SUBJECT: Administering Medicaid managed care for individuals with disabilities

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Lucio, Oliverson, Julie Johnson, Lambert, Paul, C. Turner, Vo

0 nays

2 absent — G. Bonnen, S. Davis

SENATE VOTE: On final passage, April 17 — 30-1 (Schwertner)

WITNESSES: For — Terri Carriker, Rebecca Galinsky, Natalie Gregory, and Hannah Mehta, Protect Texas Fragile Kids; Linda Litzinger, Texas Parent to Parent; (*Registered, but did not testify*: Jesse Ozuna, Doctor's Hospital at Renaissance; Christine Yanas, Methodist Healthcare Ministries of South Texas; Samuel Galinsky, Protect Texas Fragile Kids; Laurie Vanhoose, Texas Association of Health Plans; Clayton Travis, Texas Pediatric Society; Rebecca Harkleroad)

Against — None

On — Stephanie Muth, Health and Human Services Commission; (*Registered, but did not testify*: Doug Danzeiser, Texas Department of Insurance)

BACKGROUND: Government Code ch. 533 governs Medicaid managed care programs and requires contracts between the Health and Human Services Commission (HHSC) and Medicaid managed care organizations to contain certain provisions.

Government Code sec. 531.02444(a)(2) requires the executive commissioner of HHSC to implement a Medicaid buy-in program for children with disabilities whose family incomes do not exceed 300 percent of the applicable federal poverty level.

DIGEST:

CSSB 1207 would amend prior authorization procedures in Medicaid managed care, require the Health and Human Services Commission (HHSC) to contract with an external medical reviewer for evaluating denials of health care services, and expand the Medicaid Buy-In for Children program. The bill also would establish a 24/7 help line for families whose children were in the Medically Dependent Children Waiver Program.

Notice. The bill would require HHSC to ensure that a notice sent by HHSC or a Medicaid managed care organization (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 of coverage. For coverage or prior authorization requests that were unable to be approved for insufficient documentation reasons, HHSC or an MCO would have to issue a notice to the health provider that included:

- a 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 require each Medicaid MCO 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; and
- adopt and maintain a process for a provider or Medicaid recipient to contact the MCO to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request.

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. To conduct the review, the MCO would have to:

- solicit, receive, and consider input from Medicaid providers in the MCO's network;
- ensure that each prior authorization requirement was based on accurate and peer-reviewed clinical criteria that distinguished, as appropriate, between categories, including age, of recipients for whom prior authorization requests were submitted.

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.

External medical review. The bill would require HHSC to contract with an independent external medical reviewer, as defined in the bill, to conduct external medical reviews of:

- the resolution of a Medicaid recipient appeal related to a reduction in or denial of services because of medical necessity in the Medicaid managed care program; or
- an HHSC denial of eligibility for a Medicaid program in which eligibility was based on a Medicaid recipient's medical and

functional needs.

The external medical reviewer would be overseen by a medical director who was a licensed physician in Texas and would employ or consult with experienced staff in providing private duty nursing services and long-term services and support.

The bill would specify a timeline in which external medical reviews would occur. The bill would prohibit a Medicaid MCO from having a financial relationship with or ownership interest in HHSC's contracted external medical reviewer.

Waiver program interest lists. The bill would allow a legally authorized representative of a child who was notified by HHSC that the child was no longer eligible for the Medically Dependent Children Waiver Program (MDCP) to request that HHSC:

- return the child to the MDCP interest list unless the child was ineligible due to the child's age; or
- place the child on the interest list for another Section 1915(c) waiver program.

The bill would require HHSC upon the representative's request to place a child who became ineligible on certain lists as specified in the bill. These provisions would apply only to a child who was enrolled in the MDCP but became ineligible for services because the child no longer met the level of nursing facility care criteria for medical necessity or the program's age requirement.

The bill would apply to a child who became ineligible on or after December 1, 2019.

Medically dependent children waiver program. Under the bill, HHSC would have to ensure a Medicaid MCO care coordinator under the STAR Kids managed care program provided the results of the annual medical necessity determination reassessment to the parent or legally authorized

representative of a recipient under the MDCP. The bill would apply to a reassessment of the child's eligibility for the MDCP made on or after December 1, 2019.

HHSC would have to provide a parent or representative who disagreed with the reassessment results an opportunity to dispute the reassessment with the MCO through a peer-to-peer review with the treating physician of choice.

The bill would require HHSC, through the state's external quality review organization, to:

- conduct annual surveys of Medicaid recipients under the MDCP or their representatives;
- conduct annual focus groups with recipients and their representatives on identified issues; and
- at least annually calculate Medicaid MCOs' performance on performance measures using certain data sources.

Medicaid Buy-In for Children program. The bill would require the HHSC executive commissioner by rule to increase the family income used to determine children's eligibility for the Medicaid Buy-In for Children (MBIC) program to the maximum family income amount for which federal matching funds were available.

Upon request of a child's legally authorized representative, HHSC would have to directly conduct an assessment to determine the child's eligibility for the MBIC and could not contract with a Medicaid MCO or other entity to conduct the assessment. This provision would apply to a request made on or after the bill's effective date.

STAR Kids. The bill would require HHSC to operate a 24/7 Medicaid escalation help line to assist Medicaid recipients receiving benefits under the MDCP and their parents, guardians, and legally authorized representatives navigate and resolve issues regarding the STAR Kids managed care program.

A Medicaid MCO participating in STAR Kids would have to designate an individual as a single point of contact for the help line and authorize that individual to resolve escalated issues.

Advisory committee. The bill would require the STAR Kids Managed Care Advisory Committee to advise HHSC on the operation of STAR Kids. These provisions would expire and the advisory committee would be abolished September 1, 2023.

The bill would require HHSC, in consultation with the advisory committee, to improve the care needs assessment tool and initial assessment and reassessment processes. By March 1, 2020, HHSC would have to post on its website a plan to improve the assessment tool and assessment processes.

Coordination of benefits. The bill would require HHSC, in coordination with Medicaid MCOs, to adopt a clear policy for MCOs to ensure coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage. "Medicaid wrap-around benefit" would mean a Medicaid-covered service, including a pharmacy or medical benefit, that was provided to a recipient with both Medicaid and primary health benefit plan coverage when the recipient had exceeded the primary plan coverage limit or when the service was not covered by the primary plan issuer.

In developing the policy, HHSC would have to consider requiring MCOs to allow a recipient using a prescription drug previously covered by the recipient's primary health plan issuer to continue receiving the drug without requiring additional prior authorization. HHSC also would have to maintain a list of services not traditionally covered by primary health plan coverage that an MCO could approve without having to coordinate with the primary issuer and that could be resolved through third-party liability resolution processes.

HHSC would have to maintain policies allowing a health provider who

was primarily providing services to a recipient through primary health plan coverage to receive Medicaid reimbursement for ordered services regardless of whether the provider was an enrolled Medicaid provider.

The bill would require HHSC to develop a process allowing a recipient with complex medical needs who had established a relationship with a specialty provider to continue receiving care from that provider.

Report. By the 30th day after the last day of each state fiscal quarter, HHSC would submit to the governor, lieutenant governor, House speaker, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid, a report containing the most recent state fiscal quarter data. The data would include:

- enrollment in the Medicaid Buy-In for Children program;
- requests regarding interest list placements;
- use of the Medicaid escalation help line;
- use, requests to opt out, and outcomes of the external medical review procedure; and
- categorized complaints regarding the MDCP.

The bill would require HHSC to submit the first report by September 30, 2020, for the state fiscal quarter ending August 31, 2020.

Other provisions. 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 authorize HHSC to seek a federal waiver if it determined it was necessary to delay implementation of the bill's provisions.

The bill would take effect September 1, 2019.

SUPPORTERS SAY:

CSSB 1207 would safeguard and improve access to health care services for vulnerable populations under Medicaid managed care programs. Since the rollout of the STAR Kids managed care program in 2016, many

families have experienced delays in or denials of services due to managed care organizations' (MCO) stringent prior authorization requirements and have been unable to successfully appeal those decisions. Requiring an independent, clinical expert to review an MCO's denial of service or eligibility based on medical necessity would ensure a fairer process. By establishing a specific 24/7 help line, the bill would help families whose children are in the Medically Dependent Children Waiver Program (MDCP) get their issues resolved quickly and appropriately.

The bill would improve transparency of prior authorization requirements by requiring Medicaid MCOs to post timelines and accurate information regarding those requirements. By providing Medicaid MCOs with more comprehensive information, the bill would improve coordination of benefits for clients who had both private and Medicaid coverage. The bill would ensure continuity of care with a trusted provider by allowing a Medicaid recipient with complex medical needs who had established a relationship with a specialist to continue receiving care from that provider.

The bill is an appropriate use of taxpayer dollars because it would provide relief to families whose children with disabilities are on long wait lists to be served in the MDCP, which allows children to receive life-sustaining services within their home communities.

OPPONENTS SAY:

CSSB 1207 would increase costs to taxpayers by expanding eligibility for the Medicaid Buy-In for Children program.

NOTES:

According to the Legislative Budget Board, the bill would have an estimated negative impact of $9 million to general revenue related funds through fiscal 2020-21.