BILL ANALYSIS

C.S.H.B. 2453
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has been suggested that the allegations of mismanagement surrounding the state's Medicaid managed care system and contractual violations by select managed care organizations have highlighted several deficiencies in the program. Examples of these deficiencies that have been pointed to include denials of health care, an insufficient appeals process, noncompliance with various contractual obligations, and undocumented or unjustified reductions in sanctions imposed on managed care organizations by the Health and Human Services Commission. C.S.H.B. 2453 seeks to target examples of mismanagement and abuse in the managed care system and to address several issues in managed care by strengthening and updating provisions relating to contract oversight, network adequacy, prior authorizations and appeals processes, utilization review, and care coordination.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 2, 6, 9, 16, and 27 of this bill.

ANALYSIS

C.S.H.B. 2453 amends the Government Code to establish the office of ombudsman for Medicaid providers within the Health and Human Services Commission's (HHSC) Medicaid and CHIP services division to support Medicaid providers in resolving disputes, complaints, or other issues between the provider and HHSC or a Medicaid managed care organization (MCO) under a Medicaid managed care or fee-for-service delivery model. The bill requires HHSC to consider disputes, complaints, and other issues reported to the office in renewing a contract with a Medicaid MCO. The bill sets out requirements for the office's staff and data collected by the office. The bill requires HHSC to align the office's data collection practices with the data collection practices used by the HHSC office of the ombudsman to facilitate comparisons. The bill requires the executive commissioner of HHSC to adopt rules as necessary to implement these provisions.

C.S.H.B. 2453 requires the Department of Family and Protective Services (DFPS) to provide clear guidance on the process for requesting and responding to requests for documents relating to and medical records of a recipient under the STAR Health program to a Medicaid MCO that provides health care services under that program and to attorneys ad litem representing recipients under that program.

C.S.H.B. 2453 requires HHSC to adopt and implement policies that encourage the use of electronic transactions in Medicaid and requires the policies to promote electronic payment systems for Medicaid providers and to encourage providers through the use of incentives to submit claims and prior authorization requests electronically. The bill sets out notice requirements regarding Medicaid coverage to recipients and providers regarding the denial of coverage or prior authorization.

C.S.H.B. 2453 requires the executive commissioner of HHSC by rule to require each Medicaid MCO or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the MCO or entity maintains specified information on an applicable website in an easily searchable and accessible format. The bill requires HHSC to do the following for the portion of its own website relating to Medicaid:

- ensure the information is accessible and usable;
- publish Medicaid MCO performance measures; and
- organize and maintain that portion of the website in a manner that serves Medicaid recipients, providers, and MCOs, stakeholders, and the public.

C.S.H.B. 2453 requires HHSC to annually review the prior authorization requirements of a Medicaid MCO and recommend whether the MCO should change, update, or delete any of those requirements based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. The bill requires HHSC, in consultation with physicians and Medicaid MCOs, to annually review prior authorization requirements in the Medicaid vendor drug program and determine whether to change, update, or delete any of the requirements based on such criteria. The bill requires HHSC to monitor:

- Medicaid MCOs to ensure that the MCOs are not using prior authorization to negatively impact recipients' access to care; and
- whether a Medicaid MCO complies with applicable laws and rules in establishing prior authorization requirements.

The bill requires HHSC to take certain specified actions to enable HHSC to increase its utilization review resources with respect to Medicaid MCO performance and to hold an MCO accountable for services and coordination required to be provided by contract.

C.S.H.B. 2453 requires HHSC, before posting on its website the findings of a Medicaid MCO's utilization review performance or assessing liquidated damages related to that performance, to allow the MCO to review and dispute the findings and discuss concerns with HHSC. The bill requires HHSC to document comments from the MCO not later than the 60th day after the date of receipt and to post the comments along with the findings.

C.S.H.B. 2453 requires HHSC to request information regarding and to review the outcomes and timeliness of a Medicaid MCO's prior authorizations to make specified determinations for particular service requests. The bill requires the executive commissioner to determine by rule the frequency with which HHSC may request that information.

C.S.H.B. 2453 authorizes HHSC to do the following:

- require an assessment of a Medicaid MCO's employee who conducts utilization review to ensure the employee's decisions and assessments are consistent with those of other employees, clinical criteria, and guidelines;
- require the MCO to provide a sample case to test how the MCO conducts service planning and utilization review and to determine whether the MCO is following its utilization management policies and procedures in certain publicly available written

documents, including its patient handbook; and

- randomly select an employee to test how the MCO conducts service planning and utilization review, particularly in the STAR+PLUS Medicaid managed care program, STAR Kids managed care program, and STAR Health program.

C.S.H.B. 2453, with respect to prior authorizations:

- requires HHSC, to the extent feasible, to give guidance on aligning treatments and conditions subject to prior authorization to create uniformity among Medicaid managed care plans;
- requires HHSC, in consultation with physicians, other relevant providers, and Medicaid MCOs, to take into account differences in the region and recipient populations, including ages of those populations, served under a plan and other relevant factors;
- requires HHSC by rule to require each Medicaid MCO to submit certain information to HHSC at least annually; and
- requires HHSC to develop a template for a Medicaid MCO to use to post prior authorization information on the MCO's website.

C.S.H.B. 2453 limits the circumstances under which a Medicaid MCO that provides health care services under the STAR Health program or the STAR Kids managed care program may require prior authorization for an initial therapy evaluation for a recipient to those in which such a requirement aligns with clinical criteria.

C.S.H.B. 2453 requires HHSC to ensure that the care coordinator for a Medicaid MCO under the STAR Kids managed care program offers a recipient's parent or legally authorized representative the opportunity to review the recipient's completed care needs assessment. The bill sets out related provisions, including a requirement for HHSC to ensure the review does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services and to provide a parent or representative who disagrees with a care needs assessment an opportunity to dispute the assessment with HHSC through a peer-to-peer review with the treating physician of choice.

C.S.H.B. 2453 adds temporary provisions set to expire September 1, 2021, that:

- require HHSC, in consultation with stakeholders, to redesign the care needs assessment used in the STAR Kids managed care program to ensure the assessment collects useable and actionable data pertinent to a child's physical, behavioral, and long-term care needs; and
- require the STAR Kids Managed Care Advisory Committee or a successor committee to provide recommendations to HHSC for the redesign of the private duty nursing assessment tools used in the STAR Kids managed care program based on observations from other states to be more comprehensive and allow for the streamlining of the documentation for prior authorization of private duty nursing.

C.S.H.B. 2453 requires HHSC to periodically evaluate whether to continue the STAR Kids Managed Care Advisory Committee as a forum to identify and make recommendations for resolving eligibility, clinical, and administrative issues with the STAR Kids managed care program. The bill requires HHSC to annually identify and study areas of Medicaid MCO services for which HHSC needs additional information.

C.S.H.B. 2453 requires the organization that performs external quality review of a Medicaid MCO as provided by federal law to annually study and report to HHSC on at least three measures related to the identified areas and other measures HHSC considers appropriate, which

may include measures in the core set of children's health care quality measures or core set of adults' health care quality measures published by the U.S. Department of Health and Human Services. The bill sets out related requirements for the external quality review organization and requires HHSC to require each Medicaid MCO to submit quarterly certain information to be used by the external quality review organization. The bill adds a temporary provision set to expire September 1, 2021, requiring the external quality review organization to conduct a study to determine whether Medicaid MCOs could provide care coordination remotely through technology and to prepare and submit a written report of the study's results to HHSC not later than September 1, 2020.

C.S.H.B. 2453 revises the required contents of a Medicaid managed care contract, including requirements relating to monitoring of certain IDD data, compliance with the external medical review, and the payment of liquidated damages for each substantiated failure to adhere to contractual requirements. The bill requires HHSC to provide guidance and education regarding certain requirements included in the contract and under federal law to continue to provide services during an internal appeal, an external medical review, and a Medicaid fair hearing. The bill sets out additional required contents of such a contract regarding utilization review, prior authorization procedures, and reconsideration following adverse determinations on certain prior authorization requests. The bill sets out related provisions and provides for the annual review of the prior authorization requirements of each Medicaid MCO for certain prescription drugs under the Medicaid vendor drug program.

C.S.H.B. 2453 requires HHSC to develop a data-sharing platform that enables divisions within HHSC to electronically view data and access data analysis in a single location. The bill provides procedures for measuring the adequacy of a Medicaid MCO's provider network determined according to standards established by federal law and sets out provisions relating to that network adequacy, including a requirement for the executive commissioner by rule to ensure that an evaluation of provider network adequacy conducted by HHSC or the external quality review organization with information obtained from an MCO's provider network directory is based on the total number of providers listed in the directory.

C.S.H.B. 2453 requires HHSC to use its master file of Medicaid providers to validate a Medicaid MCO's provider network directory and to establish a procedure to ensure that master file is accurate and up-to-date. The bill adds a temporary provision set to expire September 1, 2021, requiring HHSC to prepare and submit to the legislature not later than December 1, 2020, a report describing that procedure and how the procedure improves the current method of verifying and updating provider lists and the master file.

C.S.H.B. 2453 authorizes HHSC to implement quality-based incentives designed to reduce the administrative burdens and number of prior authorization requirements for providers who are providing appropriate, quality care, including incentives under which Medicaid MCOs selectively require prior authorization for services ordered by providers based on provider performance on quality measures and adherence to evidence-based medicine or other contractual agreements, such as risk-sharing arrangements. The bill sets out provisions relating to the criteria for selectively requiring prior authorization and actions HHSC may encourage Medicaid MCOs to take as part of the incentives.

C.S.H.B. 2453 requires HHSC to do the following with respect to a contract between HHSC and a Medicaid MCO:

- automate the process for receiving and tracking contract amendment requests and incorporating an amendment into a contract;
- make the most recent contract amendment information readily available among divisions within HHSC; and
- provide technical assistance and education to help an HHSC employee determine whether a requested contract amendment is necessary or whether the issue could be

resolved through the uniform managed care manual, a memorandum, or guidance.

C.S.H.B. 2453 requires HHSC to create a summary compliance framework that summarizes contract provisions to help Medicaid MCOs comply with those provisions. The bill requires HHSC to annually review and assess contract deliverables and eliminate unnecessary deliverables for Medicaid managed care contracts and authorizes HHSC to identify measures to strengthen contract deliverables and implement those measures as needed.

C.S.H.B. 2453 requires HHSC to contract with an independent external medical reviewer, as defined by the bill, to conduct external medical reviews and review the following:

- the resolution of an appeal from a Medicaid recipient related to a reduction in or denial of health care services on the basis of medical necessity in the Medicaid managed care program; or
- a denial by HHSC of eligibility for a Medicaid program in which eligibility is based on a recipient's medical and functional needs.

The bill requires HHSC to establish a common procedure for reviews that provides that a health care service ordered by a health care provider is presumed medically necessary and the Medicaid MCO bears the burden of proof to show the health care service is not medically necessary. The bill requires HHSC to establish a procedure for expedited reviews that allows the reviewer to identify an appeal that requires an expedited resolution. The bill sets out related provisions, including certain required actions for the reviewer.

C.S.H.B. 2453 requires HHSC or the external medical reviewer to annually collect data for each hearing officer that conducts Medicaid fair hearings regarding the officer's decisions and rates of upholding or reversing decisions on appeal and to analyze the data to identify outliers. The bill requires HHSC to provide corrective education to hearing officers whose decisions or rates are outliers and to document the outliers identified and the corrective education provided.

C.S.H.B. 2453 includes the following as enforcement actions initiated by HHSC against a Medicaid MCO for failure to comply with the terms of a contract for which HHSC is required to prepare and maintain a record and post on the HHSC website:

- an action that results in a sanction, including a penalty;
- the imposition of a corrective action plan;
- the imposition of liquidated damages;
- the suspension of default enrollment; and
- the termination of the MCO's contract.

C.S.H.B. 2453 sets out certain required actions for HHSC in assessing liquidated damages against a Medicaid MCO and requires HHSC to include in the record prepared for an enforcement action the reason for any reduction to the sanction or penalty. The bill requires the HHSC office of inspector general to post and maintain the records relating to corrective action plans on the office's website and requires the office to update the list of records on the website at least quarterly.

C.S.H.B. 2453 includes the following among the factors HHSC must consider in assigning managed care plans and primary health care providers to Medicaid recipients who fail to choose plans and providers:

- a recipient's previous plan assignment;
- the Medicaid MCO's performance on quality assurance and improvement;

- enforcement actions, including liquidated damages, imposed against the MCO;
- corrective action plans HHSC has required the MCO to implement; and
- other reasonable factors that support the objectives of the managed care program.

C.S.H.B. 2453 requires HHSC to incorporate information HHSC determines is relevant in Medicaid managed care report cards to help new Medicaid recipients easily compare managed care plans with regard to quality and patient satisfaction measures, including certain specified information.

C.S.H.B. 2453 establishes that, after enrolling a recipient in the medically dependent children (MDCP) waiver program or the STAR+PLUS Medicaid managed care program, HHSC must require the recipient's or legally authorized representative's signature to verify the recipient received the recipient handbook. The bill requires HHSC to survey a select sample of Medicaid recipients receiving benefits under the MDCP waiver program or the STAR+PLUS Medicaid managed care program to determine whether the recipients received the recipient handbook within the required period and understand the information in the recipient handbook and requires HHSC to provide a sample recipient handbook to Medicaid MCOs.

C.S.H.B. 2453 requires HHSC to establish the following:

- a list of health care services and prescription drugs for which a Medicaid MCO must grant extended prior authorization periods or amounts, as applicable, without requiring additional proof or documentation;
- a list of disabilities, chronic health conditions, and mental health conditions the treatments for which a Medicaid MCO must grant extended prior authorization periods without requiring additional proof or documentation; and
- the extended periods and amounts.

The bill sets out provisions regarding establishing and updating the lists and requires the HHSC medical director to solicit and receive provider feedback regarding extended prior authorization periods.

C.S.H.B. 2453 requires the HHSC office of inspector general, in overseeing Medicaid MCOs, to use a program integrity methodology appropriate for managed care and authorizes the office to explore different options to measure program integrity efforts, including:

- quantifying and validating cost avoidance in a managed care context; and
- adapting existing program integrity tools within the office to permit the office to address specific risks and incentives related to risk-based and value-based arrangements.

The bill requires the office to apply standards established in a contract between a Medicaid MCO and a provider to the extent the contract is allowed by a contract between HHSC and a Medicaid MCO or state or federal law, rules, or policy.

C.S.H.B. 2453, with respect to enhanced data collection and reporting of administrative costs and with respect to contract oversight:

- requires HHSC to collect accurate, consistent, and verifiable data from Medicaid MCOs, including line-item data for administrative costs, and sets out the purposes for which HHSC is required to use that data;
- requires a Medicaid MCO to report administrative costs in the organization's financial statistical report and to report those costs to HHSC at least annually;
- requires HHSC to report the provided data and administrative cost information annually

to the lieutenant governor, the speaker of the house, and each standing committee of the legislature with jurisdiction over financing, operating, and overseeing Medicaid;

- requires HHSC to provide financial subject matter expertise for Medicaid managed care contract review and compliance oversight among divisions within HHSC;
- requires HHSC to conduct extensive validation of Medicaid managed care financial data; and
- requires HHSC to analyze the ultimate underlying cause of an issue to resolve that cause and prevent similar issues from arising in the future within Medicaid managed care.

C.S.H.B. 2453 requires the HHSC office of inspector general to assist HHSC in implementing the immediately preceding provisions and requires HHSC to establish and maintain an interactive public portal on its website that incorporates the collected data to allow Medicaid recipients to compare Medicaid MCOs within a service region.

C.S.H.B. 2453 requires HHSC to provide education and training to HHSC employees on the correct issue resolution processes for Medicaid managed care grievances and to require those employees to promptly report grievances into the grievance tracking system to enable employees to track and timely resolve grievances. The bill defines "grievance" with respect to managed care and requires HHSC to ensure the definition of a grievance is consistent among the following entities to ensure all grievances are managed consistently:

- HHSC employees and divisions and offices within HHSC;
- Medicaid MCOs;
- comprehensive long-term services and supports providers, as defined by the bill;
- the office of ombudsman for Medicaid providers; and
- DFPS.

The bill requires HHSC to enhance the grievance tracking system's reporting capabilities and standardize data reporting among divisions within HHSC.

C.S.H.B. 2453 requires HHSC, in coordination with the executive commissioner's duties regarding the HHSC office of the ombudsman, to implement a no-wrong-door system for Medicaid managed care grievances reported to HHSC and requires HHSC to ensure that HHSC employees, Medicaid MCOs, comprehensive long-term services and supports providers, DFPS, and applicable HHSC offices use common practices and policies and provide consistent resolutions for Medicaid managed care grievances.

C.S.H.B. 2453 requires HHSC, under review of the HHSC office of inspector general, to implement a data analytics program to aggregate rates of inquiries, complaints, calls, and denials and to include the aggregate rating and data analysis and fair hearing and outcomes data in each Medicaid MCO's quality rating. The bill requires HHSC to use data from grievances for contract oversight and to determine contract risk.

C.S.H.B. 2453 requires HHSC to ensure a person who is engaged by a Medicaid MCO to provide care coordination benefits is consistently referred to as a "care coordinator," as defined by the bill, throughout divisions within HHSC and across all Medicaid programs and services for recipients receiving benefits under a managed care delivery model. The bill sets out related requirements for HHSC regarding care coordination and care coordinators. The bill requires HHSC to ensure that a comprehensive long-term services and supports provider may submit grievance on behalf of a recipient.

C.S.H.B. 2453 requires the executive commissioner by rule to determine which providers are eligible to have a Medicaid MCO's care coordinator on-site or available through virtual means at

the provider's practice. The bill requires HHSC to ensure a care coordinator is reimbursed for care coordination services provided on-site or virtually and to encourage MCOs to place care coordinators on-site or make the care coordinators available through virtual means. The bill requires HHSC to ensure that care coordinators coordinate with health care providers in compiling documentation to satisfy Medicaid MCO requirements, including prior authorization requirements.

C.S.H.B. 2453 requires HHSC to change the methodology for calculating potentially preventable admissions and potentially preventable readmissions to exclude from those admission and readmission rates hospitalizations in which a Medicaid MCO did not adequately coordinate the patient's care and requires the methodology to apply to physical and behavioral health conditions. The bill establishes that the change in methodology must be clinical in nature.

C.S.H.B. 2453 requires the executive commissioner to include a provision establishing key performance metrics for care coordination in a Medicaid managed care contract regarding the provision of health care services to Medicaid recipients receiving home and community-based services under the STAR+PLUS Medicaid managed care program, the STAR Kids managed care program, or the STAR Health program. The bill requires HHSC to establish certain specified metrics for Medicaid MCOs and requires HHSC to ensure compliance with those metrics.

C.S.H.B. 2453 requires HHSC to prohibit a Medicaid MCO providing health care services under the MDCP waiver program from requiring additional authorization from an enrolled child's health care provider for a service if the child's third-party health benefit plan issuer authorizes the service, except to minimize the opportunity for fraud, waste, abuse, gross overuse, inappropriate or medically unnecessary care, or clinical abuse or misuse.

C.S.H.B. 2453 requires HHSC to provide notice of its intent to amend a contract with a Medicaid MCO, including a manual or document that is incorporated by reference into such a contract, to and allow for the receipt of comments on the proposed amendment from the Medicaid MCO, appropriate stakeholders, and other interested parties. The bill prohibits a contract amendment from taking effect before the 21st day after the date HHSC provides that notice. The bill sets out additional provisions regarding a contract amendment and the required notice.

C.S.H.B. 2453 makes the HHSC medical director responsible for convening periodic meetings with Medicaid health care providers, including hospitals, to analyze and evaluate all Medicaid managed care and health care provider quality-based programs to ensure feasibility and alignment among programs.

EFFECTIVE DATE

September 1, 2019.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2453 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute changes the entity within which the office of ombudsman for Medicaid providers is established from the HHSC office of inspector general to the HHSC Medicaid and CHIP services division. The substitute does not include provisions regarding the assessment of administrative penalties and includes provisions requiring HHSC to do the following:

- consider disputes, complaints, and other issues reported to the office in renewing a contract with a Medicaid MCO; and

- align the office's data collection practices with those of the HHSC office of the ombudsman to facilitate comparisons.

The substitute changes the agency required to provide clear guidance on the process for requesting and responding to requests for documents relating to and medical records of a recipient under the STAR Health program from HHSC to DFPS.

The substitute changes the entity required to provide corrective education to hearing officers whose decisions or rates are outliers from a third-party arbiter to HHSC and includes a requirement for HHSC to document the identified outliers and the corrective education provided.

The substitute does not include a provision requiring certain rules promulgated by HHSC to provide a Medicaid recipient the right to an in-person hearing, regardless of whether the recipient demonstrates good cause.

The substitute does not include provisions providing for an independent appeals procedure but includes provisions that instead provide for an external medical review regarding medical necessity determinations. The substitute includes provisions prohibiting a Medicaid MCO from having a financial relationship with or ownership interest in the external medical reviewer with which HHSC contracts and requiring the reviewer to be overseen by a medical director who is a licensed physician and to employ or consult with staff meeting certain conditions. The bill sets out provisions regarding when such a review occurs, a determination of medical necessity by the reviewer, and documentation relating to a reduction of services by a Medicaid MCO.

The substitute includes provisions relating to the following:

- notice requirements regarding Medicaid coverage or prior authorization denial and incomplete requests;
- the accessibility of information regarding Medicaid prior authorization requirements;
- additional requirements for the contents of a Medicaid managed care contract with respect to utilization review and prior authorization procedures and reconsideration following adverse determinations on certain prior authorization requests;
- the annual review of Medicaid MCO prior authorization requirements;
- provider incentives and selective prior authorization requirements; and
- notice from HHSC of its intent to amend a contract with a Medicaid MCO.

The substitute, with respect to the annual reviews of prior authorization requirements, does the following:

- includes a requirement for HHSC to consult with physicians and Medicaid MCOs in the annual review of those requirements in the Medicaid vendor drug program;
- does not include a provision providing HHSC the authority to determine whether a Medicaid MCO should change, update, or delete any of its prior authorization requirements but requires HHSC to instead recommend any such changes; and
- includes a requirement that the changes or updates to, or deletions of, any of the prior authorization requirements of such an MCO or the vendor drug program be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria.

The substitute changes the revisions made to the required contents of a Medicaid managed care contract.

The substitute includes a requirement for HHSC to do the following:

- monitor whether a Medicaid MCO complies with applicable laws and rules in establishing prior authorization requirements; and
- hold a Medicaid MCO accountable for services and coordination the MCO is by contract required to provide.

The substitute specifies that consideration of data on provider grievances filed with the office of ombudsman for Medicaid providers is included among the data-driven approaches HHSC is required to use to enable HHSC to increase its utilization review resources with respect to Medicaid MCO performance.

The substitute includes a provision relating to the posting of the findings of the utilization review performance of a Medicaid MCO or the assessment of liquidated damages related to that performance on the HHSC website.

The substitute revises the factors for which HHSC is required to request information regarding and review the outcomes and timeliness of a Medicaid MCO's prior authorizations to determine for particular service requests. The substitute includes a provision requiring the executive commissioner by rule to determine the frequency with which HHSC may request information regarding the outcomes and timeliness of the prior authorizations of a Medicaid MCO to make certain determinations for particular service requests.

The substitute replaces a provision requiring HHSC, to the extent feasible, to align treatments and conditions subject to prior authorization to create uniformity among Medicaid managed care plans with a provision requiring HHSC, to the extent feasible, to give guidance on such alignment. The substitute includes a provision requiring HHSC, in consultation with certain entities, to take into account differences in the region and recipient populations served under a plan and other relevant factors.

The substitute changes the frequency with which HHSC is required to require each Medicaid MCO to submit a list of the conditions and treatments subject to prior authorization under the managed care plan offered by the MCO from at least every two years to at least annually and includes additional information the MCO must submit along with that list.

The substitute does not include the following:

- a requirement for HHSC to designate a single, searchable, public-facing website that contains prior authorization lists categorized by Medicaid managed care program and subcategorized by Medicaid MCO; or
- a requirement for the prior authorization requirements of HHSC and each Medicaid MCO, including prior authorization requirements applicable in the Medicaid vendor drug program, to be based on publicly available clinical criteria and posted in an easily searchable format on the respective websites.

The substitute includes a requirement for HHSC to develop a template for a Medicaid MCO to use to post prior authorization information on the MCO's website.

The substitute revises the provision requiring HHSC to ensure that the care coordinator for a Medicaid MCO under the STAR Kids managed care program offers a recipient's parent or legally authorized representative the opportunity to review and comment on the recipient's

completed care needs assessment before the assessment is used to determine the services to be provided to the recipient by:

- not including the requirement to ensure that comment can be made on that assessment; and
- not including the requirement that the review occur before the assessment is used to make that determination.

The substitute includes a provision requiring HHSC to ensure that the review does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services. The substitute revises related provisions.

The substitute includes a temporary provision requiring the STAR Kids advisory committee or a successor committee to provide recommendations to HHSC for the redesign of the private duty nursing assessment tools used in the STAR Kids managed care program based on observations from other states to be more comprehensive and allow for the streamlining of the documentation for prior authorization of private duty nursing.

The substitute revises the areas that the external quality review organization is required to annually study and report on to HHSC and revises and sets out related requirements for the review organization.

The substitute does not include a provision prohibiting a Medicaid MCO that provides health care services under the STAR Health program from requiring prior authorization for an initial therapy evaluation for a recipient but includes a provision that instead limits the circumstances under which a Medicaid MCO that provides health care services under the STAR Health program or the STAR Kids managed care program may require such prior authorization.

The substitute, with respect to network adequacy, does the following:

- includes a provision requiring HHSC to use Medicaid MCO contract data to validate network adequacy determinations;
- does not include providers of long-term services and supports who travel to a Medicaid recipient to provide care among the persons for whom HHSC is required to establish network adequacy standards but includes instead among those persons licensed providers of home and community-based services in the home who travel to a recipient to provide care; and
- includes a provision requiring HHSC to develop and implement a process to assist Medicaid MCOs in implementing the network adequacy standards.

The substitute includes a provision requiring HHSC to establish a procedure to ensure its master file of Medicaid providers is accurate and up-to-date and includes a temporary provision requiring HHSC to prepare and submit a report related to those procedures to the legislature.

The substitute includes a requirement for HHSC to establish a list of disabilities for which a Medicaid MCO must grant extended prior authorization periods without requiring additional proof or documentation. The substitute revises the entities with which HHSC is required to consult in establishing that and another applicable list and changes the frequency with which HHSC is required to update the lists from semiannually to every two years.

The substitute includes a requirement for the HHSC office of inspector general to apply

standards established in a contract between a Medicaid MCO and a provider only to certain extents.

The substitute revises and sets out additional provisions regarding processes and tracking for managed care grievances to, among other things, change the definition of grievance and make certain of those provisions applicable with respect to a comprehensive long-term services and supports provider, for which the substitute includes a definition. The substitute includes a requirement for HHSC to include fair hearing requests and outcomes data in each Medicaid MCO's quality rating, a requirement for the HHSC office of inspector general to review related duties, and a requirement for HHSC to ensure certain providers may submit a grievance on behalf of a recipient.

The substitute includes a requirement for HHSC to ensure that Medicaid MCO care coordinators coordinate with physicians and other health care providers in compiling documentation to satisfy certain Medicaid MCO requirements. The substitute includes a requirement that the executive commissioner of HHSC by rule determine which providers are eligible to have a care coordinator. The substitute provides for the availability of care coordinators through virtual means.

The substitute revises the Medicaid MCO compliance metrics required to be established by HHSC to include care coordinator turnover rates and follow-up after hospitalization.

The substitute includes an exception to the prohibition against a Medicaid MCO providing health care services under the MDCP waiver program requiring additional authorization under certain circumstances.