BILL ANALYSIS

C.S.H.B. 4178
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

It has been suggested that the Medicaid process is encumbered with inefficiencies resulting in denied claims and payments, complexities for health care providers participating in the program, and a lack of coordination of benefits that have hindered the ability of Medicaid recipients to receive adequate care. C.S.H.B. 4178 seeks to address these issues and provide greater flexibility by revising procedures related to changes in fees, charges, and rates for payments, streamlining the enrollment and credentialing of Medicaid providers, and providing for the coordination of benefits for certain populations.

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 6, 7, and 21 of this bill.

ANALYSIS

C.S.H.B. 4178 amends the Government Code to require the Health and Human Services Commission (HHSC) to adopt policies related to the determination of fees, charges, and rates for payments under Medicaid and the child health plan program (CHIP) to ensure, to the greatest extent possible, that changes to a fee schedule are implemented in a way that minimizes administrative complexity, financial uncertainty, and retroactive adjustments for providers. In adopting those policies, HHSC is required to:

- develop a process for individuals and entities that deliver services under the Medicaid managed care program to provide oral or written input on the proposed policies; and
- ensure that Medicaid managed care organizations (MCOs) and the entity serving as the state's Medicaid claims administrator under the Medicaid fee-for-service delivery model are provided a period of not less than 45 days before the effective date of a final fee schedule change to make any necessary administrative or systems adjustments to implement the change.

Provisions relating to the required policies for implementing changes to payment rates do not apply to the fees, charges, or rates for payments made to a nursing facility or to capitation rates paid to an MCO and apply only to such a change that takes effect on or after January 1, 2021.

C.S.H.B. 4178 requires HHSC, to the extent permitted by federal law, to use available Medicare data to streamline the enrollment and credentialing of Medicaid providers by reducing the submission of duplicative information or documents. The bill requires HHSC to develop and

implement a process to expedite the Medicaid provider enrollment process for a health care provider who is providing health care services through a single case agreement to a Medicaid recipient with primary insurance coverage and to use a provider's national provider identifier number to enroll the provider. The bill requires HHSC to:

- transition from using a state-issued provider identifier number to using only a national provider identifier number;
- implement, not later than September 1, 2020, a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid; and
- implement, not later than September 1, 2023, a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services.

C.S.H.B. 4178 specifies that, for purposes of the uniform fair hearing rules promulgated by the executive commissioner of HHSC for all Medicaid-funded services or programs, the required written notice to an individual of the individual's right to a hearing must contain a clear explanation of the adverse determination, in addition to the circumstances under which Medicaid is continued if a hearing is requested, and requires the notice to also contain a clear explanation of the fair hearing process, including the individual's ability to use an independent review process.

C.S.H.B. 4178 requires HHSC to ensure that notice sent by HHSC or a Medicaid MCO to a Medicaid recipient or provider regarding the denial of coverage or prior authorization for a service includes the following:

- information required by federal and state law and applicable regulations;
- for the recipient, a clear and easy-to-understand explanation of the reason for the denial; and
- for the provider, a clinical explanation of the reason for the denial, including certain required information, as applicable.

The bill requires HHSC or a Medicaid MCO that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request to issue a notice to the provider and the Medicaid recipient on whose behalf the request was submitted. The bill sets out the required contents of the notice and requires that the notice be sent to the provider in a specified manner.

C.S.H.B. 4178 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 on its website specified information in an easily searchable and accessible format, including information relating to the timelines and up-to-date coverage criteria for prior authorization requirements;
- adopt and maintain a process for a provider or Medicaid recipient to contact the MCO or entity to clarify prior authorization requirements or assist the provider or recipient in submitting a prior authorization request; and
- ensure that such a process is not arduous or overly burdensome to a provider or recipient.

C.S.H.B. 4178 requires HHSC to contract with a certified independent review organization to make review determinations with respect to:

- a Medicaid MCO's resolution of an internal appeal challenging a medical necessity

determination;

- a denial by HHSC of eligibility for a Medicaid program on the basis of the Medicaid recipient's or applicant's medical and functional needs; and
- an action, as defined by federal law, by HHSC based on the recipient's medical and functional needs.

The bill requires the executive commissioner by rule to determine the manner in which an independent review organization is to settle the disputes, when an organization may be accessed in the appeals process, and the recourse available after the organization makes a review determination. The bill requires HHSC to ensure that such a contract does the following:

- requires an independent review organization to make a review determination in a timely manner;
- provides procedures to protect the confidentiality of medical records transmitted to the organization for use in conducting an independent review;
- sets minimum qualifications for and requires the independence of each physician or other health care provider making a review determination on behalf of the organization;
- specifies the procedures to be used by the organization in making review determinations;
- requires the timely notice to a recipient of the results of an independent review, including the clinical basis for the review determination;
- requires that the organization report certain aggregate information to HHSC in the specified form and manner and at the times prescribed by HHSC; and
- requires that, in addition to the required aggregate information, the organization include in the report the required information categorized by MCO.

The bill requires an independent review organization with which HHSC contracts to do the following:

- obtain all information relating to the dispute at issue from the Medicaid MCO or HHSC, as applicable, and the provider in accordance with time frames prescribed by HHSC;
- assign a physician or other health care provider with appropriate expertise as a reviewer to make a review determination;
- perform a check for each review to ensure that the organization and the physician or other health care provider assigned to make a review determination do not have a conflict of interest, as defined in the contract entered into between HHSC and the organization;
- communicate procedural rules, approved by HHSC, and other information regarding the appeals process to all parties; and
- render a timely review determination, as determined by HHSC.

C.S.H.B. 4178 requires HHSC to ensure that HHSC, the Medicaid MCO, the provider, and the Medicaid recipient involved in a dispute, as applicable, do not have a choice in the reviewer who is assigned to perform the review and, in selecting an independent review organization, to avoid conflicts of interest by considering and monitoring existing relationships between independent review organizations and Medicaid MCOs. The bill requires the executive commissioner to adopt rules necessary to implement these provisions.

C.S.H.B. 4178 requires the executive commissioner by rule to increase the prescribed maximum family income for determining eligibility for the Medicaid buy-in program for children with disabilities of a child who is eligible for the medically dependent children (MDCP) waiver program and is on the interest list for that program to the maximum family income amount allowable, considering available appropriations for that purpose. The bill requires HHSC, at the

request of a child's legally authorized representative, to conduct a disability determination assessment of the child to determine the child's eligibility for the Medicaid buy-in program and authorizes HHSC to seek a federal waiver to the state Medicaid plan under these provisions. The bill requires HHSC to develop and implement a process for adopting and amending policies applicable to Medicaid medical benefits under the Medicaid managed care delivery model and to seek input from the state Medicaid managed care advisory committee in developing and implementing the process. The bill requires HHSC to develop, implement, and publish on the HHSC website the process not later than December 31, 2019.

C.S.H.B 4178 requires HHSC, to the greatest extent possible, to consolidate policy manuals, handbooks, and other informational documents into one Medicaid medical benefits policy manual to clarify and provide guidance on the policies under the Medicaid managed care delivery model and to periodically update the manual to reflect policies adopted or amended using the process developed by HHSC. The bill requires HHSC, to the extent allowed by federal law, to streamline the annual reassessment for making a medical necessity determination for a recipient participating in the MDCP waiver program and requires the reassessment to focus on significant changes in function that may affect medical necessity. This requirement does not affect any rights of a recipient to appeal a reassessment determination through the internal appeal process of the Medicaid MCO or through the Medicaid fair hearing process and applies only to a reassessment of a child's eligibility for the MDCP waiver program made on or after December 1, 2019. The bill sets out certain other requirements for HHSC relating to the facilitation of those reassessments. The bill includes the impact on recipient health outcomes and continuity of care among the factors HHSC is required to consider in making a decision regarding the placement of a drug on each of the preferred drug lists adopted by HHSC.

C.S.H.B. 4178 revises the composition of the Drug Utilization Review Board by increasing from two to five the number of MCO representatives, no more than two of whom are voting members, that the board must include and requires at least one such member to be a physician and one such member be a pharmacist. The bill changes from one to not less than two the members of the board required to be consumer advocates who represent Medicaid recipients and requires at least one of these to be a nonvoting member. The bill replaces the prohibition against a voting board member from having a contractual relationship, ownership interest, or other conflict of interest with a pharmaceutical manufacturer or labeler or a certain other entity with a requirement that such a board member disclose any contractual relationship with those entities or a pharmacy benefit manager or a Medicaid MCO.

C.S.H.B. 4178 requires the STAR Kids Managed Care Advisory Committee established by the executive commissioner to advise HHSC on the operation of the STAR Kids managed care program and to make recommendations for improvements to that program. The bill establishes that the advisory committee is abolished and that requirement expires September 1, 2023. The bill sets out certain utilization review and prior authorization procedures, in addition to existing required contract provisions, for a contract between a Medicaid MCO and HHSC and provides for an annual review of prior authorization requirements and for reconsideration following adverse determinations on certain prior authorization requests.

C.S.H.B. 4178 requires HHSC, in consultation with Medicaid MCOs and the state Medicaid managed care advisory committee, to develop and implement a policy that ensures the coordinated and timely delivery to Medicaid recipients of Medicaid wrap-around benefits, defined as a Medicaid-covered service that is provided to such a recipient 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. The bill sets out the factors HHSC is required to consider in developing and implementing the policy. The bill authorizes the executive commissioner to seek a waiver from the federal government as needed to address federal policies related to coordination of benefits, third-party liability, and provider enrollment relating to Medicaid wrap-around benefits and to maximize federal financial participation for Medicaid recipients with both primary health benefit plan coverage and Medicaid coverage.

C.S.H.B. 4178 requires HHSC to ensure that the Medicaid managed care eligibility files indicate whether a recipient has primary health benefit plan coverage or health insurance premium payment coverage and sets out the information related to primary health benefit plan coverage the files are authorized to include for a recipient who has that coverage.

C.S.H.B. 4178 requires HHSC, in consultation with Medicaid MCOs and the state Medicaid managed care advisory committee, to implement a policy that ensures the coordinated and timely delivery of Medicaid wrap-around benefits. The bill requires the policy to do the following:

- include a benefits equivalency crosswalk or other method for mapping equivalent benefits under Medicaid and Medicare; and
- in a manner that is consistent with federal and state law, require sharing of information concerning third-party sources of coverage and reimbursement.

C.S.H.B. 4178 requires HHSC to seek to amend contracts entered into with Medicaid MCOs under the Medicaid managed care program before the bill's effective date to include requirements under its provisions relating to utilization review and prior authorization procedures and the reconsideration of adverse determinations with regard to certain prior authorization requests.

C.S.H.B. 4178 amends the Health and Safety Code to make conforming changes.

EFFECTIVE DATE

September 1, 2019.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 4178 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 requirement regarding the implementation of changes to fees, charges, and rates for payments under Medicaid and CHIP by requiring HHSC to adopt policies related to the determination of those fees, charges, and rates to ensure that changes to a fee schedule are implemented in a certain way. The substitute does not include provisions requiring the executive commissioner to establish an advisory committee to provide input regarding the implementation of those changes but includes provisions instead setting out requirements for the adoption of those policies. The substitute includes a provision excepting from these policies capitation rates paid to a Medicaid MCO.

The substitute makes certain revisions to provisions relating to the use of a national provider identifier number and to notice requirements regarding Medicaid coverage or prior authorization denial and incomplete requests. The substitute sets out provisions relating to the accessibility of information regarding Medicaid prior authorization requirements and to independent review organizations with regard to certain medical necessity review determinations.

The substitute includes different provisions relating to reassessments of children for the MDCP waiver program and relating to the membership of the Drug Utilization Review Board. The substitute includes provisions replacing the prohibition against a board member having a contractual relationship, ownership interest, or other conflict of interest with a pharmaceutical

manufacturer or labeler or a certain other entity with a requirement that a board member disclose any contractual relationship with those entities or a pharmacy benefit manager or a Medicaid MCO.

The substitute includes the following:

- a requirement for the executive commissioner by rule to increase the maximum family income for determining eligibility for the buy-in program of certain eligible children;
- provisions relating to a Medicaid buy-in for children program disability determination assessment and to a process for adopting and amending certain Medicaid benefit policies;
- provisions relating to the Medicaid benefits manual;
- temporary provisions relating to the STAR Kids Managed Care Advisory Committee;
- provisions relating to an annual review of prior authorization requirements; and
- provisions relating to reconsideration following adverse determinations on certain prior authorization requests.

The substitute includes provisions relating to utilization review and prior authorization procedures, to the coordination of the delivery to Medicaid recipients of Medicaid wrap-around benefits, and to the coordination of such benefits for persons dually eligible under Medicaid and Medicare. The substitute revises contract requirements relating to a Medicaid MCO receiving a prior authorization request on legal holidays.

The substitute does not include the following:

- provisions relating to a certain Medicaid medical policy manual;
- provisions relating to the adoption of certain prior authorization practice guidelines; and
- provisions making certain revisions to the limitations on Medicaid recipient disenrollment from a managed care plan.