By: Oliverson H.B. No. 4823

A BILL TO BE ENTITLED

AN ACT

relating to the provision and delivery of benefits to certain recipients under Medicaid.

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

SECTION 1. Section 531.024164(e), Government Code, is amended to read as follows:

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

(1) must conform to the utilization review and independent review process under Title 14, Insurance Code [~~identify an appeal that requires an expedited resolution~~]; [~~and~~]

(2) must include, at a minimum, the following requirements:

(A) a requirement that the person requesting the external review timely deliver to the external reviewer the recipient's relevant personal and medical information, including,

except as provided by Paragraph (B), the recipient's written statement;

(B) in the instance the review relates to a life-threatening condition, a requirement that instead of obtaining a written statement from the recipient the reviewer directly contact:

(i) the recipient or recipient's parent or legally authorized representative; and

(ii) the recipient's health care provider;

(C) a requirement that the reviewer notify the recipient or recipient's parent or legally authorized representative, the recipient's health care provider, and the commission if the reviewer does not receive the information described by Paragraph (A) within three business days after the date the reviewer is assigned to conduct the review; and

(D) a requirement that the reviewer request and maintain any other relevant information not provided under Paragraph (A) that is necessary to conduct the review, including:

(i) identifying information about the recipient, the recipient's treating health care providers, health care facilities providing care to the recipient, and the recipient's managed care plan;

(ii) the recipient's plan of care;

(iii) clinical information about the recipient's diagnosis and medical history related to the diagnosis;

(iv) the recipient's prognosis; and

(v) the recipient's treatment plan

prescribed by a health care provider and the provider's justification of the services contained in the plan;

(3) must ensure that the recipient and the recipient's health care provider are given the opportunity to provide input and additional evidence during the review; and

(4) may not prohibit a recipient, a recipient's parent or legally authorized representative, or the recipient's health care provider from submitting any information or documentation the person determines relevant to [~~resolve~~] the review [~~of the appeal within a specified period~~].

SECTION 2. Section 533.038, Government Code, is amended by amending Subsections (a), (g), and (h) and adding Subsection (j) to read as follows:

(a) In this section:

(1) "Complex medical needs" means:

(A) the condition of having one or more chronic health problems that:

(i) affect multiple organ systems; and

(ii) reduce cognitive or physical functioning and require the use of medication, durable medical equipment, therapy, surgery, or other treatments; or

(B) a life-limiting illness or rare pediatric disease, as defined by Section 529(a)(3) of the Food and Drug Administration Safety and Innovation Act (21 U.S.C. 360ff(a)).

(2) [~~,~~] "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.

(3) "Specialty provider" means a person who provides health-related goods or services to a recipient, including a provider of medication, therapy services, durable medical equipment, life-sustaining or life-stabilizing treatment, or any other treatment, services, equipment, or supplies necessary to improve health outcomes, prevent emergency room visits, maintain health care in the home and community, and avoid admission to a health care facility or other institution.

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

(1) whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage;

(2) the date the recipient enrolled in the managed care plan provided by the Medicaid managed care organization; or

(3) whether the provider is an in-network provider.

(h) If a recipient who has complex medical needs and who does not have primary health benefit plan coverage wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the managed care plan in which the recipient is enrolled, the managed care organization shall develop a simple, timely, and

efficient process to and shall make a good-faith effort to, negotiate a single-case agreement with the specialty provider. Until the Medicaid managed care organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rule, including 1 T.A.C. Section 353.4.

(j) The cancellation of a contract between a Medicaid managed care organization and a specialty provider under which the provider agrees to provide in-network services to recipients does not void or otherwise affect that organization's duty under Subsection (g) to provide continuity of care to recipients with complex medical needs, except if the cancellation is the result of fraud, waste, or abuse, as determined by the commission's office of inspector general. In the event of cancellation, the recipient has the right to select the recipient's preferred specialty provider.

SECTION 3. 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 4. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2023.