SUBJECT: Requiring HHSC to revise certain Medicaid managed care policies

COMMITTEE: Human Services — committee substitute recommended

VOTE: 8 ayes — Frank, Hinojosa, Deshotel, Klick, Meza, Miller, Noble, Rose

0 nays

1 absent — Clardy

SENATE VOTE: On final passage, May 1 — 31-0

WITNESSES: No public hearing

BACKGROUND: Government Code ch. 531, subch. B governs the powers and duties of the Health and Human Services Commission (HHSC). Ch. 533 governs Medicaid managed care programs and requires contracts between HHSC and Medicaid managed care organizations to contain certain provisions.

Some have noted that the Medicaid process can result in the inefficient resolution of denied claims and payments, creating complexities for health providers participating in Medicaid managed care programs and hindering access to care for certain patients, including medically fragile children. It has been suggested that standardizing the complaint process and prior authorization procedures would help reduce the administrative burden for providers and patients and improve access to quality care.

DIGEST: CSSB 1105 would amend prior authorization procedures in Medicaid managed care, require the Health and Human Services Commission (HHSC) to standardize certain data and to consider other delivery models for STAR Kids, and require Medicaid managed care organizations' (MCOs') contracts to contain certain provisions.

Notice. The bill would require HHSC to ensure that a notice sent by HHSC or an MCO to a Medicaid recipient or provider regarding the denial of coverage or prior authorization for a service included a clear

explanation for the denial.

If the commission or an MCO received a coverage or prior authorization request that contained insufficient or inadequate documentation to approve the request, HHSC or the MCO would have to issue a notice to the requesting provider and the Medicaid recipient on whose behalf the request was submitted. The notice would have to include:

- a clear and specific list and description of the documentation necessary to make a final determination on the request;
- the applicable timeline, based on the requested service, for the provider to submit the documentation and a description of the reconsideration process; and
- information regarding how a provider could contact an MCO.

Prior authorization. The HHSC executive commissioner by rule would have to require each Medicaid MCO or other entity responsible for authorizing health care services under Medicaid to maintain on its website the applicable timelines for prior authorization requirements and an accurate, up-to-date catalogue of coverage criteria and prior authorization requirements.

Such organizations also would be required to adopt and maintain a process for a provider or Medicaid recipient to contact the MCO or entity to clarify prior authorization requirements or to assist the provider or recipient in submitting a prior authorization request. The executive commissioner of HHSC would have to ensure that these processes were not arduous or overly burdensome to a provider or recipient.

Contract provisions. The bill would require a Medicaid MCO that contracted with HHSC to establish processes for reviewing and reconsidering certain adverse determinations on prior authorization requests. These required processes would apply only to a contract entered into or renewed on or after the bill's effective date. The bill would specify that an adverse determination on a prior authorization request would be considered a denial of services in an evaluation of the MCO only if the

determination was not amended to approve the request.

HHSC would have to seek to amend contracts with Medicaid MCOs that had been entered into before the bill's effective date to include the bill's required contract provisions.

Annual review. A Medicaid MCO would have to implement a process to conduct an annual review of the MCO's prior authorization requirements, other than those for prescription drugs under the vendor drug program.

Under the bill, a Medicaid MCO could not impose a prior authorization requirement, other than a requirement for the vendor drug program, unless the MCO had reviewed the requirement during the most recent annual review required under the bill.

Grievances. The bill would require HHSC to standardize Medicaid grievance data reporting and tracking and establish a procedure for expedited resolution of a Medicaid grievance. HHSC would have to aggregate Medicaid recipient and provider grievance data and make de-identified aggregated data available to the Legislature and the public.

Medicaid fee schedule. The bill would require HHSC to adopt policies to ensure that changes to a Medicaid fee schedule were implemented in a way that minimized administrative complexity, financial uncertainty, and retroactive adjustments for providers. HHSC would have to develop a process for individuals and entities that delivered services under the Medicaid managed care program to provide oral or written input on the proposed policies.

In adopting the policies, HHSC also would have to ensure that MCOs and the state's Medicaid claims administrator under the Medicaid fee-for-service delivery model were provided a minimum of 45 days before the final fee schedule's effective date to make any necessary administrative or systems adjustments to implement the change. These provisions would not apply to changes to the fees, charges, or payment rates made to a nursing facility or to capitation rates paid to a Medicaid MCO.

The bill would apply only to a change to a fee, charge, or rate that took effect on or after January 1, 2021.

STAR Kids. The bill would require the executive commissioner of HHSC, in collaboration with the STAR Kids Managed Care Advisory Committee, to determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under an accountable care organization model or an alternative model developed by or in collaboration with the Centers for Medicare and Medicaid Services Innovation Center.

By December 1, 2022, HHSC would have to submit a written report to the Legislature of the executive commissioner's determination. These provisions would expire September 1, 2023.

Provider identification number. The bill would require HHSC to transition from using a state-issued provider identifier number to using only a national provider identifier number.

By September 1, 2020, HHSC would have to implement a Medicaid provider management and enrollment system and only use a national provider identifier number to enroll providers in Medicaid. The commission also would have to implement a modernized claims processing system using only a national provider identifier number to process claims for and authorize Medicaid services by September 1, 2023.

Other provisions. The bill would require a managed care plan offered by an MCO to be accredited by a nationally recognized accreditation organization. By September 1, 2022, a managed care plan offered by an MCO with which HHSC entered into or renewed a contract on or after the bill's effective date would have to comply with the accreditation requirements.

As soon as practicable after the bill's effective date, the HHSC executive commissioner would adopt rules to implement the bill's provisions. HHSC

would have to implement the bill's provisions only if the Legislature appropriated money for that purpose.

The bill would take effect September 1, 2019.

NOTES:

According to the Legislative Budget Board, the bill would have an estimated negative impact of $5 million to general revenue related funds through fiscal 2020-21.