By: Kolkhorst S.B. No. 1105

(In the Senate - Filed February 25, 2019; March 7, 2019, read first time and referred to Committee on Health & Human Services; April 25, 2019, reported adversely, with favorable Committee Substitute by the following vote: Yeas 9, Nays 0; April 25, 2019, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Kolkhorst	X			
Perry	X			
Buckingham	X			
Campbell	X			
Flores	X			
Johnson	X			
Miles	X			
Powell	X			
Seliger	X			

COMMITTEE SUBSTITUTE FOR S.B. No. 1105 By: Kolkhorst

A BILL TO BE ENTITLED
AN ACT

relating to the administration and operation of Medicaid, including Medicaid managed care.

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

SECTION 1. Section 531.001, Government Code, is amended by adding Subdivision (4-c) to read as follows:

(4-c) "Medicaid managed care organization" means a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients.

SECTION 2. Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.021182, 531.02131, 531.02142, 531.024162, and 531.0511 to read as follows:

Sec. 531.021182. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER. (a) In this section, "national provider identifier number" means the national provider identifier number required under Section 1128J(e), Social Security Act (42 U.S.C. Section 1320a-7k(e)).

(b) The commission shall transition from using a state-issued provider identifier number to using only a national provider identifier number in accordance with this section.

(c) The commission shall implement a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid.

(d) The commission shall implement a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services.

Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) The commission shall adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within the commission to ensure all grievances are managed consistently.

(b) The commission shall standardize Medicaid grievance data reporting and tracking among divisions within the commission.

(c) The commission shall implement a no-wrong-door system for Medicaid grievances reported to the commission.

(d) The commission shall establish a procedure for expedited resolution of a grievance related to Medicaid that allows the commission to:

(1) identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution; and

(2) resolve the grievance within a specified period.

(e) The commission shall verify grievance data reported by a Medicaid managed care organization.

(f) The commission shall:

(1) aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances; and

(2) make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider.

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) To the extent permitted by federal law, the commission in consultation and collaboration with the appropriate advisory committees related to Medicaid shall make available to the public on the commission's Internet website in an easy-to-read format data relating to the quality of health care received by Medicaid recipients and the health outcomes of those recipients. Data made available to the public under this section must be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) In performing its duties under this section, the commission may collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data.

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING DENIAL OF COVERAGE OR PRIOR AUTHORIZATION. (a) The commission shall ensure that notice sent by the commission or a Medicaid managed care organization to a Medicaid recipient or provider regarding the denial of coverage or prior authorization for a service includes:

(1) information required by federal law;

(2) a clear and easy-to-understand explanation of the reason for the denial for the recipient; and

(3) a clinical explanation of the reason for the denial for the provider.

(b) To ensure cost-effectiveness, the commission may implement the notice requirements described by Subsection (a) at the same time as other required or scheduled notice changes.

Sec. 531.0511. MEDICALLY DEPENDENT CHILDREN WAIVER PROGRAM: CONSUMER DIRECTION OF SERVICES. Notwithstanding Sections 531.051(c)(1) and (d), a consumer direction model implemented under Section 531.051, including the consumer-directed service option, for the delivery of services under the medically dependent children (MDCP) waiver program must allow for the delivery of all services and supports available under that program through consumer direction.

SECTION 3. Section 533.00253(a)(1), Government Code, is amended to read as follows:

(1) "Advisory committee" means the STAR Kids Managed Care Advisory Committee described by [~~established under~~] Section 533.00254.

SECTION 4. Section 533.00253, Government Code, is amended by amending Subsection (c) and adding Subsections (c-1), (c-2), (f), (g), and (h) to read as follows:

(c) The commission may require that care management services made available as provided by Subsection (b)(7):

(1) incorporate best practices, as determined by the commission;

(2) integrate with a nurse advice line to ensure appropriate redirection rates;

(3) use an identification and stratification methodology that identifies recipients who have the greatest need for services;

(4) provide a care needs assessment for a recipient [~~that is comprehensive, holistic, consumer-directed, evidence-based, and takes into consideration social and medical issues, for purposes of prioritizing the recipient's needs that~~

~~threaten independent living~~];

(5) are delivered through multidisciplinary care teams located in different geographic areas of this state that use in-person contact with recipients and their caregivers;

(6) identify immediate interventions for transition of care;

(7) include monitoring and reporting outcomes that, at a minimum, include:

(A) recipient quality of life;

(B) recipient satisfaction; and

(C) other financial and clinical metrics determined appropriate by the commission; and

(8) use innovations in the provision of services.

(c-1) To improve the care needs assessment tool used for purposes of a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, the commission in consultation and collaboration with the STAR Kids Managed Care Advisory Committee shall consider changes that will:

(1) reduce the amount of time needed to complete the care needs assessment initially and at reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c-2) To the extent feasible and allowed by federal law, the commission shall streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity.

(f) Using existing resources, the executive commissioner in consultation and collaboration with the STAR Kids Managed Care Advisory Committee shall determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under:

(1) an accountable care organization model in accordance with guidelines established by the Centers for Medicare and Medicaid Services; or

(2) an alternative model developed by or in collaboration with the Centers for Medicare and Medicaid Services Innovation Center.

(g) Not later than December 1, 2022, the commission shall prepare and submit a written report to the legislature of the executive commissioner's determination under Subsection (f).

(h) Subsections (f) and (g) and this subsection expire September 1, 2023.

SECTION 5. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00254 and 533.0031 to read as follows:

Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE. (a) The STAR Kids Managed Care Advisory Committee established by the executive commissioner under Section 531.012 shall:

(1) advise the commission on the operation of the STAR Kids managed care program under Section 533.00253; and

(2) make recommendations for improvements to that program.

(b) On December 31, 2023:

(1) the advisory committee is abolished; and

(2) this section expires.

Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) A managed care plan offered by a Medicaid managed care organization must be accredited by a nationally recognized accreditation organization. The commission may choose whether to require all managed care plans offered by Medicaid managed care organizations to be accredited by the same organization or to allow for accreditation by different organizations.

(b) The commission may use the data, scoring, and other information provided to or received from an accreditation organization in the commission's contract oversight processes.

SECTION 6. The Health and Human Services Commission shall issue a request for information to seek information and comments regarding contracting with a managed care organization to arrange for or provide a managed care plan under the STAR Kids managed care program established under Section 533.00253, Government Code, as amended by this Act, throughout the state instead of on a regional basis.

SECTION 7. (a) Using available resources, the Health and Human Services Commission shall report available data on the 30-day limitation on reimbursement for inpatient hospital care provided to Medicaid recipients enrolled in the STAR+PLUS Medicaid managed care program under 1 T.A.C. Section 354.1072(a)(1) and other applicable law. To the extent data is available on the subject, the commission shall also report on:

(1) the number of Medicaid recipients affected by the limitation and their clinical outcomes; and

(2) the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days and any cost savings achieved by the limitation under Medicaid.

(b) Not later than December 1, 2020, the Health and Human Services Commission shall submit the report containing the data described by Subsection (a) of this section to the governor, the legislature, and the Legislative Budget Board. The report required under this subsection may be combined with any other report required by this Act or other law.

SECTION 8. The Health and Human Services Commission shall implement:

(1) the Medicaid provider management and enrollment system required by Section 531.021182(c), Government Code, as added by this Act, not later than September 1, 2020; and

(2) the modernized claims processing system required by Section 531.021182(d), Government Code, as added by this Act, not later than September 1, 2023.

SECTION 9. Not later than March 1, 2020, the Health and Human Services Commission shall:

(1) develop a plan to improve the care needs assessment tool and the initial assessment and reassessment processes as required by Sections 533.00253(c-1) and (c-2), Government Code, as added by this Act; and

(2) post the plan on the commission's Internet website.

SECTION 10. The Health and Human Services Commission shall require that a managed care plan offered by a managed care organization with which the commission enters into or renews a contract under Chapter 533, Government Code, on or after the effective date of this Act comply with Section 533.0031, Government Code, as added by this Act, not later than September 1, 2022.

SECTION 11. 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 12. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

SECTION 13. This Act takes effect September 1, 2019.

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