

CONFERENCE COMMITTEE REPORT FORM

Austin, Texas

May 25, 2019
Date

Honorable Dan Patrick
President of the Senate

Honorable Dennis Bonnen
Speaker of the House of Representatives

Sirs:

We, Your Conference Committee, appointed to adjust the differences between the Senate and the House of Representatives on SB1207 have had the same under consideration, and beg to report it back with the recommendation that it do pass in the form and text hereto attached.

Chad Perry
Perry

Peter P. Flores
Flores

Jim W. Kolkhorst
Kolkhorst

Greg Nelson
Nelson

Thur Watson
On the part of the Senate
Watson

Matt Krause
Krause

Julie Johnson
Johnson, Julie

Leach
Leach

Oliver Olson
Oliver Olson

Tom Parker
On the part of the House
Parker

Note to Conference Committee Clerk:

Please type the names of the members of the Conference Committee under the lines provided for signature. Those members desiring to sign the report should sign each of the six copies. Attach a copy of the Conference Committee Report and a Section by Section side by side comparison to each of the six reporting forms. The original and two copies are filed in house of origin of the bill, and three copies in the other house.

CONFERENCE COMMITTEE REPORT

3rd Printing

S.B. No. 1207

A BILL TO BE ENTITLED

AN ACT

relating to the operation and administration of Medicaid, including the Medicaid managed care program and the medically dependent children (MDCP) waiver program.

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. Section 531.024, Government Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) The rules promulgated under Subsection (a)(7) must provide due process to an applicant for Medicaid services and to a Medicaid recipient who seeks a Medicaid service, including a service that requires prior authorization. The rules must provide the protections for applicants and recipients required by 42 C.F.R. Part 431, Subpart E, including requiring that:

(1) the written notice to an individual of the individual's right to a hearing must:

(A) contain an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and

1 (B) be delivered by mail, and postmarked ~~[mailed]~~
2 at least 10 business days, before the date the individual's
3 Medicaid eligibility or service is scheduled to be terminated,
4 suspended, or reduced, except as provided by 42 C.F.R. Section
5 431.213 or 431.214; and

6 (2) if a hearing is requested before the date a
7 Medicaid recipient's service, including a service that requires
8 prior authorization, is scheduled to be terminated, suspended, or
9 reduced, the agency may not take that proposed action before a
10 decision is rendered after the hearing unless:

11 (A) it is determined at the hearing that the sole
12 issue is one of federal or state law or policy; and

13 (B) the agency promptly informs the recipient in
14 writing that services are to be terminated, suspended, or reduced
15 pending the hearing decision.

16 (c) The commission shall develop a process to address a
17 situation in which:

18 (1) an individual does not receive adequate notice as
19 required by Subsection (b)(1); or

20 (2) the notice required by Subsection (b)(1) is
21 delivered without a postmark.

22 SECTION 3. (a) To the extent of any conflict, Section
23 531.024162, Government Code, as added by this section, prevails
24 over any provision of another Act of the 86th Legislature, Regular
25 Session, 2019, relating to notice requirements regarding Medicaid
26 coverage or prior authorization denials or incomplete requests,
27 that becomes law.

(b) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024162, 531.024163, 531.024164, 531.0601, 531.0602, 531.06021, 531.0603, and 531.0604 to read as follows:

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING MEDICAID COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS.

(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, partial denial, reduction, or termination of coverage or denial of prior authorization for a service includes:

(1) information required by federal and state law and applicable regulations;

(2) for the recipient:

(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;

(B) a copy of the information sent to the provider; and

(C) an educational component that includes a description of the recipient's rights, an explanation of the process related to appeals and Medicaid fair hearings, and a description of the role of an external medical review; and

(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, including, as applicable, information required under Subsection (b).

(b) The commission or a Medicaid managed care organization

1 that receives from a provider a coverage or prior authorization
2 request that contains insufficient or inadequate documentation to
3 approve the request shall issue a notice to the provider and the
4 Medicaid recipient on whose behalf the request was submitted. The
5 notice issued under this subsection must:

6 (1) include a section specifically for the provider
7 that contains:

8 (A) a clear and specific list and description of
9 the documentation necessary for the commission or organization to
10 make a final determination on the request;

11 (B) the applicable timeline, based on the
12 requested service, for the provider to submit the documentation and
13 a description of the reconsideration process described by Section
14 533.00284, if applicable; and

15 (C) information on the manner through which a
16 provider may contact a Medicaid managed care organization or other
17 entity as required by Section 531.024163; and

18 (2) be sent:

19 (A) to the provider:

20 (i) using the provider's preferred method
21 of communication, to the extent practicable using existing
22 resources; and

23 (ii) as applicable, through an electronic
24 notification on an Internet portal; and

25 (B) to the recipient using the recipient's
26 preferred method of communication, to the extent practicable using
27 existing resources.

1 Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING
2 MEDICAID PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive
3 commissioner by rule shall require each Medicaid managed care
4 organization or other entity responsible for authorizing coverage
5 for health care services under Medicaid to ensure that the
6 organization or entity maintains on the organization's or entity's
7 Internet website in an easily searchable and accessible format:

8 (1) the applicable timelines for prior authorization
9 requirements, including:

10 (A) the time within which the organization or
11 entity must make a determination on a prior authorization request;

12 (B) a description of the notice the organization
13 or entity provides to a provider and Medicaid recipient on whose
14 behalf the request was submitted regarding the documentation
15 required to complete a determination on a prior authorization
16 request; and

17 (C) the deadline by which the organization or
18 entity is required to submit the notice described by Paragraph (B);
19 and

20 (2) an accurate and up-to-date catalogue of coverage
21 criteria and prior authorization requirements, including:

22 (A) for a prior authorization requirement first
23 imposed on or after September 1, 2019, the effective date of the
24 requirement;

25 (B) a list or description of any supporting or
26 other documentation necessary to obtain prior authorization for a
27 specified service; and

1 (C) the date and results of each review of the
2 prior authorization requirement conducted under Section 533.00283,
3 if applicable.

4 (b) The executive commissioner by rule shall require each
5 Medicaid managed care organization or other entity responsible for
6 authorizing coverage for health care services under Medicaid to:

7 (1) adopt and maintain a process for a provider or
8 Medicaid recipient to contact the organization or entity to clarify
9 prior authorization requirements or to assist the provider in
10 submitting a prior authorization request; and

11 (2) ensure that the process described by Subdivision
12 (1) is not arduous or overly burdensome to a provider or recipient.

13 Sec. 531.024164. EXTERNAL MEDICAL REVIEW. (a) In this
14 section, "external medical reviewer" and "reviewer" mean a
15 third-party medical review organization that provides objective,
16 unbiased medical necessity determinations conducted by clinical
17 staff with education and practice in the same or similar practice
18 area as the procedure for which an independent determination of
19 medical necessity is sought in accordance with applicable state law
20 and rules.

21 (b) The commission shall contract with an independent
22 external medical reviewer to conduct external medical reviews and
23 review:

24 (1) the resolution of a Medicaid recipient appeal
25 related to a reduction in or denial of services on the basis of
26 medical necessity in the Medicaid managed care program; or

27 (2) a denial by the commission of eligibility for a

1 Medicaid program in which eligibility is based on a Medicaid
2 recipient's medical and functional needs.

3 (c) A Medicaid managed care organization may not have a
4 financial relationship with or ownership interest in the external
5 medical reviewer with which the commission contracts.

6 (d) The external medical reviewer with which the commission
7 contracts must:

8 (1) be overseen by a medical director who is a
9 physician licensed in this state; and

10 (2) employ or be able to consult with staff with
11 experience in providing private duty nursing services and long-term
12 services and supports.

13 (e) The commission shall establish a common procedure for
14 reviews. To the greatest extent possible, the procedure must
15 reduce administrative burdens on providers and the submission of
16 duplicative information or documents. Medical necessity under the
17 procedure must be based on publicly available, up-to-date,
18 evidence-based, and peer-reviewed clinical criteria. The reviewer
19 shall conduct the review within a period specified by the
20 commission. The commission shall also establish a procedure and
21 time frame for expedited reviews that allows the reviewer to:

22 (1) identify an appeal that requires an expedited
23 resolution; and

24 (2) resolve the review of the appeal within a
25 specified period.

26 (f) A Medicaid recipient or applicant, or the recipient's or
27 applicant's parent or legally authorized representative, must

1 affirmatively request an external medical review. If requested:

2 (1) an external medical review described by Subsection
3 (b)(1) occurs after the internal Medicaid managed care organization
4 appeal and before the Medicaid fair hearing and is granted when a
5 Medicaid recipient contests the internal appeal decision of the
6 Medicaid managed care organization; and

7 (2) an external medical review described by Subsection
8 (b)(2) occurs after the eligibility denial and before the Medicaid
9 fair hearing.

10 (g) The external medical reviewer's determination of
11 medical necessity establishes the minimum level of services a
12 Medicaid recipient must receive, except that the level of services
13 may not exceed the level identified as medically necessary by the
14 ordering health care provider.

15 (h) The external medical reviewer shall require a Medicaid
16 managed care organization, in an external medical review relating
17 to a reduction in services, to submit a detailed reason for the
18 reduction and supporting documents.

19 (i) To the extent money is appropriated for this purpose,
20 the commission shall publish data regarding prior authorizations
21 reviewed by the external medical reviewer, including the rate of
22 prior authorization denials overturned by the external medical
23 reviewer and additional information the commission and the external
24 medical reviewer determine appropriate.

25 Sec. 531.0601. LONG-TERM CARE SERVICES WAIVER PROGRAM
26 INTEREST LISTS. (a) This section applies only to a child who is
27 enrolled in the medically dependent children (MDCP) waiver program

1 but becomes ineligible for services under the program because the
2 child no longer meets:

3 (1) the level of care criteria for medical necessity
4 for nursing facility care; or

5 (2) the age requirement for the program.

6 (b) A legally authorized representative of a child who is
7 notified by the commission that the child is no longer eligible for
8 the medically dependent children (MDCP) waiver program following a
9 Medicaid fair hearing, or without a Medicaid fair hearing if the
10 representative opted in writing to forego the hearing, may request
11 that the commission:

12 (1) return the child to the interest list for the
13 program unless the child is ineligible due to the child's age; or

14 (2) place the child on the interest list for another
15 Section 1915(c) waiver program.

16 (c) At the time a child's legally authorized representative
17 makes a request under Subsection (b), the commission shall:

18 (1) for a child who becomes ineligible for the reason
19 described by Subsection (a)(1), place the child:

20 (A) on the interest list for the medically
21 dependent children (MDCP) waiver program in the first position on
22 the list; or

23 (B) except as provided by Subdivision (3), on the
24 interest list for another Section 1915(c) waiver program in a
25 position relative to other persons on the list that is based on the
26 date the child was initially placed on the interest list for the
27 medically dependent children (MDCP) waiver program;

1 (2) except as provided by Subdivision (3), for a child
2 who becomes ineligible for the reason described by Subsection
3 (a)(2), place the child on the interest list for another Section
4 1915(c) waiver program in a position relative to other persons on
5 the list that is based on the date the child was initially placed on
6 the interest list for the medically dependent children (MDCP)
7 waiver program; or

8 (3) for a child who becomes ineligible for a reason
9 described by Subsection (a) and who is already on an interest list
10 for another Section 1915(c) waiver program, move the child to a
11 position on the interest list relative to other persons on the list
12 that is based on the date the child was initially placed on the
13 interest list for the medically dependent children (MDCP) waiver
14 program, if that date is earlier than the date the child was
15 initially placed on the interest list for the other waiver program.

16 (d) Notwithstanding Subsection (c)(1)(B) or (c)(2), a child
17 may be placed on an interest list for a Section 1915(c) waiver
18 program in the position described by those subsections only if the
19 child has previously been placed on the interest list for that
20 waiver program.

21 (e) At the time the commission provides notice to a legally
22 authorized representative that a child is no longer eligible for
23 the medically dependent children (MDCP) waiver program following a
24 Medicaid fair hearing, or without a Medicaid fair hearing if the
25 representative opted in writing to forego the hearing, the
26 commission shall inform the representative in writing about:

27 (1) the options under this section for placing the

1 child on an interest list; and

2 (2) the process for applying for the Medicaid buy-in
3 program for children with disabilities implemented under Section
4 531.02444.

5 (f) This section expires December 1, 2021.

6 Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER
7 PROGRAM ASSESSMENTS AND REASSESSMENTS. (a) The commission shall
8 ensure that the care coordinator for a Medicaid managed care
9 organization under the STAR Kids managed care program provides the
10 results of the initial assessment or annual reassessment of medical
11 necessity to the parent or legally authorized representative of a
12 recipient receiving benefits under the medically dependent
13 children (MDCP) waiver program for review. The commission shall
14 ensure the provision of the results does not delay the
15 determination of the services to be provided to the recipient or the
16 ability to authorize and initiate services.

17 (b) The commission shall require the parent's or
18 representative's signature to verify the parent or representative
19 received the results of the initial assessment or reassessment from
20 the care coordinator under Subsection (a). A Medicaid managed care
21 organization may not delay the delivery of care pending the
22 signature.

23 (c) The commission shall provide a parent or representative
24 who disagrees with the results of the initial assessment or
25 reassessment an opportunity to request to dispute the results with
26 the Medicaid managed care organization through a peer-to-peer
27 review with the treating physician of choice.

1 (d) This section does not affect any rights of a recipient
2 to appeal an initial assessment or reassessment determination
3 through the Medicaid managed care organization's internal appeal
4 process, the Medicaid fair hearing process, or the external medical
5 review process.

6 Sec. 531.06021. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER
7 PROGRAM QUALITY MONITORING; REPORT. (a) The commission, based on
8 the state's external quality review organization's initial report
9 on the STAR Kids managed care program, shall determine whether the
10 findings of the report necessitate additional data and research to
11 improve the program. If the commission determines additional data
12 and research are needed, the commission, through the external
13 quality review organization, may:

14 (1) conduct annual surveys of Medicaid recipients
15 receiving benefits under the medically dependent children (MDCP)
16 waiver program, or their representatives, using the Consumer
17 Assessment of Healthcare Providers and Systems;

18 (2) conduct annual focus groups with recipients
19 described by Subdivision (1) or their representatives on issues
20 identified through:

21 (A) the Consumer Assessment of Healthcare
22 Providers and Systems;

23 (B) other external quality review organization
24 activities; or

25 (C) stakeholders, including the STAR Kids
26 Managed Care Advisory Committee described by Section 533.00254; and

27 (3) in consultation with the STAR Kids Managed Care

1 Advisory Committee described by Section 533.00254 and as frequently
2 as feasible, calculate Medicaid managed care organizations'
3 performance on performance measures using available data sources
4 such as the collaborative innovation improvement network.

5 (b) Not later than the 30th day after the last day of each
6 state fiscal quarter, the commission shall submit to the governor,
7 the lieutenant governor, the speaker of the house of
8 representatives, the Legislative Budget Board, and each standing
9 legislative committee with primary jurisdiction over Medicaid a
10 report containing, for the most recent state fiscal quarter, the
11 following information and data related to access to care for
12 Medicaid recipients receiving benefits under the medically
13 dependent children (MDCP) waiver program:

14 (1) enrollment in the Medicaid buy-in for children
15 program implemented under Section 531.02444;

16 (2) requests relating to interest list placements
17 under Section 531.0601;

18 (3) use of the Medicaid escalation help line
19 established under Section 533.00253, if the help line was
20 operational during the applicable state fiscal quarter;

21 (4) use of, requests for, and outcomes of the external
22 medical review procedure established under Section 531.024164; and

23 (5) complaints relating to the medically dependent
24 children (MDCP) waiver program, categorized by disposition.

25 Sec. 531.0603. ELIGIBILITY OF CERTAIN CHILDREN FOR
26 MEDICALLY DEPENDENT CHILDREN (MDCP) OR DEAF-BLIND WITH MULTIPLE
27 DISABILITIES (DBMD) WAIVER PROGRAM. (a) Notwithstanding any other

1 law and to the extent allowed by federal law, in determining
2 eligibility of a child for the medically dependent children (MDCP)
3 waiver program, the deaf-blind with multiple disabilities (DBMD)
4 waiver program, or a "Money Follows the Person" demonstration
5 project, the commission shall consider whether the child:

6 (1) is diagnosed as having a condition included in the
7 list of compassionate allowances conditions published by the United
8 States Social Security Administration; or

9 (2) receives Medicaid hospice or palliative care
10 services.

11 (b) If the commission determines a child is eligible for a
12 waiver program under Subsection (a), the child's enrollment in the
13 applicable program is contingent on the availability of a slot in
14 the program. If a slot is not immediately available, the commission
15 shall place the child in the first position on the interest list for
16 the medically dependent children (MDCP) waiver program or
17 deaf-blind with multiple disabilities (DBMD) waiver program, as
18 applicable.

19 Sec. 531.0604. MEDICALLY DEPENDENT CHILDREN PROGRAM
20 ELIGIBILITY REQUIREMENTS; NURSING FACILITY LEVEL OF CARE. To the
21 extent allowed by federal law, the commission may not require that a
22 child reside in a nursing facility for an extended period of time to
23 meet the nursing facility level of care required for the child to be
24 determined eligible for the medically dependent children (MDCP)
25 waiver program.

26 SECTION 4. Section 533.00253(a)(1), Government Code, is
27 amended to read as follows:

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

SECTION 5. Section 533.00253, Government Code, is amended by amending Subsection (c) and adding Subsections (c-1), (c-2), (f), (g), (h), (i), (j), (k), and (l) 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:

- 1 (A) recipient quality of life;
2 (B) recipient satisfaction; and
3 (C) other financial and clinical metrics
4 determined appropriate by the commission; and
5 (8) use innovations in the provision of services.

6 (c-1) To improve the care needs assessment tool used for
7 purposes of a care needs assessment provided as a component of care
8 management services and to improve the initial assessment and
9 reassessment processes, the commission in consultation and
10 collaboration with the advisory committee shall consider changes
11 that will:

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

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

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

23 (f) The commission shall operate a Medicaid escalation help
24 line through which Medicaid recipients receiving benefits under the
25 medically dependent children (MDCP) waiver program or the
26 deaf-blind with multiple disabilities (DBMD) wavier program and
27 their legally authorized representatives, parents, guardians, or

1 other representatives have access to assistance. The escalation
2 help line must be:

3 (1) dedicated to assisting families of Medicaid
4 recipients receiving benefits under the medically dependent
5 children (MDCP) waiver program or the deaf-blind with multiple
6 disabilities (DBMD) waiver program in navigating and resolving
7 issues related to the STAR Kids managed care program, including
8 complying with requirements related to the continuation of benefits
9 during an internal appeal, a Medicaid fair hearing, or a review
10 conducted by an external medical reviewer; and

11 (2) operational at all times, including evenings,
12 weekends, and holidays.

13 (g) The commission shall ensure staff operating the
14 Medicaid escalation help line:

15 (1) return a telephone call not later than two hours
16 after receiving the call during standard business hours; and

17 (2) return a telephone call not later than four hours
18 after receiving the call during evenings, weekends, and holidays.

19 (h) The commission shall require a Medicaid managed care
20 organization participating in the STAR Kids managed care program
21 to:

22 (1) designate an individual as a single point of
23 contact for the Medicaid escalation help line; and

24 (2) authorize that individual to take action to
25 resolve escalated issues.

26 (i) To the extent feasible, a Medicaid managed care
27 organization shall provide information that will enable staff

1 operating the Medicaid escalation help line to assist recipients,
2 such as information related to service coordination and prior
3 authorization denials.

4 (j) Not later than September 1, 2020, the commission shall
5 assess the utilization of the Medicaid escalation help line and
6 determine the feasibility of expanding the help line to additional
7 Medicaid programs that serve medically fragile children.

8 (k) Subsections (f), (g), (h), (i), and (j) and this
9 subsection expire September 1, 2024.

10 (l) Not later than September 1, 2020, the commission shall
11 evaluate risk-adjustment methods used for recipients under the STAR
12 Kids managed care program, including recipients with private health
13 benefit plan coverage, in the quality-based payment program under
14 Chapter 536 to ensure that higher-volume providers are not unfairly
15 penalized. This subsection expires January 1, 2021.

16 SECTION 6. Subchapter A, Chapter 533, Government Code, is
17 amended by adding Sections 533.00254, 533.00282, 533.00283,
18 533.00284, 533.002841, and 533.038 to read as follows:

19 Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE.

20 (a) The STAR Kids Managed Care Advisory Committee established by
21 the executive commissioner under Section 531.012 shall:

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

24 (2) make recommendations for improvements to that
25 program.

26 (b) On December 31, 2023:

27 (1) the advisory committee is abolished; and

1 (2) this section expires.

2 Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION
3 PROCEDURES. (a) Section 4201.304(a)(2), Insurance Code, does not
4 apply to a Medicaid managed care organization or a utilization
5 review agent who conducts utilization reviews for a Medicaid
6 managed care organization.

7 (b) In addition to the requirements of Section 533.005, a
8 contract between a Medicaid managed care organization and the
9 commission must require that:

10 (1) before issuing an adverse determination on a prior
11 authorization request, the organization provide the physician
12 requesting the prior authorization with a reasonable opportunity to
13 discuss the request with another physician who practices in the
14 same or a similar specialty, but not necessarily the same
15 subspecialty, and has experience in treating the same category of
16 population as the recipient on whose behalf the request is
17 submitted; and

18 (2) the organization review and issue determinations
19 on prior authorization requests with respect to a recipient who is
20 not hospitalized at the time of the request according to the
21 following time frames:

22 (A) within three business days after receiving
23 the request; or

24 (B) within the time frame and following the
25 process established by the commission if the organization receives
26 a request for prior authorization that does not include sufficient
27 or adequate documentation.

1 (c) In consultation with the state Medicaid managed care
2 advisory committee, the commission shall establish a process for
3 use by a Medicaid managed care organization that receives a prior
4 authorization request, with respect to a recipient who is not
5 hospitalized at the time of the request, that does not include
6 sufficient or adequate documentation. The process must provide a
7 time frame within which a provider may submit the necessary
8 documentation. The time frame must be longer than the time frame
9 specified by Subsection (b)(2)(A) within which a Medicaid managed
10 care organization must issue a determination on a prior
11 authorization request.

12 Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION
13 REQUIREMENTS. (a) Each Medicaid managed care organization, in
14 consultation with the organization's provider advisory group
15 required by contract, shall develop and implement a process to
16 conduct an annual review of the organization's prior authorization
17 requirements, other than a prior authorization requirement
18 prescribed by or implemented under Section 531.073 for the vendor
19 drug program. In conducting a review, the organization must:

20 (1) solicit, receive, and consider input from
21 providers in the organization's provider network; and

22 (2) ensure that each prior authorization requirement
23 is based on accurate, up-to-date, evidence-based, and
24 peer-reviewed clinical criteria that distinguish, as appropriate,
25 between categories, including age, of recipients for whom prior
26 authorization requests are submitted.

27 (b) A Medicaid managed care organization may not impose a

1 prior authorization requirement, other than a prior authorization
2 requirement prescribed by or implemented under Section 531.073 for
3 the vendor drug program, unless the organization has reviewed the
4 requirement during the most recent annual review required under
5 this section.

6 (c) The commission shall periodically review each Medicaid
7 managed care organization to ensure the organization's compliance
8 with this section.

9 Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE
10 DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In
11 consultation with the state Medicaid managed care advisory
12 committee, the commission shall establish a uniform process and
13 timeline for Medicaid managed care organizations to reconsider an
14 adverse determination on a prior authorization request that
15 resulted solely from the submission of insufficient or inadequate
16 documentation. In addition to the requirements of Section 533.005,
17 a contract between a Medicaid managed care organization and the
18 commission must include a requirement that the organization
19 implement the process and timeline.

20 (b) The process and timeline must:

21 (1) allow a provider to submit any documentation that
22 was identified as insufficient or inadequate in the notice provided
23 under Section 531.024162;

24 (2) allow the provider requesting the prior
25 authorization to discuss the request with another provider who
26 practices in the same or a similar specialty, but not necessarily
27 the same subspecialty, and has experience in treating the same

1 category of population as the recipient on whose behalf the request
2 is submitted; and

3 (3) require the Medicaid managed care organization to
4 amend the determination on the prior authorization request as
5 necessary, considering the additional documentation.

6 (c) An adverse determination on a prior authorization
7 request is considered a denial of services in an evaluation of the
8 Medicaid managed care organization only if the determination is not
9 amended under Subsection (b)(3) to approve the request.

10 (d) The process and timeline for reconsidering an adverse
11 determination on a prior authorization request under this section
12 do not affect:

13 (1) any related timelines, including the timeline for
14 an internal appeal, a Medicaid fair hearing, or a review conducted
15 by an external medical reviewer; or

16 (2) any rights of a recipient to appeal a
17 determination on a prior authorization request.

18 Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION
19 DECISION; ACCESS TO CARE. The time frames prescribed by the
20 utilization review and prior authorization procedures described by
21 Section 533.00282 and the timeline for reconsidering an adverse
22 determination on a prior authorization described by Section
23 533.00284 together may not exceed the time frame for a decision
24 under federally prescribed time frames. It is the intent of the
25 legislature that these provisions allow sufficient time to provide
26 necessary documentation and avoid unnecessary denials without
27 delaying access to care.

1 Sec. 533.038. COORDINATION OF BENEFITS. (a) In this
2 section, "Medicaid wrap-around benefit" means a Medicaid-covered
3 service, including a pharmacy or medical benefit, that is provided
4 to a recipient with both Medicaid and primary health benefit plan
5 coverage when the recipient has exceeded the primary health benefit
6 plan coverage limit or when the service is not covered by the
7 primary health benefit plan issuer.

8 (b) The commission, in coordination with Medicaid managed
9 care organizations and in consultation with the STAR Kids Managed
10 Care Advisory Committee described by Section 533.00254, shall
11 develop and adopt a clear policy for a Medicaid managed care
12 organization to ensure the coordination and timely delivery of
13 Medicaid wrap-around benefits for recipients with both primary
14 health benefit plan coverage and Medicaid coverage. In developing
15 the policy, the commission shall consider requiring a Medicaid
16 managed care organization to allow, notwithstanding Sections
17 531.073 and 533.005(a)(23) or any other law, a recipient using a
18 prescription drug for which the recipient's primary health benefit
19 plan issuer previously provided coverage to continue receiving the
20 prescription drug without requiring additional prior
21 authorization.

22 (c) If the commission determines that a recipient's primary
23 health benefit plan issuer should have been the primary payor of a
24 claim, the Medicaid managed care organization that paid the claim
25 shall work with the commission on the recovery process and make
26 every attempt to reduce health care provider and recipient
27 abrasion.

1 (d) The executive commissioner may seek a waiver from the
2 federal government as needed to:

3 (1) address federal policies related to coordination
4 of benefits and third-party liability; and

5 (2) maximize federal financial participation for
6 recipients with both primary health benefit plan coverage and
7 Medicaid coverage.

8 (e) The commission may include in the Medicaid managed care
9 eligibility files an indication of whether a recipient has primary
10 health benefit plan coverage or is enrolled in a group health
11 benefit plan for which the commission provides premium assistance
12 under the health insurance premium payment program. For recipients
13 with that coverage or for whom that premium assistance is provided,
14 the files may include the following up-to-date, accurate
15 information related to primary health benefit plan coverage to the
16 extent the information is available to the commission:

17 (1) the health benefit plan issuer's name and address
18 and the recipient's policy number;

19 (2) the primary health benefit plan coverage start and
20 end dates; and

21 (3) the primary health benefit plan coverage benefits,
22 limits, copayment, and coinsurance information.

23 (f) To the extent allowed by federal law, the commission
24 shall maintain processes and policies to allow a health care
25 provider who is primarily providing services to a recipient through
26 primary health benefit plan coverage to receive Medicaid
27 reimbursement for services ordered, referred, or prescribed,

1 regardless of whether the provider is enrolled as a Medicaid
 2 provider. The commission shall allow a provider who is not enrolled
 3 as a Medicaid provider to order, refer, or prescribe services to a
 4 recipient based on the provider's national provider identifier
 5 number and may not require an additional state provider identifier
 6 number to receive reimbursement for the services. The commission
 7 may seek a waiver of Medicaid provider enrollment requirements for
 8 providers of recipients with primary health benefit plan coverage
 9 to implement this subsection.

10 (g) The commission shall develop a clear and easy process,
 11 to be implemented through a contract, that allows a recipient with
 12 complex medical needs who has established a relationship with a
 13 specialty provider to continue receiving care from that provider.

14 SECTION 7. (a) Section 531.0601, Government Code, as added
 15 by this Act, applies only to a child who becomes ineligible for the
 16 medically dependent children (MDCP) waiver program on or after
 17 December 1, 2019.

18 (b) Section 531.0602, Government Code, as added by this Act,
 19 applies only to an assessment or reassessment of a child's
 20 eligibility for the medically dependent children (MDCP) waiver
 21 program made on or after December 1, 2019.

22 (c) Notwithstanding Section 531.06021, Government Code, as
 23 added by this Act, the Health and Human Services Commission shall
 24 submit the first report required by that section not later than
 25 September 30, 2020, for the state fiscal quarter ending August 31,
 26 2020.

27 (d) Not later than March 1, 2020, the Health and Human

1 Services Commission shall:

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

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

8 (e) Sections 533.00282 and 533.00284, Government Code, as
9 added by this Act, apply only to a contract between the Health and
10 Human Services Commission and a Medicaid managed care organization
11 under Chapter 533, Government Code, that is entered into or renewed
12 on or after the effective date of this Act.

13 (f) As soon as practicable after the effective date of this
14 Act but not later than September 1, 2020, the Health and Human
15 Services Commission shall seek to amend contracts entered into with
16 Medicaid managed care organizations under Chapter 533, Government
17 Code, before the effective date of this Act to include the
18 provisions required by Sections 533.00282 and 533.00284,
19 Government Code, as added by this Act.

20 SECTION 8. As soon as practicable after the effective date
21 of this Act, the executive commissioner of the Health and Human
22 Services Commission shall adopt rules necessary to implement the
23 changes in law made by this Act.

24 SECTION 9. If before implementing any provision of this Act
25 a state agency determines that a waiver or authorization from a
26 federal agency is necessary for implementation of that provision,
27 the agency affected by the provision shall request the waiver or

1 authorization and may delay implementing that provision until the
2 waiver or authorization is granted.

3 SECTION 10. The Health and Human Services Commission is
4 required to implement a provision of this Act only if the
5 legislature appropriates money specifically for that purpose. If
6 the legislature does not appropriate money specifically for that
7 purpose, the commission may, but is not required to, implement a
8 provision of this Act using other appropriations available for that
9 purpose.

10 SECTION 11. This Act takes effect September 1, 2019.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

No equivalent provision. (But see SECTION 1 - Sec. 533.038, Government Code, below.)

No equivalent provision.

No equivalent provision.

HOUSE VERSION (IE)

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. Section 531.02444, Government Code, is amended. [FA1(1), FA1(2), FA1(3)]

Same as Senate version.

CONFERENCE

SECTION 1. Same as House version.

Same as Senate version.

SECTION 2. Section 531.024, Government Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:
(b) The rules promulgated under Subsection (a)(7) must provide due process to an applicant for Medicaid services and to a Medicaid recipient who seeks a Medicaid service, including a service that requires prior authorization. The rules must provide the protections for applicants and recipients required by 42 C.F.R. Part 431, Subpart E, including requiring that:
(1) the written notice to an individual of the individual's right to a hearing must:
(A) contain an explanation of the circumstances under which Medicaid is continued if a hearing is requested; and
(B) be delivered by mail, and postmarked [mailed] at least 10 business days, before the date the individual's Medicaid eligibility or service is scheduled to be terminated, suspended, or reduced, except as provided by 42 C.F.R. Section 431.213 or 431.214; and

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

(2) if a hearing is requested before the date a Medicaid recipient's service, including a service that requires prior authorization, is scheduled to be terminated, suspended, or reduced, the agency may not take that proposed action before a decision is rendered after the hearing unless:

(A) it is determined at the hearing that the sole issue is one of federal or state law or policy; and

(B) the agency promptly informs the recipient in writing that services are to be terminated, suspended, or reduced pending the hearing decision.

(c) The commission shall develop a process to address a situation in which:

(1) an individual does not receive adequate notice as required by Subsection (b)(1); or

(2) the notice required by Subsection (b)(1) is delivered without a postmark.

[The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.]

SECTION 3.

SECTION 3. (a) *To the extent of any conflict, Section 531.024162, Government Code, as added by this section, prevails over any provision of another Act of the 86th Legislature, Regular Session, 2019, relating to notice requirements regarding Medicaid coverage or prior authorization denials or incomplete requests, that becomes law.*

[The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the

No equivalent provision.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024162, 531.024163, 531.024164, 531.0601, 531.0602, and 531.06021 to read as follows:

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING MEDICAID COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS. (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, partial denial, reduction, or termination of coverage or denial of prior authorization for a service ***must be mailed 10 business days in advance and postmarked, and*** includes: [FA1(4)-(4x)]
(1) information required by federal and state law and applicable regulations;
(2) for the recipient:
(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;
(B) a copy of the information sent to the provider; and
(C) an educational component that includes a description of the recipient's rights, an explanation of the process related to appeals and Medicaid fair hearings, and a description of the role of an external medical review; and [FA1(5)]
(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, including, as

presiding officer can make the final determination on this issue.]

(b) Subchapter B, Chapter 531, Government Code, is amended by adding Sections 531.024162, 531.024163, 531.024164, 531.0601, 531.0602, 531.06021, 531.0603, and 531.0604 to read as follows:

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING MEDICAID COVERAGE OR PRIOR AUTHORIZATION DENIAL AND INCOMPLETE REQUESTS. (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, partial denial, reduction, or termination of coverage or denial of prior authorization for a service includes:

(1) information required by federal and state law and applicable regulations;
(2) for the recipient:
(A) a clear and easy-to-understand explanation of the reason for the decision, including a clear explanation of the medical basis, applying the policy or accepted standard of medical practice to the recipient's particular medical circumstances;
(B) a copy of the information sent to the provider; and
(C) an educational component that includes a description of the recipient's rights, an explanation of the process related to appeals and Medicaid fair hearings, and a description of the role of an external medical review; and
(3) for the provider, a thorough and detailed clinical explanation of the reason for the decision, including, as applicable, information required under Subsection (b).

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

applicable, information required under Subsection (b).
[FA1(6)]

(b) The commission or a Medicaid managed care organization that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request shall issue a notice to the provider and the Medicaid recipient on whose behalf the request was submitted. The notice issued under this subsection must:

(1) include a section specifically for the provider that contains:

(A) a clear and specific list and description of the documentation necessary for the commission or organization to make a final determination on the request;

(B) the applicable timeline, based on the requested service, for the provider to submit the documentation and a description of the reconsideration process described by Section 533.00284, if applicable; and

(C) information on the manner through which a provider may contact a Medicaid managed care organization or other entity as required by Section 531.024163; and

(2) be sent:

(A) to the provider:

(i) using the provider's preferred method of communication, to the extent practicable using existing resources; and

(ii) as applicable, through an electronic notification on an Internet portal; and

(B) to the recipient using the recipient's preferred method of communication, to the extent practicable using existing resources. [FA1(7)]

Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING MEDICAID PRIOR AUTHORIZATION

(b) The commission or a Medicaid managed care organization that receives from a provider a coverage or prior authorization request that contains insufficient or inadequate documentation to approve the request shall issue a notice to the provider and the Medicaid recipient on whose behalf the request was submitted. The notice issued under this subsection must:

(1) include a section specifically for the provider that contains:

(A) a clear and specific list and description of the documentation necessary for the commission or organization to make a final determination on the request;

(B) the applicable timeline, based on the requested service, for the provider to submit the documentation and a description of the reconsideration process described by Section 533.00284, if applicable; and

(C) information on the manner through which a provider may contact a Medicaid managed care organization or other entity as required by Section 531.024163; and

(2) be sent:

(A) to the provider:

(i) using the provider's preferred method of communication, to the extent practicable using existing resources; and

(ii) as applicable, through an electronic notification on an Internet portal; and

(B) to the recipient using the recipient's preferred method of communication, to the extent practicable using existing resources.

Sec. 531.024163. ACCESSIBILITY OF INFORMATION REGARDING MEDICAID PRIOR AUTHORIZATION REQUIREMENTS. (a) The executive commissioner by

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

REQUIREMENTS. (a) The executive commissioner by rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the organization or entity maintains on the organization's or entity's Internet website in an easily searchable and accessible format:

(1) the applicable timelines for prior authorization requirements, including:

(A) the time within which the organization or entity must make a determination on a prior authorization request;

(B) a description of the notice the organization or entity provides to a provider and Medicaid recipient on whose behalf the request was submitted regarding the documentation required to complete a determination on a prior authorization request; and

(C) the deadline by which the organization or entity is required to submit the notice described by Paragraph (B); and

(2) an accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, including:

(A) for a prior authorization requirement first imposed on or after September 1, 2019, the effective date of the requirement;

(B) a list or description of any supporting or other documentation necessary to obtain prior authorization for a specified service; and

(C) the date and results of each review conducted under Section 533.00283(b), if applicable. [FA1(8)]

(b) The executive commissioner by rule shall require each Medicaid managed care organization or other entity

CONFERENCE

rule shall require each Medicaid managed care organization or other entity responsible for authorizing coverage for health care services under Medicaid to ensure that the organization or entity maintains on the organization's or entity's Internet website in an easily searchable and accessible format:

(1) the applicable timelines for prior authorization requirements, including:

(A) the time within which the organization or entity must make a determination on a prior authorization request;

(B) a description of the notice the organization or entity provides to a provider and Medicaid recipient on whose behalf the request was submitted regarding the documentation required to complete a determination on a prior authorization request; and

(C) the deadline by which the organization or entity is required to submit the notice described by Paragraph (B); and

(2) an accurate and up-to-date catalogue of coverage criteria and prior authorization requirements, including:

(A) for a prior authorization requirement first imposed on or after September 1, 2019, the effective date of the requirement;

(B) a list or description of any supporting or other documentation necessary to obtain prior authorization for a specified service; and

(C) the date and results of each review *of the prior authorization requirement* conducted under Section 533.00283, if applicable.

(b) The executive commissioner by rule shall require each Medicaid managed care organization or other entity

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

responsible for authorizing coverage for health care services under Medicaid to:

(1) adopt and maintain a process for a provider or Medicaid recipient to contact the organization or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request; and

(2) ensure that the process described by Subdivision (1) is not arduous or overly burdensome to a provider or recipient. Sec. 531.024164. EXTERNAL MEDICAL REVIEW. (a) In this section, "external medical reviewer" and "reviewer" mean a third-party medical review organization that provides objective, unbiased medical necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with applicable state law and rules.

(b) The commission shall contract with an independent external medical reviewer to conduct external medical reviews and review:

(1) the resolution of a Medicaid recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program; or

(2) a denial by the commission of eligibility for a Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs.

(c) A Medicaid managed care organization may not have a financial relationship with or ownership interest in the external medical reviewer with which the commission contracts.

(d) The external medical reviewer with which the commission contracts must:

CONFERENCE

responsible for authorizing coverage for health care services under Medicaid to:

(1) adopt and maintain a process for a provider or Medicaid recipient to contact the organization or entity to clarify prior authorization requirements or to assist the provider in submitting a prior authorization request; and

(2) ensure that the process described by Subdivision (1) is not arduous or overly burdensome to a provider or recipient. Sec. 531.024164. EXTERNAL MEDICAL REVIEW. (a) In this section, "external medical reviewer" and "reviewer" mean a third-party medical review organization that provides objective, unbiased medical necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought in accordance with applicable state law and rules.

(b) The commission shall contract with an independent external medical reviewer to conduct external medical reviews and review:

(1) the resolution of a Medicaid recipient appeal related to a reduction in or denial of services on the basis of medical necessity in the Medicaid managed care program; or

(2) a denial by the commission of eligibility for a Medicaid program in which eligibility is based on a Medicaid recipient's medical and functional needs.

(c) A Medicaid managed care organization may not have a financial relationship with or ownership interest in the external medical reviewer with which the commission contracts.

(d) The external medical reviewer with which the commission contracts must:

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

- (1) be overseen by a medical director who is a physician licensed in this state; and
- (2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.
- (e) The commission shall establish a common procedure for reviews. To the maximum extent possible, the procedure shall reduce administrative burden on providers and the submission of duplicative information or documents. Medical necessity under the procedure must be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. The reviewer shall conduct the review within a period specified by the commission. The commission shall also establish a procedure and time frame for expedited reviews that allows the reviewer to:
 - (1) identify an appeal that requires an expedited resolution; and
 - (2) resolve the review of the appeal within a specified period.
- [FA1(9)-(11)]
- (f)

An external medical review described by Subsection (b)(1) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing and is granted when a Medicaid recipient contests the internal appeal decision of the Medicaid managed care organization.

An external medical review described by Subsection (b)(2) occurs after the eligibility denial and before the Medicaid fair hearing. ***The Medicaid recipient or applicant, or the***

CONFERENCE

- (1) be overseen by a medical director who is a physician licensed in this state; and
- (2) employ or be able to consult with staff with experience in providing private duty nursing services and long-term services and supports.
- (e) The commission shall establish a common procedure for reviews. To the greatest extent possible, the procedure must reduce administrative burdens on providers and the submission of duplicative information or documents. Medical necessity under the procedure must be based on publicly available, up-to-date, evidence-based, and peer-reviewed clinical criteria. The reviewer shall conduct the review within a period specified by the commission. The commission shall also establish a procedure and time frame for expedited reviews that allows the reviewer to:
 - (1) identify an appeal that requires an expedited resolution; and
 - (2) resolve the review of the appeal within a specified period.
- (f) A Medicaid recipient or applicant, or the recipient's or applicant's parent or legally authorized representative, must affirmatively request an external medical review. If requested:***
 - (1) an external medical review described by Subsection (b)(1) occurs after the internal Medicaid managed care organization appeal and before the Medicaid fair hearing and is granted when a Medicaid recipient contests the internal appeal decision of the Medicaid managed care organization;
 - and***
 - (2) an external medical review described by Subsection (b)(2) occurs after the eligibility denial and before the Medicaid fair hearing.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

recipient's or applicant's parent or legally authorized representative, must affirmatively opt out of the external medical review to proceed to a Medicaid fair hearing without first participating in the external medical review.

(g) The external medical reviewer's determination of medical necessity establishes the minimum level of services a Medicaid recipient must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

(h) The external medical reviewer shall require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

() To the extent money is appropriated for this purpose, the commission shall publish data regarding prior authorizations reviewed by the external medical reviewer, including the rate of prior authorization denials overturned by the external medical reviewer and additional information the commission and the external medical reviewer determine appropriate.
[FA1(12)]

Sec. 531.0601. LONG-TERM CARE SERVICES WAIVER PROGRAM INTEREST LISTS. (a) This section applies only to a child who is enrolled in the medically dependent children (MDCP) waiver program but becomes ineligible for services under the program because the child no longer meets:

(1) the level of care criteria for medical necessity for nursing facility care; or

(2) the age requirement for the program.

(b) A legally authorized representative of a child who is notified by the commission that the child is no longer eligible for the medically dependent children (MDCP) waiver

(g) The external medical reviewer's determination of medical necessity establishes the minimum level of services a Medicaid recipient must receive, except that the level of services may not exceed the level identified as medically necessary by the ordering health care provider.

(h) The external medical reviewer shall require a Medicaid managed care organization, in an external medical review relating to a reduction in services, to submit a detailed reason for the reduction and supporting documents.

(i) To the extent money is appropriated for this purpose, the commission shall publish data regarding prior authorizations reviewed by the external medical reviewer, including the rate of prior authorization denials overturned by the external medical reviewer and additional information the commission and the external medical reviewer determine appropriate.

Sec. 531.0601. LONG-TERM CARE SERVICES WAIVER PROGRAM INTEREST LISTS. (a) This section applies only to a child who is enrolled in the medically dependent children (MDCP) waiver program but becomes ineligible for services under the program because the child no longer meets:

(1) the level of care criteria for medical necessity for nursing facility care; or

(2) the age requirement for the program.

(b) A legally authorized representative of a child who is notified by the commission that the child is no longer eligible for the medically dependent children (MDCP) waiver

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, may request that the commission:

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

(c) At the time a child's legally authorized representative makes a request under Subsection (b), the commission shall:

- (1) for a child who becomes ineligible for the reason described by Subsection (a)(1), place the child:

(A) on the interest list for the medically dependent children (MDCP) waiver program in the first position on the list; or

(B) except as provided by Subdivision (3), on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program;

(2) except as provided by Subdivision (3), for a child who becomes ineligible for the reason described by Subsection (a)(2), place the child on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program; or

(3) for a child who becomes ineligible for a reason described by Subsection (a) and who is already on an interest list for another Section 1915(c) waiver program, move the child to a position on the interest list relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program, if that date is earlier than the date

CONFERENCE

program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, may request that the commission:

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

(c) At the time a child's legally authorized representative makes a request under Subsection (b), the commission shall:

- (1) for a child who becomes ineligible for the reason described by Subsection (a)(1), place the child:

(A) on the interest list for the medically dependent children (MDCP) waiver program in the first position on the list; or

(B) except as provided by Subdivision (3), on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program;

(2) except as provided by Subdivision (3), for a child who becomes ineligible for the reason described by Subsection (a)(2), place the child on the interest list for another Section 1915(c) waiver program in a position relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program; or

(3) for a child who becomes ineligible for a reason described by Subsection (a) and who is already on an interest list for another Section 1915(c) waiver program, move the child to a position on the interest list relative to other persons on the list that is based on the date the child was initially placed on the interest list for the medically dependent children (MDCP) waiver program, if that date is earlier than the date

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

the child was initially placed on the interest list for the other waiver program.

(d) At the time the commission provides notice to a legally authorized representative that a child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, the commission shall inform the representative in writing about:

(1) the options under this section for placing the child on an interest list; and

(2) the process for applying for the Medicaid buy-in program for children with disabilities implemented under Section 531.02444, and the availability of the disability determination assessment for that program described by Section 531.02444(e). [FA1(13)]

Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM ASSESSMENTS AND REASSESSMENTS. (a) The commission shall ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program provides the results of the initial assessment or annual reassessment of medical necessity to the parent or legally authorized representative of a recipient receiving benefits under the medically dependent children (MDCP) waiver

the child was initially placed on the interest list for the other waiver program.

(d) Notwithstanding Subsection (c)(1)(B) or (c)(2), a child may be placed on an interest list for a Section 1915(c) waiver program in the position described by those subsections only if the child has previously been placed on the interest list for that waiver program.

(e) At the time the commission provides notice to a legally authorized representative that a child is no longer eligible for the medically dependent children (MDCP) waiver program following a Medicaid fair hearing, or without a Medicaid fair hearing if the representative opted in writing to forego the hearing, the commission shall inform the representative in writing about:

(1) the options under this section for placing the child on an interest list; and

(2) the process for applying for the Medicaid buy-in program for children with disabilities implemented under Section 531.02444.

(f) This section expires December 1, 2021.

Sec. 531.0602. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM ASSESSMENTS AND REASSESSMENTS. (a) The commission shall ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program provides the results of the initial assessment or annual reassessment of medical necessity to the parent or legally authorized representative of a recipient receiving benefits under the medically dependent children (MDCP) waiver program for review. The commission shall ensure the

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

program for review. The commission shall ensure the provision of the results does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services. [FA1(14)-(15)]

(b) The commission shall require the parent's or representative's signature to verify the parent or representative received the results of the initial assessment or reassessment from the care coordinator under Subsection (a). A Medicaid managed care organization may not delay the delivery of care pending the signature. [FA1(16)]

(c) The commission shall provide a parent or representative who disagrees with the results of the initial assessment or reassessment an opportunity to request to dispute the results with the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice. [FA1(17)-(18)]

(d) This section does not affect any rights of a recipient to appeal an initial assessment or reassessment determination through the Medicaid managed care organization's internal appeal process or through the Medicaid fair hearing process. [FA1(19)]

Sec. 531.06021. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM QUALITY MONITORING; REPORT. (a) The commission, through the *state's* external quality review organization, *shall*:

CONFERENCE

provision of the results does not delay the determination of the services to be provided to the recipient or the ability to authorize and initiate services.

(b) The commission shall require the parent's or representative's signature to verify the parent or representative received the results of the initial assessment or reassessment from the care coordinator under Subsection (a). A Medicaid managed care organization may not delay the delivery of care pending the signature.

(c) The commission shall provide a parent or representative who disagrees with the results of the initial assessment or reassessment an opportunity to request to dispute the results with the Medicaid managed care organization through a peer-to-peer review with the treating physician of choice.

(d) This section does not affect any rights of a recipient to appeal an initial assessment or reassessment determination through the Medicaid managed care organization's internal appeal process, the Medicaid fair hearing process, *or the external medical review process.*

Sec. 531.06021. MEDICALLY DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM QUALITY MONITORING; REPORT. (a) The commission, *based on the state's external quality review organization's initial report on the STAR Kids managed care program, shall determine whether the findings of the report necessitate additional data and research to improve the program. If the commission determines additional data and research are needed, the commission,* through the external quality review organization, *may*:

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

(1) conduct annual surveys of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;
(2) conduct annual focus groups with recipients described by Subdivision (1) or their representatives on issues identified through:
(A) the Consumer Assessment of Healthcare Providers and Systems;
(B) other external quality review organization activities; or
(C) stakeholders, including the STAR Kids Managed Care Advisory Committee described by Section 533.00254; and
(3) in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254 and as frequently as feasible **but not less frequently than annually**, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as **COIIN Project** [FA1(20)-(20x)]
(b) Not later than the 30th day after the last day of each state fiscal quarter, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program:
(1) enrollment in the Medicaid buy-in for children program implemented under Section 531.02444;
(2) requests relating to interest list placements under Section 531.0601;

CONFERENCE

(1) conduct annual surveys of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program, or their representatives, using the Consumer Assessment of Healthcare Providers and Systems;
(2) conduct annual focus groups with recipients described by Subdivision (1) or their representatives on issues identified through:
(A) the Consumer Assessment of Healthcare Providers and Systems;
(B) other external quality review organization activities; or
(C) stakeholders, including the STAR Kids Managed Care Advisory Committee described by Section 533.00254; and
(3) in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254 and as frequently as feasible, calculate Medicaid managed care organizations' performance on performance measures using available data sources such as **the collaborative innovation improvement network**.
(b) Not later than the 30th day after the last day of each state fiscal quarter, the commission shall submit to the governor, the lieutenant governor, the speaker of the house of representatives, the Legislative Budget Board, and each standing legislative committee with primary jurisdiction over Medicaid a report containing, for the most recent state fiscal quarter, the following information and data related to access to care for Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program:
(1) enrollment in the Medicaid buy-in for children program implemented under Section 531.02444;
(2) requests relating to interest list placements under Section 531.0601;

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

(3) use of the Medicaid escalation help line established under Section 533.00253, if the help line was operational during the applicable state fiscal quarter; [FA1(21)]
(4) use, requests *to opt out*, and outcomes of the external medical review procedure established under Section 531.024164; and
(5) complaints relating to the medically dependent children (MDCP) waiver program, categorized by disposition.

(3) use of the Medicaid escalation help line established under Section 533.00253, if the help line was operational during the applicable state fiscal quarter;
(4) use *of*, requests *for*, and outcomes of the external medical review procedure established under Section 531.024164; and
(5) complaints relating to the medically dependent children (MDCP) waiver program, categorized by disposition.

No equivalent provision.

SECTION __. Sec. __. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN **PROGRAM AND** DEAF BLIND MULTIPLE DISABILITIES. (a) Notwithstanding any other law and to the extent allowed by federal law, when determining eligibility for the medically dependent children (MDCP) and deaf blind multiple disabilities (DBMD) waiver programs or a "Money Follows the Person" demonstration project, the commission shall consider if a child:

(1) is diagnosed as having a condition included in the list of compassionate allowances conditions published by the United States Social Security Administration; or
(2) receives Medicaid hospice or palliative care services.
(b) *If a child is determined* eligible for the MDCP or DBMD waiver programs under subsection (a), enrollment in the MDCP or DBMD waiver programs is contingent on the availability of a *waiver* slot. If a slot is not immediately available, the commission shall place the child on the interest list for the MDCP or DBMD waiver programs in the first position on the list. [FA1(45)]

Sec. 531.0603. ELIGIBILITY OF CERTAIN CHILDREN FOR MEDICALLY DEPENDENT CHILDREN (**MDCP**) **OR** DEAF-BLIND **WITH** MULTIPLE DISABILITIES (**DBMD**) **WAIVER PROGRAM.** (a) Notwithstanding any other law and to the extent allowed by federal law, in determining eligibility *of a child* for the medically dependent children (MDCP) waiver program, the deaf-blind *with* multiple disabilities (DBMD) waiver program, or a "Money Follows the Person" demonstration project, the commission shall consider whether the child:

(1) is diagnosed as having a condition included in the list of compassionate allowances conditions published by the United States Social Security Administration; or
(2) receives Medicaid hospice or palliative care services.
(b) *If the commission determines a child is* eligible for a waiver program under Subsection (a), the child's enrollment in the applicable program is contingent on the availability of a slot *in the program*. If a slot is not immediately available, the commission shall place the child in the first position on the interest list for the medically dependent children (MDCP) waiver program or deaf-blind with multiple disabilities (DBMD) waiver program, *as applicable*.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

No equivalent provision.

No equivalent provision.

No equivalent provision.

HOUSE VERSION (IE)

SECTION _____. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0605 to read as follows:

Sec. 531.0605. MEDICALLY DEPENDENT CHILDREN PROGRAM ELIGIBILITY REQUIREMENTS; NURSING FACILITY LEVEL OF CARE. To the extent allowed by federal law, the commission may not require that a child reside in a nursing facility for an extended period of time to meet the nursing facility level of care required for the child to be determined eligible for the medically dependent children (MDCP) waiver program. [FA1,3rd]

SECTION 4. 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 5. Section 533.00253, Government Code, is amended by adding Subsections (c-1), (c-2), (f), (g), (h), (i), and (j) to read as follows: [FA1(22)]

CONFERENCE

Sec. 531.0604. Same as House version.

SECTION 4. Same as House version.

SECTION 5. Section 533.00253, Government Code, is amended by amending Subsection (c) and adding Subsections (c-1), (c-2), (f), (g), (h), (i), (j), (k), and (l) 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;

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

(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 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

(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 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

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity.

(f) The commission shall operate a Medicaid escalation help line through which Medicaid recipients receiving benefits under the medically dependent children (MDCP) the deaf blind multiple disabilities (DBMD) waiver programs and their legally authorized representatives, parents, guardians, or other representatives have access to assistance. The escalation help line must be: [FA1(22x1)-(22x2)]

(1) dedicated to assisting families of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program in navigating and resolving issues related to the STAR Kids managed care program, including complying with requirements related to the continuation of benefits during an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; and [FA1(23)]

(2) operational at all times, including evenings, weekends, and holidays.

(g) The commission shall ensure staff operating the Medicaid escalation help line:

(1) return a telephone call not later than two hours after receiving the call during standard business hours; and

(2) return a telephone call not later than four hours after receiving the call during evenings, weekends, and holidays.

(h) The commission shall require a Medicaid managed care organization participating in the STAR Kids managed care program to:

(1) designate an individual as a single point of contact for the Medicaid escalation help line; and

CONFERENCE

program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity.

(f) The commission shall operate a Medicaid escalation help line through which Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program or the deaf-blind *with* multiple disabilities (DBMD) wavier program and their legally authorized representatives, parents, guardians, or other representatives have access to assistance. The escalation help line must be:

(1) dedicated to assisting families of Medicaid recipients receiving benefits under the medically dependent children (MDCP) waiver program *or the deaf-blind with multiple disabilities (DBMD) waiver program* in navigating and resolving issues related to the STAR Kids managed care program, including complying with requirements related to the continuation of benefits during an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; and

(2) operational at all times, including evenings, weekends, and holidays.

(g) The commission shall ensure staff operating the Medicaid escalation help line:

(1) return a telephone call not later than two hours after receiving the call during standard business hours; and

(2) return a telephone call not later than four hours after receiving the call during evenings, weekends, and holidays.

(h) The commission shall require a Medicaid managed care organization participating in the STAR Kids managed care program to:

(1) designate an individual as a single point of contact for the Medicaid escalation help line; and

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

(2) authorize that individual to take action to resolve escalated issues.

(g) The commission shall assess the utilization of the escalation help line and determine the feasibility of expanding the help line to additional Medicaid programs that serve medically fragile children by September 1, 2020.
[FA1(23x)]

(i) Subsections (f), (g), and (h) and this subsection expire September 1, 2024.

(j) Not later than September 1, 2020, the commission shall evaluate risk-adjustment methods used for recipients under the STAR Kids managed care program, including recipients with private health benefit plan coverage, in the quality-based payment program under Chapter 536 to ensure that higher-volume providers are not unfairly penalized. During the evaluation period, the commission may exclude recipients under the STAR Kids managed care program, including recipients with private health benefit plan coverage, from the potentially preventable event rate methodology. This subsection expires January 1, 2021.
[FA1(24)]

SECTION __. Section 533.00253 is amended by amending subsection (c)(4) to read as follows: (4) provide a care needs assessment for a recipient [that is comprehensive, holistic, consumer directed, evidence based, and takes into

(2) authorize that individual to take action to resolve escalated issues.

(i) To the extent feasible, a Medicaid managed care organization shall provide information that will enable staff operating the Medicaid escalation help line to assist recipients, such as information related to service coordination and prior authorization denials.

(j) Not later than September 1, 2020, the commission shall assess the utilization of the Medicaid escalation help line and determine the feasibility of expanding the help line to additional Medicaid programs that serve medically fragile children.

(k) Subsections (f), (g), (h), (i), and (j) and this subsection expire September 1, 2024.

(l) Not later than September 1, 2020, the commission shall evaluate risk-adjustment methods used for recipients under the STAR Kids managed care program, including recipients with private health benefit plan coverage, in the quality-based payment program under Chapter 536 to ensure that higher-volume providers are not unfairly penalized. This subsection expires January 1, 2021.

[The conference committee may have exceeded the limitations imposed on its jurisdiction, but only the presiding officer can make the final determination on this issue.]

Same as Senate version.

No equivalent provision.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

~~consideration social and medical issues, for purposes of prioritizing the recipient's needs that threaten independent living;FA1(45)]~~

No equivalent provision.

SECTION 6. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00254, 533.00282, 533.00283, 533.00284, 533.002841, and 533.038 to read as follows: [FA1(25)]

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 *September 1, 2023*:

(1) the advisory committee is abolished; and
(2) this section expires.

Sec. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. (a) Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization.

(b) In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must require that:

(1) before issuing an adverse determination on a prior authorization request, the organization provide the physician

SECTION 6. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.00254, 533.00282, 533.00283, 533.00284, 533.002841, and 533.038 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. 533.00282. UTILIZATION REVIEW AND PRIOR AUTHORIZATION PROCEDURES. (a) Section 4201.304(a)(2), Insurance Code, does not apply to a Medicaid managed care organization or a utilization review agent who conducts utilization reviews for a Medicaid managed care organization.

(b) In addition to the requirements of Section 533.005, a contract between a Medicaid managed care organization and the commission must require that:

(1) before issuing an adverse determination on a prior authorization request, the organization provide the physician

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and

(2) the organization review and issue determinations on prior authorization requests with respect to a recipient who is not hospitalized at the time of the request according to the following time frames:

(A) within three business days after receiving the request; or
(B) within the time frame and following the process established by the commission if the organization receives a request for prior authorization that does not include sufficient or adequate documentation.

(c) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a process **consistent with** for use by a Medicaid managed care organization that receives a prior authorization request, with respect to a recipient who is not hospitalized at the time of the request, that does not include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(2)(A) within which a Medicaid managed care organization must issue a determination on a prior authorization request. [FA1(26)-(28)]

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed care organization, in consultation with the organization's provider advisory group required by

CONFERENCE

requesting the prior authorization with a reasonable opportunity to discuss the request with another physician who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and

(2) the organization review and issue determinations on prior authorization requests with respect to a recipient who is not hospitalized at the time of the request according to the following time frames:

(A) within three business days after receiving the request; or
(B) within the time frame and following the process established by the commission if the organization receives a request for prior authorization that does not include sufficient or adequate documentation.

(c) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a process for use by a Medicaid managed care organization that receives a prior authorization request, with respect to a recipient who is not hospitalized at the time of the request, that does not include sufficient or adequate documentation. The process must provide a time frame within which a provider may submit the necessary documentation. The time frame must be longer than the time frame specified by Subsection (b)(2)(A) within which a Medicaid managed care organization must issue a determination on a prior authorization request.

Sec. 533.00283. ANNUAL REVIEW OF PRIOR AUTHORIZATION REQUIREMENTS. (a) Each Medicaid managed care organization, in consultation with the organization's provider advisory group required by

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

contract, shall develop and implement a process to conduct an annual review of the organization's prior authorization requirements, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program. In conducting a review, the organization must: [FA1(28x)]

(1) solicit, receive, and consider input from providers in the organization's provider network; and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted.

(c) The commission shall periodically review managed care **organizations'** to ensure compliance with **subsection (a)**. [FA1(29)]

(b) A Medicaid managed care organization may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program, unless the organization has reviewed the requirement during the most recent annual review required under this section.

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a uniform process and timeline for Medicaid managed care organizations to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. In addition to the requirements

CONFERENCE

contract, shall develop and implement a process to conduct an annual review of the organization's prior authorization requirements, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program. In conducting a review, the organization must:

(1) solicit, receive, and consider input from providers in the organization's provider network; and

(2) ensure that each prior authorization requirement is based on accurate, up-to-date, evidence-based, and peer-reviewed clinical criteria that distinguish, as appropriate, between categories, including age, of recipients for whom prior authorization requests are submitted.

(c) The commission shall periodically review **each Medicaid** managed care **organization** to ensure **the organization's** compliance with **this section**.

(b) A Medicaid managed care organization may not impose a prior authorization requirement, other than a prior authorization requirement prescribed by or implemented under Section 531.073 for the vendor drug program, unless the organization has reviewed the requirement during the most recent annual review required under this section.

Sec. 533.00284. RECONSIDERATION FOLLOWING ADVERSE DETERMINATIONS ON CERTAIN PRIOR AUTHORIZATION REQUESTS. (a) In consultation with the state Medicaid managed care advisory committee, the commission shall establish a uniform process and timeline for Medicaid managed care organizations to reconsider an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation. In addition to the requirements

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

of Section 533.005, a contract between a Medicaid managed care organization and the commission must include a requirement that the organization implement the process and timeline. **reconsidering an adverse determination on a prior authorization request that resulted solely from the submission of insufficient or inadequate documentation.**

[FA1(30)-(31)]

(b) The process and timeline must: [FA1(33)]

(1) allow a provider to submit any documentation that was identified as insufficient or inadequate in the notice provided under Section 531.024162; [FA1(34)]

(2) allow the provider requesting the prior authorization to discuss the request with another provider who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and [FA1(35)]

(3) require the Medicaid managed care organization to amend the determination on the prior authorization request as necessary, considering the additional documentation. [FA1(36)-(37)]

(4) [Deleted by FA1(38)]

(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the Medicaid managed care organization only if the determination is not amended under Subsection (b)(3) to approve the request.

(d) The process and timeline for reconsidering an adverse determination on a prior authorization request under this section do not affect: [FA1(39)-(40)]

of Section 533.005, a contract between a Medicaid managed care organization and the commission must include a requirement that the organization implement the process and timeline.

(b) The process and timeline must:

(1) allow a provider to submit any documentation that was identified as insufficient or inadequate in the notice provided under Section 531.024162;

(2) allow the provider requesting the prior authorization to discuss the request with another provider who practices in the same or a similar specialty, but not necessarily the same subspecialty, and has experience in treating the same category of population as the recipient on whose behalf the request is submitted; and

(3) require the Medicaid managed care organization to amend the determination on the prior authorization request as necessary, considering the additional documentation.

(c) An adverse determination on a prior authorization request is considered a denial of services in an evaluation of the Medicaid managed care organization only if the determination is not amended under Subsection (b)(3) to approve the request.

(d) The process and timeline for reconsidering an adverse determination on a prior authorization request under this section do not affect:

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

(1) any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; or [FA1(41)]
(2) any rights of a recipient to appeal a determination on a prior authorization request.
Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. The time frames prescribed by the utilization review and prior authorization procedures described by Section 533.00282 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 533.00284 together may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care. [FA1(42)]

(1) any related timelines, including the timeline for an internal appeal, a Medicaid fair hearing, or a review conducted by an external medical reviewer; or
(2) any rights of a recipient to appeal a determination on a prior authorization request.
Sec. 533.002841. MAXIMUM PERIOD FOR PRIOR AUTHORIZATION DECISION; ACCESS TO CARE. The time frames prescribed by the utilization review and prior authorization procedures described by Section 533.00282 and the timeline for reconsidering an adverse determination on a prior authorization described by Section 533.00284 together may not exceed the time frame for a decision under federally prescribed time frames. It is the intent of the legislature that these provisions allow sufficient time to provide necessary documentation and avoid unnecessary denials without delaying access to care.

SECTION 1. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.038 to read as follows:

Sec. 533.038. COORDINATION OF BENEFITS. (a) In this section:

(1) "Medicaid managed care organization" means a managed care organization that contracts with the commission under *this chapter* to provide health care services to recipients.

(2) "Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient with both Medicaid and primary health benefit plan coverage when the recipient has exceeded the primary health benefit plan coverage limit or

Sec. 533.038. COORDINATION OF BENEFITS. (a) In this section,
(See SECTION 1 above.)

"Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient with both Medicaid and primary health benefit plan coverage when the recipient has exceeded the primary health benefit plan coverage limit or when the

Sec. 533.038. (a) Same as House version.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

when the service is not covered by the primary health benefit plan issuer.

(b) The commission, in coordination with Medicaid managed care organizations, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage.

(c) To further assist with the coordination of benefits, the commission, in coordination with Medicaid managed care organizations, shall develop and maintain a list of services that are not traditionally covered by primary health benefit plan coverage that a Medicaid managed care organization may approve without having to coordinate with the primary health benefit plan issuer and that can be resolved through third-party liability resolution processes. The commission shall review and update the list quarterly.

(d) A Medicaid managed care organization that in good faith and following commission policies provides coverage for a

HOUSE VERSION (IE)

service is not covered by the primary health benefit plan issuer.

(b) The commission, in coordination with Medicaid managed care organizations *and in consultation with the STAR Kids Managed Care Advisory Committee described by Section 533.00254*, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage. *In developing the policy, the commission shall consider requiring a Medicaid managed care organization to allow, notwithstanding Sections 531.073 and 533.005(a)(23) or any other law, a recipient using a prescription drug for which the recipient's primary health benefit plan issuer previously provided coverage to continue receiving the prescription drug without requiring additional prior authorization.*
[FA1(43)]

No equivalent provision. (c) [Deleted by FA1(44)]

No equivalent provision. (d) [Deleted by FA1(44)]

CONFERENCE

(b) Same as House version.

Same as House version.

Same as House version.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

Medicaid wrap-around benefit shall include the cost of providing the benefit in the organization's financial reports. The commission shall include the reported costs in computing capitation rates for the managed care organization.

(e) (e) Same as Senate version.

(f) (f) Same as Senate version.

(g) Notwithstanding Sections 531.073 and 533.005(a)(23) or any other law, the commission shall ensure that a prescription drug that is covered under the Medicaid vendor drug program or other applicable formulary and is prescribed to a recipient with primary health benefit plan coverage is not subject to any prior authorization requirement if:
(1) the primary health benefit plan issuer will pay at least \$0.01 on the prescription drug claim; or
(2) the prescription drug is covered by the primary health benefit plan issuer but the primary health benefit plan issuer will pay nothing on the claim because the recipient has not met the deductible.

No equivalent provision.

(c) Same as Senate version.

(d) Same as Senate version.

Same as House version.

(h) Except as provided by Subsection (g)(2), a prescription drug prescribed to a recipient with primary health benefit plan coverage is subject to any applicable Medicaid clinical or nonpreferred prior authorization requirement if the primary health benefit plan issuer will pay nothing on the prescription drug claim.

No equivalent provision.

Same as House version.

(i) (g) Same as Senate version.

(e) Same as Senate version.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

(j) The commission shall maintain processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, prescribed, or **delivered**, regardless of whether the provider is enrolled as a Medicaid provider. The commission shall allow a provider who is not enrolled as a Medicaid provider to order, refer, prescribe, or **deliver** services to a recipient based on the provider's national provider identifier number and may not require an additional state provider identifier number to receive reimbursement for the services. The commission may seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(k) The commission shall develop **and implement** a clear and easy process **to allow** a recipient with complex medical needs who has established a relationship with a specialty provider **in an area outside of the recipient's Medicaid managed care organization's service delivery area** to continue receiving care from that provider. ***If a provider outside of the organization's service delivery area enters into a single-case agreement with the Medicaid managed care organization to continue providing that care, the single-case agreement is not considered an out-of-network agreement.***

(l) The commission shall develop and implement processes to:

HOUSE VERSION (IE)

(h) ***To the extent allowed by federal law,*** the commission shall maintain processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed, regardless of whether the provider is enrolled as a Medicaid provider. The commission shall allow a provider who is not enrolled as a Medicaid provider to order, refer, or prescribe services to a recipient based on the provider's national provider identifier number and may not require an additional state provider identifier number to receive reimbursement for the services. The commission may seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(i) The commission shall develop a clear and easy process, ***to be implemented through a contract, that allows*** a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider.

No equivalent provision.

CONFERENCE

(f) Same as House version.

(g) Same as House version.

Same as House version.

Senate Bill 1207
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SENATE VERSION

(1) reimburse a recipient with primary health benefit plan coverage who pays a copayment or coinsurance amount out of pocket because the primary health benefit plan issuer refuses to enroll in Medicaid, enter into a single-case agreement, or bill the recipient's Medicaid managed care organization; and
(2) capture encounter data for the Medicaid wrap-around benefits provided by the Medicaid managed care organization under this subsection.

No equivalent provision.

HOUSE VERSION (IE)

SECTION 7. *(a) Section 531.02444(e), Government Code, as added by this Act, applies to a request for a disability determination assessment to determine eligibility for the Medicaid buy-in for children program made on or after the effective date of this Act.*

(b) Section 531.0601, Government Code, as added by this Act, applies only to a child who becomes ineligible for the medically dependent children (MDCP) waiver program on or after December 1, 2019.

(c) Section 531.0602, Government Code, as added by this Act, applies only to a reassessment of a child's eligibility for the medically dependent children (MDCP) waiver program made on or after December 1, 2019.

(d) Notwithstanding Section 531.06021, Government Code, as added by this Act, the Health and Human Services Commission shall submit the first report required by that section not later than September 30, 2020, for the state fiscal quarter ending August 31, 2020.

(e) Not later than March 1, 2020, the Health and Human Services Commission shall:

CONFERENCE

SECTION 7.

(a) Section 531.0601, Government Code, as added by this Act, applies only to a child who becomes ineligible for the medically dependent children (MDCP) waiver program on or after December 1, 2019.

(b) Section 531.0602, Government Code, as added by this Act, applies only to ***an assessment or*** reassessment of a child's eligibility for the medically dependent children (MDCP) waiver program made on or after December 1, 2019.

(c) Notwithstanding Section 531.06021, Government Code, as added by this Act, the Health and Human Services Commission shall submit the first report required by that section not later than September 30, 2020, for the state fiscal quarter ending August 31, 2020.

(d) Not later than March 1, 2020, the Health and Human Services Commission shall:

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

(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.
(f) Sections 533.00282 and 533.00284, Government Code, as added by this Act, apply only to a contract between the Health and Human Services Commission and a Medicaid managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act.
(g) As soon as practicable after the effective date of this Act but not later than September 1, 2020, the Health and Human Services Commission shall seek to amend contracts entered into with Medicaid managed care organizations under Chapter 533, Government Code, before the effective date of this Act to include the provisions required by Sections 533.00282 and 533.00284, Government Code, as added by this Act. [FA1(45)]

(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.
(e) Sections 533.00282 and 533.00284, Government Code, as added by this Act, apply only to a contract between the Health and Human Services Commission and a Medicaid managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act.
(f) As soon as practicable after the effective date of this Act but not later than September 1, 2020, the Health and Human Services Commission shall seek to amend contracts entered into with Medicaid managed care organizations under Chapter 533, Government Code, before the effective date of this Act to include the provisions required by Sections 533.00282 and 533.00284, Government Code, as added by this Act.

SECTION 8. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement the changes in law made by this Act.

SECTION 8. Same as House version.

SECTION 9. Same as Senate version.

SECTION 9. Same as Senate version.

No equivalent provision.

SECTION 2. 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.

Senate Bill 1207
Conference Committee Report
Section-by-Section Analysis

SENATE VERSION

HOUSE VERSION (IE)

CONFERENCE

SECTION 3. 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 10. Same as Senate version.

SECTION 10. Same as Senate version.

SECTION 4. This Act takes effect September 1, 2019.

SECTION 11. Same as Senate version.

SECTION 11. Same as Senate version.

LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION

May 25, 2019

TO: Honorable Dan Patrick, Lieutenant Governor, Senate
Honorable Dennis Bonnen, Speaker of the House, House of Representatives

FROM: John McGeady, Assistant Director Sarah Keyton, Assistant Director
Legislative Budget Board

IN RE: SB1207 by Perry (Relating to the operation and administration of Medicaid, including the Medicaid managed care program and the medically dependent children (MDCP) waiver program.), **Conference Committee Report**

Estimated Two-year Net Impact to General Revenue Related Funds for SB1207, Conference Committee Report: a negative impact of (\$7,407,004) through the biennium ending August 31, 2021.

The bill would make no appropriation but could provide the legal basis for an appropriation of funds to implement the provisions of the bill. The agency 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 agency may, but is not required to, implement a provision of this Act using other appropriations available for that purpose. **Additional costs related to changes to managed care organization capitation rates as a result of changes to third party recoveries cannot be determined at this time.**

General Revenue-Related Funds, Five-Year Impact:

Fiscal Year	Probable Net Positive/(Negative) Impact to General Revenue Related Funds
2020	(\$3,151,464)
2021	(\$4,255,540)
2022	(\$4,449,491)
2023	(\$4,591,927)
2024	(\$6,416,984)

All Funds, Five-Year Impact:

Fiscal Year	Probable Savings/(Cost) from General Revenue Fund 1	Probable Savings/(Cost) from GR Match For Medicaid 758	Probable Savings/(Cost) from Federal Funds 555	Probable Revenue Gain/(Loss) from General Revenue Fund 1
2020	(\$799,369)	(\$2,352,095)	(\$4,058,524)	\$0
2021	(\$727,584)	(\$3,727,549)	(\$6,164,458)	\$149,695
2022	(\$449,545)	(\$4,147,474)	(\$6,385,358)	\$110,646
2023	(\$444,593)	(\$4,279,653)	(\$6,582,726)	\$99,239
2024	(\$444,974)	(\$6,108,961)	(\$6,741,942)	\$102,713

Fiscal Year	Probable Revenue Gain/(Loss) from Foundation School Fund 193
2020	\$0
2021	\$49,898
2022	\$36,882
2023	\$33,080
2024	\$34,238

Fiscal Year	Change in Number of State Employees from FY 2019
2020	18.8
2021	19.1
2022	19.1
2023	19.1
2024	19.1

Fiscal Analysis

The bill would require the Health and Human Services Commission (HHSC) to contract with an external medical review organization to review the resolution of certain appeals of a managed care organization's (MCO's) adverse determination on the basis of medical necessity or an HHSC denial of eligibility based on medical or functional need when the recipient or applicant affirmatively requests an external medical review and would require HHSC to conduct annual surveys and focus groups through the external quality review organization (EQRO) and to calculate an MCO's performance on performance measures using available data if HHSC determines through the EQRO's initial report on the STAR Kids managed care program that additional data and research are necessary to improve the Medically Dependent Children waiver program (MDCP). The bill would require HHSC to submit a quarterly report about access to care for recipients in MDCP. The bill would also require HHSC to develop and maintain a list of services that are not traditionally covered by primary health benefit plans (PHBP) and that a Medicaid managed care organization (MCO) may approve without coordinating with the issuer of the PHBP and that could be resolved through third party liability resolution. The bill would require HHSC to provide certain information on a recipient's third party insurance, including benefits, limits, copayments, and coinsurance. The bill would require HHSC to develop and implement a process to allow a provider who primarily provides services to a recipient through PHBP coverage to receive Medicaid reimbursement for services ordered, referred, or prescribed

regardless of whether the provider is enrolled as a Medicaid provider. The bill would take effect September 1, 2019.

Methodology

Based on estimates provided by HHSC, this analysis assumes that HHSC would require 18.5 FTEs in each fiscal year beginning in fiscal year 2020 to establish and maintain an escalation help line for MDCP and Deaf-Blind Multiple Disabilities (DBMD) waiver program recipients, 0.3 FTEs beginning in fiscal year 2021 to collect, analyze, and report on data required by provisions of the bill, and 0.3 FTEs for indirect administrative support. FTEs include 16.5 Program Specialist VII, 2.0 Manager V, 0.3 Research Specialist V, and 3.0 Texas Works Advisor I and 1.0 Texas Works Advisor II in fiscal year 2020 increasing to 5.0 Texas Works Advisor I, 1.0 Texas Works Advisor II, and 1.0 Texas Works Supervisor I in fiscal year 2021. Total FTE-related costs, including salaries and benefits, is assumed to be \$2.6 million in All Funds, including \$1.2 million in General Revenue, in fiscal year 2020 and \$2.8 million in All Funds, including \$1.2 million in General Revenue, in fiscal year 2021.

HHSC indicates that costs to contract with an external medical review organization would total \$0.7 million in All Funds, including \$0.4 million in General Revenue, in each fiscal year beginning in fiscal year 2020 based on an estimated \$800 per case for review, and a volume of cases based on 50 percent of the number of clients with an appeal related to a medical necessity or eligibility case who request and complete the entire fair hearings process. HHSC estimates the increased costs for additional services from the external quality review organization would total \$0.5 million in All Funds, including \$0.2 million in General Revenue, in each fiscal year beginning in fiscal year 2020.

HHSC estimates costs of \$0.1 million in All Funds, including \$30,000 in General Revenue, for system modifications to Community Services Interest List (CSIL) and auxiliary technology services.

This analysis assumes a cost of \$3.4 million in All Funds, including \$1.3 million in General Revenue, in fiscal year 2020 and \$7.0 million in All Funds, including \$2.7 million in General Revenue in fiscal year 2021, increasing to \$7.7 million in All Funds, including \$3.0 million in General Revenue by fiscal year 2024, related to the requirement for MCOs to establish a process for reconsidering an adverse determination on a prior authorization request that resulted from the submission of insufficient or inadequate information, assuming an effective date of March 1, 2020.

The net increase in client services payments through managed care are assumed to result in an increase to insurance premium tax revenue, resulting in assumed increased collections of \$0.2 million in fiscal year 2021, and \$0.1 million in each fiscal year beginning in fiscal year 2022. Pursuant to Section 227.001(b), Insurance Code, 25 percent of the revenue is assumed to be deposited to the credit of the Foundation School Fund.

Technology

FTE-related technology costs are estimated to total \$0.1 million in All Funds in each fiscal year beginning in fiscal year 2020. System modifications to Community Services Interest List (CSIL) and auxiliary technology services are estimated to total \$0.1 million in All Funds, including \$30,000 in General Revenue in fiscal year 2020.

Local Government Impact

No significant fiscal implication to units of local government is anticipated.

Source Agencies: 529 Health and Human Services Commission

LBB Staff: WP, CMa, EP, MDI, AKi