

SB 1207 (86R)	SB 1648 (87R)	HB 4823 (88R)
<p><u>Sec. 531.024164. EXTERNAL MEDICAL REVIEW.</u></p> <p><u>(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:</u></p> <p><u>(1) identify an appeal that requires an expedited resolution; and</u></p> <p><u>(2) resolve the review of the appeal within a specified period.</u></p>	<p>N/A</p>	<p><u>Sec. 531.024164. EXTERNAL MEDICAL REVIEW.</u></p> <p><u>(e) The commission shall establish a common procedure for conducting external medical reviews. <del>[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.]</del> The <del>[commission shall also establish a]</del> procedure <del>[and time frame for expedited reviews that allows the reviewer to]:</del></u></p> <p><u>(1) must conform to the utilization review and independent review process under Title 14, Insurance Code <del>[identify an appeal that requires an expedited resolution]; [and]</del></u></p> <p><u>(2) must include, at a minimum, the following requirements:</u></p> <p><u>(A) a requirement that the person requesting the external review timely deliver to the external reviewer the recipient's relevant personal and medical information, including, except as provided by Paragraph (B), the recipient's written statement;</u></p> <p><u>(B) in the instance the review relates to a life-threatening condition, a requirement that instead of obtaining a written statement from the recipient the reviewer directly contact:</u></p> <p><u>(i) the recipient or recipient's parent or legally authorized representative; and</u></p>

		<p><u>(ii) the recipient's health care provider;</u></p> <p><u>(C) a requirement that the reviewer notify the recipient or recipient's parent or legally authorized representative, the recipient's health care provider, and the commission if the reviewer does not receive the information described by Paragraph (A) within three business days after the date the reviewer is assigned to conduct the review; and</u></p> <p><u>(D) a requirement that the reviewer request and maintain any other relevant information not provided under Paragraph (A) that is necessary to conduct the review, including:</u></p> <p><u>(i) identifying information about the recipient, the recipient's treating health care providers, health care facilities providing care to the recipient, and the recipient's managed care plan;</u></p> <p><u>(ii) the recipient's plan of care;</u></p> <p><u>(iii) clinical information about the recipient's diagnosis and medical history related to the diagnosis;</u></p> <p><u>(iv) the recipient's prognosis; and</u></p> <p><u>(v) the recipient's treatment plan prescribed by a health care provider and the provider's justification of the services contained in the plan;</u></p> <p><u>(3) must ensure that the recipient and the recipient's health care provider are given the opportunity to provide input and additional evidence during the review; and</u></p> <p><u>(4) may not prohibit a recipient, a recipient's parent or legally authorized representative, or the recipient's health care provider from submitting any information or documentation the person determines</u></p>
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<p><u>Sec. 533.038. COORDINATION OF BENEFITS.</u></p> <p><u>(a) In this section, "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 service is not covered by the primary health benefit plan issuer.</u></p> <p><u>(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.</u></p> <p><u>(c) If the commission determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, the Medicaid managed care organization that paid the claim shall work with the</u></p>	<p><u>Sec. 533.038. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS.</u></p>	<p><u>Sec. 533.038. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS.</u></p> <p><u>(a) In this section:</u></p> <p><u>(1) "Complex medical needs" means:</u></p> <p><u>(A) the condition of having one or more chronic health problems that:</u></p> <p><u>(i) affect multiple organ systems;</u></p> <p><u>and</u></p> <p><u>(ii) reduce cognitive or physical functioning and require the use of medication, durable medical equipment, therapy, surgery, or other treatments; or</u></p> <p><u>(B) a life-limiting illness or rare pediatric disease, as defined by Section 529(a)(3) of the Food and Drug Administration Safety and Innovation Act (21 U.S.C. 360ff(a)).</u></p> <p><u>(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 when the service is not covered by the primary health benefit plan issuer.</u></p> <p><u>(3) "Specialty provider" means a person who provides health-related goods or services to a recipient, including a provider of medication, therapy services, durable medical equipment, life-sustaining or life-stabilizing treatment, or any other treatment, services, equipment, or supplies</u></p>

commission on the recovery process and make every attempt to reduce health care provider and recipient abrasion.

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

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

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

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

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

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

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

(f) 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

necessary to improve health outcomes, prevent emergency room visits, maintain health care in the home and community, and avoid admission to a health care facility or other institution.

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.

(g) 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.

(g) 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, regardless of whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage.

(h) If a recipient who has complex medical needs wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the managed care plan in which the recipient is enrolled, the managed care organization shall develop a simple, timely, and efficient process to and shall make a good-faith effort to negotiate a single-case agreement with the specialty

(g) 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 at any time with a specialty provider to continue receiving care from that provider, regardless of:

(1) whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage;

(2) the date the recipient enrolled in the managed care plan provided by the Medicaid managed care organization; or

(3) whether the provider is an in-network provider.

(h) If a recipient who has complex medical needs and who does not have primary health benefit plan coverage wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the managed care plan in which the recipient is enrolled, the managed care organization shall develop a simple, timely, and efficient process to and shall make a

	<p><u>provider. Until the Medicaid managed care organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rule, including 1 T.A.C. Section 353.4.</u></p> <p><u>(i) A single-case agreement entered into under this section is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements.</u></p>	<p>good-faith effort to, negotiate a single-case agreement with the specialty provider. Until the Medicaid managed care organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rule, including 1 T.A.C. Section 353.4.</p> <p><u>(j) The cancellation of a contract between a Medicaid managed care organization and a specialty provider under which the provider agrees to provide in-network services to recipients does not void or otherwise affect that organization's duty under Subsection (g) to provide continuity of care to recipients with complex medical needs, except if the cancellation is the result of fraud, waste, or abuse, as determined by the commission's office of inspector general. In the event of cancellation, the recipient has the right to select the recipient's preferred specialty provider.</u></p>