment in the drug price effective on the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager, as appropriate;

(d) if the challenge is denied, provide the reason for the denial; and

(e) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period;

(vii) must notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail;

and

(viii) must provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to that provider; and

(L) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) may not require a prior authorization, other than a clinical prior authorization or a prior authorization imposed by the commission to minimize the opportunity for waste, fraud, or abuse, for or impose any other barriers to a drug that is prescribed to a child enrolled in the STAR Kids managed care program for a particular disease or treatment and that is on the vendor drug program formulary or require additional prior authorization for a drug included in the preferred drug list adopted under Section 531.072;

(ii) must provide for continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the managed care organization's formulary;

(iii) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug that the child's physician recommends for the child's treatment before the managed care organization provides coverage for the recommended drug; and

(iv) must pay liquidated damages to the

commission for each failure, as determined by the commission, to comply with this paragraph in an amount that is a reasonable forecast of the damages caused by the noncompliance;

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan;

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reductions; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; and

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

SECTION 2. Sections 533.0063(b) and (c), Government Code, are amended to read as follows:

(b) A [~~Except as provided by Subsection (c), a~~] managed care organization is required to send a paper form of the organization's provider network directory for the program only to a recipient who

requests to receive the directory in paper form. If a recipient requests to receive the directory in paper form, the managed care organization shall mail to the recipient the most recent paper form of the directory not later than the fifth business day after the date the organization receives the recipient's request.

(c) At least annually, a [~~A~~] managed care organization [~~participating in the STAR + PLUS Medicaid managed care program or STAR Kids Medicaid managed care program established under Section 533.00253~~] shall include in the organization's outreach efforts directed at and educational materials sent to recipients enrolled in a managed care plan offered by the organization a written or verbal offer allowing each recipient to elect to receive the organization's[~~, for a recipient in that program, issue a~~] provider network directory for the program, including any updates to the directory, in paper form [~~unless the recipient opts out of receiving the directory in paper form~~].

SECTION 3. Section 32.025(g), Human Resources Code, is amended to read as follows:

(g) The application form adopted under this section must include:

(1) for an applicant who is pregnant, a question regarding whether the pregnancy is the woman's first gestational pregnancy; [~~and~~]

(2) for an applicant who may be enrolled in a Medicaid managed care plan under Chapter 533, Government Code, an option for an applicant to elect to receive the provider network directory, including any updates to the directory, associated with the plan in

which the applicant is enrolled in paper form; and

(3) a question regarding the applicant's preferences for being contacted, as follows:

"If you are determined eligible for benefits, your managed care organization or health plan provider may contact you by telephone, text message, or e-mail about health care matters, including reminders for appointments and information about immunizations or well check visits. All preferred methods of contact listed on this application will be shared with your managed care organization or health plan provider. Please indicate below your preferred methods of contact in order of preference, with the number 1 being the most preferable method:

(1) By telephone (if contacted by cellular telephone, the call may be autodialed or prerecorded, and your carrier's usage rates may apply)? Yes No

Telephone number: _____

Order of preference: 1 2 3 (circle a number)

(2) By text message (a free autodialed service, but your carrier may charge message and data rates)? Yes No

Cellular telephone number: _____

Order of preference: 1 2 3 (circle a number)

(3) By e-mail? Yes No

E-mail address: _____

Order of preference: 1 2 3 (circle a number)".

SECTION 4. (a) Section 533.005(a), Government Code, as amended by this Act, applies only to a contract between the Health and Human Services Commission and a managed care organization that

is entered into or renewed on or after the effective date of this Act.

(b) To the extent permitted by the terms of the contract, the Health and Human Services Commission shall seek to amend a contract entered into before the effective date of this Act with a managed care organization to comply with Section 533.005(a), Government Code, as amended by this Act.

SECTION 5. As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall adopt a revised application form for medical assistance benefits that conforms to the requirements of Section 32.025(g), Human Resources Code, as amended by this Act.

SECTION 6. Using existing resources, the Commission shall conduct a study to assess the impact of revising Star+Plus capitation for managed long term care from payment based on site of care to a blended rate. The study will assess how revising the method of calculating the capitation impacts consumers' choice of setting as well as conduct an actuarial analysis of the impact on program spending. The study shall take into consideration the experience of other states utilizing a blended rate for Medicaid managed long term care. The Commission shall provide a report with their findings to the Speaker, Lieutenant Governor, House Human Services Committee and Senate Health and Human Services Committee.

SECTION 7. 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 8. This Act takes effect September 1, 2021.

ADOPTED

MAY 22 2021

Secretary of the Senate

By: Kolkhorst H.B. No. 2658

Substitute the following for H.B. No. 2658:

By: Beverly Powell C.S.H.B. No. 2658

A BILL TO BE ENTITLED

AN ACT

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

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

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024142, 531.02493, 531.0501, 531.0512, and 531.0605 to read as follows:

Sec. 531.024142. NONHOSPITAL AMBULANCE TRANSPORT AND TREATMENT PROGRAM. (a) The commission by rule shall develop and implement a program designed to improve quality of care and lower costs in Medicaid by:

(1) reducing avoidable transports to hospital emergency departments and unnecessary hospitalizations;

(2) encouraging transports to alternative care settings for appropriate care; and

(3) providing greater flexibility to ambulance care providers to address the emergency health care needs of Medicaid recipients following a 9-1-1 emergency services call.

(b) The program must be substantially similar to the Centers for Medicare and Medicaid Services' Emergency Triage, Treat, and Transport (ET3) model.

Sec. 531.02493. CERTIFIED NURSE AIDE PROGRAM. (a) The commission shall study:

(1) the cost-effectiveness of providing, as a Medicaid

benefit through a certified nurse aide trained in the Grand-Aide curriculum or a substantially similar training program, in-home support to a Medicaid recipient's care team after the recipient's discharge from a hospital; and

(2) the feasibility of allowing a Medicaid managed care organization to treat payments to certified nurse aides providing care as described by Subdivision (1) as quality improvement costs.

(b) Not later than December 1, 2022, the commission shall prepare and submit a report to the governor and the legislature that summarizes the commission's findings and conclusions from the study.

(c) This section expires September 1, 2023.

Sec. 531.0501. MEDICAID WAIVER PROGRAMS: INTEREST LIST MANAGEMENT. (a) The commission, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053 and the STAR Kids Managed Care Advisory Committee, shall study the feasibility of creating an online portal for individuals to request to be placed and check the individual's placement on a Medicaid waiver program interest list. As part of the study, the commission shall determine the most cost-effective automated method for determining the level of need of an individual seeking services through a Medicaid waiver program.

(b) Not later than January 1, 2023, the commission shall prepare and submit a report to the governor, the lieutenant governor, the speaker of the house of representatives, and the

standing legislative committees with primary jurisdiction over health and human services that summarizes the commission's findings and conclusions from the study.

(c) Subsections (a) and (b) and this subsection expire September 1, 2023.

(d) The commission shall develop a protocol in the office of the ombudsman to improve the capture and updating of contact information for an individual who contacts the office of the ombudsman regarding Medicaid waiver programs or services.

Sec. 531.0512. NOTIFICATION REGARDING CONSUMER DIRECTION MODEL. The commission shall:

(1) develop a procedure to:

(A) verify that a Medicaid recipient or the recipient's parent or legal guardian is informed regarding the consumer direction model and provided the option to choose to receive care under that model; and

(B) if the individual declines to receive care under the consumer direction model, document the declination; and

(2) ensure that each Medicaid managed care organization implements the procedure.

Sec. 531.0605. ADVANCING CARE FOR EXCEPTIONAL KIDS PILOT PROGRAM. (a) The commission shall collaborate with Medicaid managed care organizations and the STAR Kids Managed Care Advisory Committee to develop and implement a pilot program that is substantially similar to the program described by Section [illegible], Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16), to provide coordinated care through a health home

to children with complex medical conditions.

(b) The commission shall seek guidance from the Centers for Medicare and Medicaid Services and the United States Department of Health and Human Services regarding the design of the program and, based on the guidance, may actively seek and apply for federal funding to implement the program.

(c) Not later than December 31, 2024, the commission shall prepare and submit a report to the legislature that includes:

(1) a summary of the commission's implementation of the pilot program; and

(2) if the pilot program has been operating for a period sufficient to obtain necessary data, a summary of the commission's evaluation of the effect of the pilot program on the coordination of care for children with complex medical conditions and a recommendation as to whether the pilot program should be continued, expanded, or terminated.

(d) The pilot program terminates and this section expires September 1, 2025.

SECTION 2. Section 533.00251, Government Code, is amended by adding Subsection (h) to read as follows:

(h) In addition to the minimum performance standards the commission establishes for nursing facility providers seeking to participate in the STAR+PLUS Medicaid managed care program, the executive commissioner shall adopt rules establishing minimum performance standards applicable to nursing facility providers that participate in the program. The commission is responsible for monitoring provider performance in accordance with the standards

and requiring corrective actions, as the commission determines necessary, from providers that do not meet the standards. The commission shall share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.

SECTION 3. Section 533.005(a), Government Code, is amended to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that:

(A) include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the plan; and

(B) ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization

provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan on any claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

(A) not later than:

(i) the 10th day after the date the claim is received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

(ii) the 30th day after the date the claim is received if the claim relates to the provision of long-term services and supports not subject to Subparagraph (i); and

(iii) the 45th day after the date the claim is received if the claim is not subject to Subparagraph (i) or (ii); or

(B) within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(7-a) a requirement that the managed care organization

demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general and the office of the attorney general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that, notwithstanding any other law, including Sections 843.312 and 1301.052, Insurance Code, the

organization:

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network; and

(B) treat advanced practice registered nurses and physician assistants in the same manner as primary care physicians with regard to:

(i) selection and assignment as primary care providers;

(ii) inclusion as primary care providers in the organization's provider network; and

(iii) inclusion as primary care providers in any provider network directory maintained by the organization;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the recipient does not have a referral from the recipient's primary care physician;

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status

and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal;

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider; and

(D) the managed care organization to allow a provider with a claim that has not been paid before the time prescribed by Subdivision (7)(A)(ii) to initiate an appeal of that claim;

(16) a requirement that a medical director who is authorized to make medical necessity determinations is available to the region where the managed care organization provides health care services;

(17) a requirement that the managed care organization ensure that a medical director and patient care coordinators and provider and recipient support services personnel are located in the South Texas service region, if the managed care organization provides a managed care plan in that region;

(18) a requirement that the managed care organization provide special programs and materials for recipients with limited English proficiency or low literacy skills;

(19) a requirement that the managed care organization develop and establish a process for responding to provider appeals

in the region where the organization provides health care services;

(20) a requirement that the managed care organization:

(A) develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by the commission, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; and

(D) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a) and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on the average length of time between:

(i) the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; and

(ii) the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated;

(21) a requirement that the managed care organization demonstrate to the commission, before the organization begins to provide health care services to recipients, that, subject to the provider access standards established under Section 533.0061:

(A) the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the organization;

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types;

(iii) a sufficient number of providers of long-term services and supports and specialty pediatric care providers of home and community-based services; and

(iv) providers located throughout the region where the organization will provide health care services; and

(C) health care services will be accessible to recipients through the organization's provider network to a

comparable extent that health care services would be available to recipients under a fee-for-service or primary care case management model of Medicaid managed care;

(22) a requirement that the managed care organization develop a monitoring program for measuring the quality of the health care services provided by the organization's provider network that:

(A) incorporates the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set (HEDIS) measures or, as applicable, the national core indicators adult consumer survey and the national core indicators child family survey for individuals with an intellectual or developmental disability;

(B) focuses on measuring outcomes; and

(C) includes the collection and analysis of clinical data relating to prenatal care, preventive care, mental health care, and the treatment of acute and chronic health conditions and substance abuse;

(23) subject to Subsection (a-1), a requirement that the managed care organization develop, implement, and maintain an outpatient pharmacy benefit plan for its enrolled recipients:

(A) that, except as provided by Paragraph (L)(ii), exclusively employs the vendor drug program formulary and preserves the state's ability to reduce waste, fraud, and abuse under Medicaid;

(B) that adheres to the applicable preferred drug list adopted by the commission under Section 531.072;

(C) that, except as provided by Paragraph (L)(i), includes the prior authorization procedures and requirements prescribed by or implemented under Sections 531.073(b), (c), and (g) for the vendor drug program;

(C-1) that does not require a clinical, nonpreferred, or other prior authorization for any antiretroviral drug, as defined by Section 531.073, or a step therapy or other protocol, that could restrict or delay the dispensing of the drug except to minimize fraud, waste, or abuse;

(D) for purposes of which the managed care organization:

(i) may not negotiate or collect rebates associated with pharmacy products on the vendor drug program formulary; and

(ii) may not receive drug rebate or pricing information that is confidential under Section 531.071;

(E) that complies with the prohibition under Section 531.089;

(F) under which the managed care organization may not prohibit, limit, or interfere with a recipient's selection of a pharmacy or pharmacist of the recipient's choice for the provision of pharmaceutical services under the plan through the imposition of different copayments;

(G) that allows the managed care organization or any subcontracted pharmacy benefit manager to contract with a pharmacist or pharmacy providers separately for specialty pharmacy services, except that:

(i) the managed care organization and pharmacy benefit manager are prohibited from allowing exclusive contracts with a specialty pharmacy owned wholly or partly by the pharmacy benefit manager responsible for the administration of the pharmacy benefit program; and

(ii) the managed care organization and pharmacy benefit manager must adopt policies and procedures for reclassifying prescription drugs from retail to specialty drugs, and those policies and procedures must be consistent with rules adopted by the executive commissioner and include notice to network pharmacy providers from the managed care organization;

(H) under which the managed care organization may not prevent a pharmacy or pharmacist from participating as a provider if the pharmacy or pharmacist agrees to comply with the financial terms and conditions of the contract as well as other reasonable administrative and professional terms and conditions of the contract;

(I) under which the managed care organization may include mail-order pharmacies in its networks, but may not require enrolled recipients to use those pharmacies, and may not charge an enrolled recipient who opts to use this service a fee, including postage and handling fees;

(J) under which the managed care organization or pharmacy benefit manager, as applicable, must pay claims in accordance with Section 843.339, Insurance Code;

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) to place a drug on a maximum allowable cost list, must ensure that:

(a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

(b) the drug is generally available for purchase by pharmacies in the state from national or regional wholesalers and is not obsolete;

(ii) must provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

(iii) must review and update maximum allowable cost price information at least once every seven days to reflect any modification of maximum allowable cost pricing;

(iv) must, in formulating the maximum allowable cost price for a drug, use only the price of the drug and drugs listed as therapeutically equivalent in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic Equivalence Evaluations, also known as the Orange Book;

(v) must establish a process for eliminating products from the maximum allowable cost list or

modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(vi) must:

(a) provide a procedure under which a network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

(b) respond to a challenge not later than the 15th day after the date the challenge is made;

(c) if the challenge is successful, make an adjustment in the drug price effective on the date the challenge is resolved and make the adjustment applicable to all similarly situated network pharmacy providers, as determined by the managed care organization or pharmacy benefit manager, as appropriate;

(d) if the challenge is denied, provide the reason for the denial; and

(e) report to the commission every 90 days the total number of challenges that were made and denied in the preceding 90-day period for each maximum allowable cost list drug for which a challenge was denied during the period;

(vii) must notify the commission not later than the 21st day after implementing a practice of using a maximum allowable cost list for drugs dispensed at retail but not by mail; and

(viii) must provide a process for each of its network pharmacy providers to readily access the maximum

allowable cost list specific to that provider; and

(L) under which the managed care organization or pharmacy benefit manager, as applicable:

(i) may not require a prior authorization, other than a clinical prior authorization or a prior authorization imposed by the commission to minimize the opportunity for waste, fraud, or abuse, for or impose any other barriers to a drug that is prescribed to a child enrolled in the STAR Kids managed care program for a particular disease or treatment and that is on the vendor drug program formulary or require additional prior authorization for a drug included in the preferred drug list adopted under Section 531.072;

(ii) must provide for continued access to a drug prescribed to a child enrolled in the STAR Kids managed care program, regardless of whether the drug is on the vendor drug program formulary or, if applicable on or after August 31, 2023, the managed care organization's formulary;

(iii) may not use a protocol that requires a child enrolled in the STAR Kids managed care program to use a prescription drug or sequence of prescription drugs other than the drug that the child's physician recommends for the child's treatment before the managed care organization provides coverage for the recommended drug; and

(iv) must pay liquidated damages to the commission for each failure, as determined by the commission, to comply with this paragraph in an amount that is a reasonable forecast of the damages caused by the noncompliance;

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan;

(25) a requirement that the managed care organization not implement significant, nonnegotiated, across-the-board provider reimbursement rate reductions unless:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the reductions; or

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission; and

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

SECTION 4. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00515 to read as follows:

Sec. 533.00515. MEDICATION THERAPY MANAGEMENT. The executive commissioner shall collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.

SECTION 5. Section 533.009(c), Government Code, is amended

to read as follows:

(c) The executive commissioner, by rule, shall prescribe the minimum requirements that a managed care organization, in providing a disease management program, must meet to be eligible to receive a contract under this section. The managed care organization must, at a minimum, be required to:

(1) provide disease management services that have performance measures for particular diseases that are comparable to the relevant performance measures applicable to a provider of disease management services under Section 32.057, Human Resources Code; [~~and~~]

(2) show evidence of ability to manage complex diseases in the Medicaid population; and

(3) if a disease management program provided by the organization has low active participation rates, identify the reason for the low rates and develop an approach to increase active participation in disease management programs for high-risk recipients.

SECTION 6. Section 32.028, Human Resources Code, is amended by adding Subsection (p) to read as follows:

(p) The executive commissioner shall establish a reimbursement rate for medication therapy management services.

SECTION 7. Section 32.054, Human Resources Code, is amended by adding Subsection (f) to read as follows:

(f) To prevent serious medical conditions and reduce emergency room visits necessitated by complications resulting from a lack of access to dental care, the commission shall provide

medical assistance reimbursement for preventive dental services, including reimbursement for at least one preventive dental care visit per year, for an adult recipient with a disability who is enrolled in the STAR+PLUS Medicaid managed care program. This subsection does not apply to an adult recipient who is enrolled in the STAR+PLUS home and community-based services (HCBS) waiver program. This subsection may not be construed to reduce dental services available to persons with disabilities that are otherwise reimbursable under the medical assistance program.

SECTION 8. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Sections 32.0317 and 32.0611 to read as follows:

Sec. 32.0317. REIMBURSEMENT FOR SERVICES PROVIDED UNDER SCHOOL HEALTH AND RELATED SERVICES PROGRAM. The executive commissioner shall adopt rules requiring parental consent for services provided under the school health and related services program in order for a school district to receive reimbursement for the services. The rules must allow a school district to seek a waiver to receive reimbursement for services provided to a student who does not have a parent or legal guardian who can provide consent.

Sec. 32.0611. COMMUNITY ATTENDANT SERVICES: QUALITY INITIATIVES AND EDUCATION INCENTIVES. (a) The commission shall develop specific quality initiatives for attendants providing community attendant services to improve quality outcomes for recipients.

(b) The commission shall coordinate with the Texas Higher

Education Coordinating Board and the Texas Workforce Commission to develop a program to facilitate the award of academic or workforce education credit for programs of study or courses of instruction leading to a degree, certificate, or credential in a health-related field based on an attendant's work experience providing community attendant services.

SECTION 9. (a) In this section, "commission," "executive commissioner," and "Medicaid" have the meanings assigned by Section 531.001, Government Code.

(b) Using existing resources, the commission shall:

(1) review the commission's staff rate enhancement programs to:

(A) identify and evaluate methods for improving administration of those programs to reduce administrative barriers that prevent an increase in direct care staffing and direct care wages and benefits in nursing homes; and

(B) develop recommendations for increasing participation in the programs;

(2) revise the commission's policies regarding the quality incentive payment program (QIPP) to require improvements to staff-to-patient ratios in nursing facilities participating in the program by January 1, 2023;

(3) examine, in collaboration with the Department of Family and Protective Services, implementation in other states of the Centers for Medicare and Medicaid Services' Integrated Care for Kids (InCK) Model to determine whether implementing the model could benefit children in this state, including children enrolled in the

STAR Health Medicaid managed care program; and

(4) identify factors influencing active participation by Medicaid recipients in disease management programs by examining variations in:

(A) eligibility criteria for the programs; and

(B) participation rates by health plan, disease management program, and year.

(c) The executive commissioner may approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model.

SECTION 10. (a) In this section, "commission" and "Medicaid" have the meanings assigned by Section 531.001, Government Code.

(b) As soon as practicable after the effective date of this Act, the commission shall conduct a study to determine the cost-effectiveness and feasibility of providing to Medicaid recipients who have been diagnosed with diabetes, including Type 1 diabetes, Type 2 diabetes, and gestational diabetes:

(1) diabetes self-management education and support services that follow the National Standards for Diabetes Self-Management Education and Support and that may be delivered by a certified diabetes educator; and

(2) medical nutrition therapy services.

(c) If the commission determines that providing one or both of the types of services described by Subsection (b) of this section would improve health outcomes for Medicaid recipients and lower Medicaid costs, the commission shall, notwithstanding Section

32.057, Human Resources Code, or Section 533.009, Government Code, and to the extent allowed by federal law develop a program to provide the benefits and seek prior approval from the Legislative Budget Board before implementing the program.

SECTION 11. (a) In this section, "commission" and "Medicaid" have the meanings assigned by Section 531.001, Government Code.

(b) As soon as practicable after the effective date of this Act, the commission shall conduct a study to:

(1) identify benefits and services, other than long-term services and supports, provided under Medicaid that are not provided in this state under the Medicaid managed care model; and

(2) evaluate the feasibility, cost-effectiveness, and impact on Medicaid recipients of providing the benefits and services identified under Subdivision (1) of this subsection through the Medicaid managed care model.

(c) Not later than December 1, 2022, the commission shall prepare and submit a report to the legislature that includes:

(1) a summary of the commission's evaluation under Subsection (b)(2) of this section; and

(2) a recommendation as to whether the commission should implement providing benefits and services identified under Subsection (b)(1) of this section through the Medicaid managed care model.

SECTION 12. (a) In this section:

(1) "Commission," "Medicaid," and "Medicaid managed

care organization" have the meanings assigned by Section 531.001, Government Code.

(2) "Dually eligible individual" has the meaning assigned by Section 531.0392, Government Code.

(b) The commission shall conduct a study regarding dually eligible individuals who are enrolled in the Medicaid managed care program. The study must include an evaluation of:

(1) Medicare cost-sharing requirements for those individuals;

(2) the cost-effectiveness for a Medicaid managed care organization to provide all Medicaid-eligible services not covered under Medicare and require cost-sharing for those services; and

(3) the impact on dually eligible individuals and Medicaid providers that would result from the implementation of Subdivision (2) of this subsection.

(c) Not later than September 1, 2022, the commission shall prepare and submit a report to the legislature that includes:

(1) a summary of the commission's findings from the study conducted under Subsection (b) of this section; and

(2) a recommendation as to whether the commission should implement Subsection (b)(2) of this section.

SECTION 13. (a) Using existing resources, the Health and Human Services Commission shall conduct a study to assess the impact of revising the capitation rate setting strategy used to cover long-term care services and supports provided to recipients under the STAR+PLUS Medicaid managed care program from a strategy based on the setting in which services are provided to a strategy

based on a blended rate. The study must:

(1) assess the potential impact using a blended capitation rate would have on recipients' choice of setting;

(2) include an actuarial analysis of the impact using a blended capitation rate would have on program spending; and

(3) consider the experience of other states that use a blended capitation rate to reimburse managed care organizations for the provision of long-term care services and supports under Medicaid.

(b) Not later than September 1, 2022, the Health and Human Services Commission shall prepare and submit a report that summarizes the findings of the study conducted under Subsection (a) of this section to the governor, the lieutenant governor, the speaker of the house of representatives, the House Human Services Committee, and the Senate Health and Human Services Committee.

SECTION 14. Notwithstanding Section 2, Chapter 1117 (H.B. 3523), Acts of the 84th Legislature, Regular Session, 2015, Section 533.00251(c), Government Code, as amended by Section 2 of that Act, takes effect September 1, 2023.

SECTION 15. (a) Section 533.005(a), Government Code, as amended by this Act, applies only to a contract between the Health and Human Services Commission and a managed care organization that is entered into or renewed on or after the effective date of this Act.

(b) To the extent permitted by the terms of the contract, the Health and Human Services Commission shall seek to amend a contract entered into before the effective date of this Act with a

managed care organization to comply with Section 533.005(a), Government Code, as amended by this Act.

SECTION 16. As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall conduct the study and make the determination required by Section 531.0501(a), 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. The Health and Human Services Commission is required to implement 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 this Act using other appropriations available for the purpose.

SECTION 19. This Act takes effect September 1, 2021.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

May 23, 2021

TO: Honorable Dade Phelan, Speaker of the House, House of Representatives

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: HB2658 by Frank (Relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.), **As Passed 2nd House**

The fiscal implications of the bill cannot be determined at this time, primarily due to uncertainty regarding utilization of new programs and services and the effect on utilization of existing programs and services.

The Health and Human Services Commission, Department of Family and Protective Services, Texas Education Agency, Texas Workforce Commission, and Texas Higher Education Coordinating Board are 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 agencies may, but are not required to, implement a provision of this Act using other appropriations available for that purpose.

The bill would require the Health and Human Services Commission (HHSC) to establish a program substantially similar to the Centers for Medicare and Medicaid Services (CMS) Emergency Triage, Treat, and Transport (ET3) model. While there would be a cost associated with implementing the program, the fiscal implications cannot be determined at this time due to uncertainly regarding utilization of new services and the effect on utilization of existing services.

The bill would require HHSC to study the cost-effectiveness of providing Medicaid reimbursement for Certified Nurse Aides (CNAs) trained in certain programs who provide in-home support after a Medicaid recipient is discharged from a hospital and allowing managed care organizations (MCOs) to treat the payments as quality payments. According to HHSC, this provision can be accomplished within existing resources.

The bill would require HHSC to study the feasibility of creating an online portal for an individual to request to be placed on a Medicaid waiver program interest list and monitor their place on an interest list. HHSC would also be required to determine the most cost-effective automated method for determining the level of need of an individual on an interest list. The bill would also require the Office of the Ombudsman to improve methods to capture and update contact information for an individual who contacts the office regarding Medicaid waiver services. According to HHSC, these provisions can be accomplished within existing resources.

The bill would require HHSC to develop a procedure for informing Medicaid recipients of the Consumer Directed Services (CDS) option and documenting if CDS is declined. This analysis assumes there would be a minimal cost associated with implementing this provision.

The bill would require HHSC to implement an Advancing Care for Exceptional Kids (ACE Kids) pilot program to provide coordinated care through a health home to children with complex medical conditions, complete an evaluation of the program, and submit a report. According to HHSC, 1.0 Program Specialist VI would be needed in each fiscal year to develop and implement the ACE Kids pilot program. Additionally, it is assumed 2.5 Research Specialist V in fiscal years 2022 through 2023 and 1.5 Research Specialist V in fiscal year 2024 would be needed to complete the evaluation of the program. The estimated cost of the additional full-time-equivalents (FTEs) is $0.4 million in fiscal years 2022 through 2024, $0.5 million in fiscal year 2025, and $0.1 million in subsequent years. Additional costs related to implementing the pilot program cannot be determined

at this time because it is not known how many individuals would enroll in the pilot.

The bill would require HHSC to adopt rules establishing minimum performance standards for nursing facility providers that participate in the STAR+PLUS Medicaid managed care program. HHSC would be required to monitor provider performance and share performance data with STAR+PLUS MCOs as appropriate. It is assumed HHSC would require 1.0 Program Specialist VII to monitor performance of nursing facilities, at an estimated cost of $0.1 million each fiscal year.

The bill would require HHSC to collaborate with Medicaid managed care organizations (MCOs) to implement medication therapy management (MTM) services, and establish a reimbursement rate for MTM. While there would be a cost associated with implementing MTM, the fiscal implications cannot be determined at this time due to uncertainty regarding utilization. It is possible that implementation of MTM could result in cost savings, especially related to decreased adverse drug events, but savings cannot not be estimated at this time.

The bill would require HHSC to establish rules to require MCOs with disease management programs with low active participation rates to identify the reason for the low participation and develop an approach to increase active participation. According to HHSC, implementing this provision would have no significant fiscal impact to the agency.

The bill would require HHSC to provide Medicaid reimbursement for preventive dental services for an adult recipient with a disability who is enrolled in the STAR+PLUS managed care program. This analysis assumes HHSC would create a new dental benefit through a Special Terms and Conditions amendment to the Section 1115 Demonstration Waiver to offer preventative dental services to adults in STAR+PLUS who are not also in STAR+PLUS HCBS or in a 1915(c) intellectual and developmental disability waiver program. Because this benefit would be limited to certain adults, it is uncertain whether CMS would approve the benefit; HHSC may be required to provide preventative dental services to all adults enrolled in Medicaid or may be unable to implement the benefit at all. If implemented for adults enrolled in STAR+PLUS, the total Medicaid client services cost is estimated to be $81.7 million in All Funds, including $31.9 million in General Revenue Funds, in fiscal year 2023, increasing to $91.6 million in All Funds, including $36.3 million in General Revenue Funds, in fiscal year 2026, assuming implementation beginning September 1, 2022. The total Medicaid client services savings due to reduced dental-related emergency room visits is estimated to be $6.2 million in All Funds, including $2.4 in General Revenue Funds, in fiscal year 2023, increasing to $7.5 million in All Funds, including $3.0 million in General Revenue Funds, in fiscal year 2026. The increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures. Revenue is adjusted for assumed timing of payments and prepayments resulting in assumed increased collections of $0.9 million in fiscal year 2023, $2.3 million in fiscal year 2024, $1.4 million in fiscal year 2025, and $1.0 million in fiscal year 2026. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

The bill would require HHSC to adopt rules regarding parental consent for services provided under the School Health and Related Services program. According to HHSC, these provisions can be accomplished within existing resources.

The bill would require HHSC to develop quality initiatives for attendants providing services under the community attendant services program to improve quality outcomes and to coordinate with the Texas Higher Education Coordinating Board (THECB) and Texas Workforce Commission (TWC) to develop a program to award academic or workforce education credit based on an attendant's work experience under the community attendant services program. According to HHSC, 0.5 Program Specialist VI would be needed to develop, implement, and manage the attendant workforce education program at an estimated cost of $0.1 million each fiscal year.

The bill would require HHSC to utilize existing resources to do the following: review staff rate enhancement programs; review policies regarding the Quality Incentive Payment Program (QIPP); examine, in collaboration with the Department of Family and Protective Services (DFPS), the implementation of the CMS Integrated Care for Kids (InCK) model in other states; and identify factors influencing participation by Medicaid recipients in disease management programs. While it is assumed HHSC could complete these activities within existing resources, it is possible that other program activities could be effected.

The bill would allow HHSC to approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model. If the capitated model is used to provide new services, then there would be a cost, however the cost cannot be determined at this time due to uncertainty regarding service utilization.

The bill would require HHSC to conduct three separate studies regarding the following: providing certain services to Medicaid recipients with diabetes; providing certain Medicaid benefits and services through managed care; and providing all Medicaid-eligible services not covered by Medicare to dually-eligible Medicaid recipients through a managed care model and requiring cost-sharing for those services. If HHSC determines providing certain services to Medicaid recipients with diabetes would improve health outcomes and lower costs, HHSC would be required to develop the program and seek prior approval from the Legislative Budget Board before implementation. It is assumed HHSC would require 1.5 Program Specialist VI to complete the studies. It is assumed the additional FTEs would only be needed in fiscal years 2022 and 2023 at an estimated cost of $0.2 million each fiscal year.

The bill would amend the provisions HHSC is required to include in contracts with managed care organizations and would require the commission to conduct a study regarding STAR+PLUS capitation rates. HHSC indicates it could absorb these costs within existing resources.

DFPS, TWC, TEA, and THECB indicate that any costs associated with the bill could be absorbed within existing resources.

Local Government Impact

The fiscal impact to local entities cannot be determined at this time.

Source Agencies: 320 Texas Workforce Commission, 529 Hlth & Human Svcs Comm, 530 Family & Protective Services, 701 Texas Education Agency, 781 Higher Education Coordinating Board

LBB Staff: JMc, LBO, AKI, JLI, RD, AAL

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

May 21, 2021

TO: Honorable Lois W. Kolkhorst, Chair, Senate Committee on Health & Human Services

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB2658** by Frank (Relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.), **Committee Report 2nd House, Substituted**

The fiscal implications of the bill cannot be determined at this time, primarily due to uncertainty regarding utilization of new programs and services and the effect on utilization of existing programs and services.

The Health and Human Services Commission, Department of Family and Protective Services, Texas Education Agency, Texas Workforce Commission, and Texas Higher Education Coordinating Board are 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 agencies may, but are not required to, implement a provision of this Act using other appropriations available for that purpose.

The bill would require the Health and Human Services Commission (HHSC) to establish a program substantially similar to the Centers for Medicare and Medicaid Services (CMS) Emergency Triage, Treat, and Transport (ET3) model. While there would be a cost associated with implementing the program, the fiscal implications cannot be determined at this time due to uncertainly regarding utilization of new services and the effect on utilization of existing services.

The bill would require HHSC to study the cost-effectiveness of providing Medicaid reimbursement for Certified Nurse Aides (CNAs) trained in certain programs who provide in-home support after a Medicaid recipient is discharged from a hospital and allowing managed care organizations (MCOs) to treat the payments as quality payments. According to HHSC, this provision can be accomplished within existing resources.

The bill would require HHSC to study the feasibility of creating an online portal for an individual to request to be placed on a Medicaid waiver program interest list and monitor their place on an interest list. HHSC would also be required to determine the most cost-effective automated method for determining the level of need of an individual on an interest list. The bill would also require the Office of the Ombudsman to improve methods to capture and update contact information for an individual who contacts the office regarding Medicaid waiver services. According to HHSC, these provisions can be accomplished within existing resources.

The bill would require HHSC to develop a procedure for informing Medicaid recipients of the Consumer Directed Services (CDS) option and documenting if CDS is declined. This analysis assumes there would be a minimal cost associated with implementing this provision.

The bill would require HHSC to implement an Advancing Care for Exceptional Kids (ACE Kids) pilot program to provide coordinated care through a health home to children with complex medical conditions, complete an evaluation of the program, and submit a report. According to HHSC, 1.0 Program Specialist VI would be needed in each fiscal year to develop and implement the ACE Kids pilot program. Additionally, it is assumed 2.5 Research Specialist V in fiscal years 2022 through 2023 and 1.5 Research Specialist V in fiscal year 2024 would be needed to complete the evaluation of the program. The estimated cost of the additional full-time-equivalents (FTEs) is $0.4 million in fiscal years 2022 through 2024, $0.5 million in fiscal year 2025, and $0.1 million in subsequent years. Additional costs related to implementing the pilot program cannot be determined

at this time because it is not known how many individuals would enroll in the pilot.

The bill would require HHSC to adopt rules establishing minimum performance standards for nursing facility providers that participate in the STAR+PLUS Medicaid managed care program. HHSC would be required to monitor provider performance and share performance data with STAR+PLUS MCOs as appropriate. It is assumed HHSC would require 1.0 Program Specialist VII to monitor performance of nursing facilities, at an estimated cost of $0.1 million each fiscal year.

The bill would require HHSC to collaborate with Medicaid managed care organizations (MCOs) to implement medication therapy management (MTM) services, and establish a reimbursement rate for MTM. While there would be a cost associated with implementing MTM, the fiscal implications cannot be determined at this time due to uncertainty regarding utilization. It is possible that implementation of MTM could result in cost savings, especially related to decreased adverse drug events, but savings cannot not be estimated at this time.

The bill would require HHSC to establish rules to require MCOs with disease management programs with low active participation rates to identify the reason for the low participation and develop an approach to increase active participation. According to HHSC, implementing this provision would have no significant fiscal impact to the agency.

The bill would require HHSC to provide Medicaid reimbursement for preventive dental services for an adult recipient with a disability who is enrolled in the STAR+PLUS managed care program. This analysis assumes HHSC would create a new dental benefit through a Special Terms and Conditions amendment to the Section 1115 Demonstration Waiver to offer preventative dental services to adults in STAR+PLUS who are not also in STAR+PLUS HCBS or in a 1915(c) intellectual and developmental disability waiver program. Because this benefit would be limited to certain adults, it is uncertain whether CMS would approve the benefit; HHSC may be required to provide preventative dental services to all adults enrolled in Medicaid or may be unable to implement the benefit at all. If implemented for adults enrolled in STAR+PLUS, the total Medicaid client services cost is estimated to be $81.7 million in All Funds, including $31.9 million in General Revenue Funds, in fiscal year 2023, increasing to $91.6 million in All Funds, including $36.3 million in General Revenue Funds, in fiscal year 2026, assuming implementation beginning September 1, 2022. The total Medicaid client services savings due to reduced dental-related emergency room visits is estimated to be $6.2 million in All Funds, including $2.4 in General Revenue Funds, in fiscal year 2023, increasing to $7.5 million in All Funds, including $3.0 million in General Revenue Funds, in fiscal year 2026. The increases in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, estimated as 1.75 percent of the increased managed care expenditures. Revenue is adjusted for assumed timing of payments and prepayments resulting in assumed increased collections of $0.9 million in fiscal year 2023, $2.3 million in fiscal year 2024, $1.4 million in fiscal year 2025, and $1.0 million in fiscal year 2026. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

The bill would require HHSC to adopt rules regarding parental consent for services provided under the School Health and Related Services program. According to HHSC, these provisions can be accomplished within existing resources.

The bill would require HHSC to develop quality initiatives for attendants providing services under the community attendant services program to improve quality outcomes and to coordinate with the Texas Higher Education Coordinating Board (THECB) and Texas Workforce Commission (TWC) to develop a program to award academic or workforce education credit based on an attendant's work experience under the community attendant services program. According to HHSC, 0.5 Program Specialist VI would be needed to develop, implement, and manage the attendant workforce education program at an estimated cost of $0.1 million each fiscal year.

The bill would require HHSC to utilize existing resources to do the following: review staff rate enhancement programs; review policies regarding the Quality Incentive Payment Program (QIPP); examine, in collaboration with the Department of Family and Protective Services (DFPS), the implementation of the CMS Integrated Care for Kids (InCK) model in other states; and identify factors influencing participation by Medicaid recipients in disease management programs. While it is assumed HHSC could complete these activities within existing resources, it is possible that other program activities could be effected.

The bill would allow HHSC to approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model. If the capitated model is used to provide new services, then there would be a cost, however the cost cannot be determined at this time due to uncertainty regarding service utilization.

The bill would require HHSC to conduct three separate studies regarding the following: providing certain services to Medicaid recipients with diabetes; providing certain Medicaid benefits and services through managed care; and providing all Medicaid-eligible services not covered by Medicare to dually-eligible Medicaid recipients through a managed care model and requiring cost-sharing for those services. If HHSC determines providing certain services to Medicaid recipients with diabetes would improve health outcomes and lower costs, HHSC would be required to develop the program and seek prior approval from the Legislative Budget Board before implementation. It is assumed HHSC would require 1.5 Program Specialist VI to complete the studies. It is assumed the additional FTEs would only be needed in fiscal years 2022 and 2023 at an estimated cost of $0.2 million each fiscal year.

The bill would amend the provisions HHSC is required to include in contracts with managed care organizations and would require the commission to conduct a study regarding STAR+PLUS capitation rates. HHSC indicates it could absorb these costs within existing resources.

DFPS, TWC, TEA, and THECB indicate that any costs associated with the bill could be absorbed within existing resources.

Local Government Impact

The fiscal impact to local entities cannot be determined at this time.

Source Agencies: 320 Texas Workforce Commission, 529 Hlth & Human Svcs Comm, 530 Family & Protective Services, 701 Texas Education Agency, 781 Higher Education Coordinating Board

LBB Staff: JMc, AKI, JLI, RD, AAL

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

May 9, 2021

TO: Honorable Lois W. Kolkhorst, Chair, Senate Committee on Health & Human Services

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB2658** by Frank (Relating to the operation and administration of the Medicaid managed care program, including requirements for and reimbursement of managed care organizations.), **As Engrossed**

No significant fiscal implication to the State is anticipated.

The bill would amend the provisions the Health and Human Services Commission is required to include in contracts with managed care organizations and would require the commission to conduct a study regarding STAR+PLUS capitation rates.

The Health and Human Services Commission indicates it could absorb the costs associated with the bill within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Hlth & Human Svcs Comm

LBB Staff: JMc, AKI, JLI, RD

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

April 11, 2021

TO: Honorable James B. Frank, Chair, House Committee on Human Services

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB2658** by Frank (Relating to the operation and administration of the Medicaid managed care program, including requirements for and reimbursement of managed care organizations.), **Committee Report 1st House, Substituted**

No significant fiscal implication to the State is anticipated.

The bill would amend the provisions the Health and Human Services Commission is required to include in contracts with managed care organizations.

The Health and Human Services Commission indicates it could absorb the costs associated with the bill within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Hlth & Human Svcs Comm

LBB Staff: JMc, AKI, JLI, RD

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 87TH LEGISLATIVE REGULAR SESSION

March 20, 2021

TO: Honorable James B. Frank, Chair, House Committee on Human Services

FROM: Jerry McGinty, Director, Legislative Budget Board

IN RE: **HB2658** by Frank (Relating to the operation and administration of certain health insurance programs and medical assistance program.), **As Introduced**

No significant fiscal implication to the State is anticipated.

The bill would amend the provisions the Health and Human Services Commission is required to include in contracts with managed care organizations.

The Health and Human Services Commission indicates it could absorb the costs associated with the bill within existing resources.

Local Government Impact

No fiscal implication to units of local government is anticipated.

Source Agencies: 529 Hlth & Human Svcs Comm

LBB Staff: JMc, AKI, JLI, RD