SESSION HIGHLIGHTS:

87TH TEXAS LEGISLATURE

WORKING TOWARD QUALITY, AFFORDABLE, TRANSPARENT HEALTH CARE FOR ALL TEXANS

TAHP

The Texas Association of Health Plans

About TAHP

Led by a team of experienced health care policy experts, the Texas Association of Health Plans (TAHP) is the statewide trade association representing health insurers, Medicaid plans, Medicare Advantage plans, and other related health care entities operating in Texas.

For three decades, TAHP has been a leader on issues that improve the lives of Texans and strengthen health care in Texas.

TAHP is dedicated to promoting affordable health care for all Texans through advocacy and education. It is our goal to increase public awareness about our members' services, health care delivery benefits, and contributions to communities throughout the state. TAHP strives to build and foster valuable relationships with its members, industry, and community stakeholders, as well as with representatives of the Texas Legislature and state agencies.

Letter from the CEO

Dear Texan,

This guide is a summary of health care legislation from the 87th Texas Legislature and how it affects health care coverage in the state. With the COVID-19 crisis as a backdrop, we knew that health care would be an essential part of this session's policy discussions.

From a focus on telehealth and telemedicine to expanding coverage for mothers on Medicaid, lawmakers tackled some of the most pressing issues in our state. Many bills reflected the division of parties in our state government but others inspired bipartisan support and compromise.

In this guide, we offer summaries of passed legislation to help you understand each bill individually but also to share a more comprehensive overview of health care policy reflecting where Texas is headed. One thing that became clear both throughout the COVID-19 response and then through policy debates this session is that health care only works when all the players are at the table: providers, administrators, patients, and payers.

At the Texas Association of Health Plans, we are proud to represent health plans and their interests in creating a healthier Texas. We are committed to finding policies that provide the right care at the right time for everyone in the state. We are thankful to our members, lawmakers, legislative staff, coalition partners, and everyday Texans who are working to make health care work.

In addition to this guide, please consider the Texas Association of Health Plans a resource for you when it comes to Texas health care policy. You'll always find new content on our website, www.tahp.org, or feel free to reach out to us directly.

Sincerely,

Jamie Dudensing

Jamie Dudensing, RN
CEO
Texas Association of Health Plans

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The Texas Association of Health Plans

...monitored **433 bills,** of which
133 received a hearing

...actively supported
59 bills

...actively opposed
47 bills

...testified
59 times

...submitted
79 position cards

...submitted
82 written testimonies

...produced
51 hearing recaps

10 Things You

1

The State Budget

SB 1 includes $163 billion in General Revenue funds and $248 billion in the All Funds General Appropriations bill for 2022-2023. $23.5 billion in GR and $64 billion in All Funds have been appropriated for Medicaid client services. The Governor will call a special session this fall to determine how to appropriate federal relief funding.

2

Postpartum Medicaid Coverage Expansion

The Legislature extended Medicaid coverage for women by 4 months to allow for a total 6 months of postpartum coverage through HB 133.

3

Insulin Copay Cap

After several pieces of similar legislation failed to pass, SB 827 succeeded in capping insulin copays at $25 per prescription for a 30-day supply of insulin listed on an insurer's formulary.

4

Texas Cares Rx Program

Without expanding Medicaid, HB 18 establishes a program to provide uninsured Texans access to prescription drugs at "post-rebate" prices.

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Alternative Coverage

Two bills allow the Texas Farm Bureau and Texas Mutual to offer alternative forms of health "coverage" that are not subject to the state's health insurance rules and regulations.

Need to Know

Telehealth Expansion

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To continue ensuring equitable access to care for Medicaid families, the Legislature made permanent many temporary telehealth solutions introduced during the COVID-19 pandemic. Additionally, a priority bill additionally expands the Governor's broadband development council in order to move the state towards widespread broadband access.

PA Gold-Carding

7

Prohibits a health plan from applying prior authorization (PA) medical criteria to most health care services.

Healthy Texas Women's Carve-In

8

Makes Medicaid Managed Care Organizations responsible for administering the Healthy Texas Women's program which means women will get to keep their health plan, doctors and insurance card in-between pregnancies.

Cancer Screening Benefit Mandates

9

Three new mandates expand current mandated benefits for ovarian cancer screening, breast cancer diagnosis and screening, and colorectal cancer screening to include additional forms of testing and screening.

Health Care Cost Transparency and APCD

10

Recognizing rapidly rising health care costs and the lack of transparency in the health care system, the Legislature passed a bill incorporating recent federal transparency rules into state law.

Key Health Care Legislation

TAHP
The Texas Association of Health Plans

During the 87th Legislature, the Texas Association of Health Plans advocated to maintain a competitive health insurance market and strong Medicaid managed care program in Texas. TAHP worked to educate legislators and their staff on the negative consequences of overly-prescriptive regulations and burdensome government mandates that stifle innovation in the Medicaid program and drive up the cost of health coverage. TAHP and its member plans prevented many measures, including those that would have restricted private market negotiations, reduced competition, negatively impacted the ability of MCOs to provide high quality care, increased costs for Texans, and limited affordable health plan coverage options, from advancing this session.

COVID-19 Related Legislation

This session, the Legislature addressed a number of issues stemming from and highlighted by the COVID-19 pandemic, including protections against expected COVID-related lawsuits, the establishment of an institute to protect Texas public health and support disaster preparedness, and updating the licensure of certain providers to allow the administration of vaccines for communicable diseases.

Home Health Administration of COVID-19 Vaccines

HB 797 by Reps. Howard, Price, Jetton, Guerra, and Klick

Due to a technicality in prior law, home care and hospice nurses in Texas could not administer COVID-19 vaccines. Despite home care and hospice employees being clinically authorized to administer the COVID-19 vaccine as licensed nurses, their employers were prohibited from handling a vaccine that was not explicitly listed in their licensing statute, which effectively prevented them from administering the COVID-19 vaccine. HB 797 updates the licensing statute of home care and hospice agencies to grant a narrow exemption for COVID-19 and other FDA-approved vaccines for communicable diseases. This will allow home care and hospice nurses to administer the COVID-19 vaccine to vulnerable Texans safely in their homes.

Signed by the Governor. Effective May 18, 2021.

COVID-19 Liability Protections

SB 6 by Sen. Hancock et al.

This legislation addresses widespread concerns regarding the long-term effects of the COVID-19 pandemic on the state's health care system, business infrastructure, and educational institutions, including potential lawsuits. SB 6 provides retroactive liability protection for physicians, health care providers, first responders, educational institutions and other parties who may have exposed an individual to a pandemic disease.

The liability protection will not apply if the claimant can establish that the person or institution who exposed them knowingly failed to warn of or remediate a condition likely to result in exposure. Additionally a claimant would need to show the person or institution had a reasonable opportunity and ability to remediate the risk or warn the individual before contact. The liability protection will also not apply if the person who caused the exposure knowingly failed to implement or comply with government-promulgated standards, guidance, or protocols intended to lower the likelihood of exposure and if they had a reasonable opportunity to comply with the standards but refused to do so. In either scenario, the claimant must also show reliable scientific evidence that the failure to warn, remediate, implement or comply with government-promulgated standards was the cause in fact of the individual contracting the disease. The bill also establishes standards for such lawsuits.

Applies only to an action commenced on or after March 13, 2020, for which a judgment has not become final before the effective date.

Signed by the Governor. Effective immediately.

Workers' Compensation Presumptions for COVID-19

SB 22 by Sen. Springer et al.

SB 22 provides that a detention officer, corrections employee, firefighter, peace office, or EMT who suffered from COVID-19 (as shown by an FDA-approved test) that resulted in death or disability would be presumed to have contracted the virus or disease during the course and scope of employment if the person was employed in the area designated in a disaster declaration by the governor related to SARS-CoV-2 or COVID19 and contracted the disease during the disaster. The bill includes a provision preventing subrogation — health plans are prohibited from recovering claim payments from workers' compensation carriers for services that should be reimbursable under workers compensation coverage.

The changes apply to a claim for benefits pending on or filed on or after the effective date of this Act. A claim for benefits filed before that date is covered by the law in effect on the date the claim was made.

Signed by the Governor. Effective immediately.

Epidemic Health Institute

SB 1780 by Sen. Creighton

SB 1780 establishes the Texas Epidemic Public Health Institute, which, through a network of public health professionals, community health workers, state and local public health agencies, health care organizations, universities throughout Texas, and others, will coordinate state efforts to protect public health in Texas and support pandemic and epidemic disaster preparedness efforts.

Effective September 1, 2021.

Telemedicine Legislation

This session, the Legislature made several long-term policy changes to allow telehealth to address patients' needs beyond the COVID-19 crisis, including expanding high-speed broadband internet access. The Legislature also made permanent many temporary policies implemented during the COVID crisis to ensure that telehealth can address patients' needs without adopting costly mandates such as payment parity and audio-only mandates.

Expanding Telemedicine Access in Medicaid

HB 4 by Reps. Price, Oliverson, Coleman, Ashby, and Guillen

The COVID-19 crisis demonstrated the importance of telehealth in the Texas Medicaid program.

These temporary telehealth solutions improved the program and proved to be popular among Texas Medicaid families. HB 4 makes many of these solutions permanent and improves greater access to health care by ensuring that telehealth can continue to address patients' needs beyond the crisis.

The bill requires HHSC to establish policies and procedures by rule to allow an MCO to conduct assessments and care coordination services using telecommunications or information technology to the extent the MCO determines is appropriate for the client and the client requests and consents (either verbally or written). If an MCO conducts an assessment of or provides care coordination services to a recipient using telecommunications or information technology, the MCO must monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse and determine whether additional social services or supports are needed.

The bill requires HHSC to determine categories of recipients of home and community-based services who must receive in-person visits and requires an MCO to provide those persons at least one in-person visit, except during emergency circumstances, to make an initial waiver eligibility determination and conduct additional in-person visits with the recipient if necessary as determined by the MCO. HHSC may on a case-by-case basis require MCOs to discontinue the use of telecommunications or information technology for assessment or service coordination services if it determines that the discontinuation is in the best interest of the recipient.

Additional provisions in the bill include:

- HHSC must ensure by rule that rural health clinics may be reimbursed as both the patient and the distant site (where the provider is delivering service) for telemedicine and telehealth services.
- To the extent permitted by federal law and to the extent that it is cost-effective and clinically effective, HHSC must ensure clients have the option to receive preventive health and wellness services, case management services, behavioral health services, therapy services (PT, OT, ST), nutritional counseling services assessment services, outpatient chemical dependency treatment services via telemedicine or

telehealth delivery modes.

- To the extent permitted by federal law and to the extent that it is cost-effective and clinically effective, HHSC by rule must develop a system that ensures behavioral health services may be provided via audio-only communication.
- MCOs may reimburse providers for home telemonitoring services for conditions or risk factors other than those that are currently in law, as long as the reimbursement for the service is cost-effective and clinically effective.
- HHSC must consider the availability of telehealth and telemedicine services for MCO network adequacy requirements.
- HHSC must develop guidelines to allow an MCO to communicate with clients via text message.
- Requires changes to a Medicaid recipient's enrollment application to allow them to select their preferred method of contact and for that information to be shared with their MCO. The application will also allow the client to provide consent for MCOs to communicate with the client via their preferred method, including via text message.

Signed by the Governer. Effective immediately but allows HHSC to delay implementation pending federal approval.

Broadband Expansion

HB 5 by Reps. Ashby, Anderson, Paddie, Price, and Canales

Hundreds of thousands of Texans are currently without access to quality broadband; this bill will move Texas forward in bridging the digital divide. HB 5 expands the governor's broadband development council, which will research the progress of broadband development in unserved areas, deployment of broadband statewide, purchase of broadband by residential and commercial customers, and patterns and discrepancies in access. "Broadband service" means internet service capable of providing a download speed of at least 25 Mbps and an upload speed of at least 3 Mbps (and may be altered to meet federal thresholds).

The bill creates the broadband development office within the comptroller's office and a broadband development account in the general revenue fund. The development office will annually publish a map classifying designated areas in Texas as an eligible area if less than 80% of the addresses have access to broadband service. It will also establish a program to award financial incentives to applicants for the purpose of expanding access to and adoption of broadband service in eligible areas. In developing the state broadband plan, the office must collaborate with state agencies, political subdivisions, industry stakeholders and representatives, and community organizations. The office must also consider recommendations of the broadband development council, favor policies that are technology-neutral and protect all members of the public, explore state and regional approaches to broadband development, and examine broadband service needs related to public safety, public education and public health.

Signed by the Governor. Effective immediately.

Teledentistry

HB 2056 by Reps. Klick and Guerra

This bill allows dentists and dental professionals to communicate and share patient information, which will expand access to dental care professionals. It amends the current telehealth statute to include teledentistry, dentists, and dental hygienists. It additionally gives the Texas State Board of Dental Examiners authority to promulgate rules to ensure that appropriate quality care is provided, prevent fraud and abuse, ensure adequate supervision of non-dentist health professionals, and establish the maximum number of non-dentist health professionals that a dentist may supervise through a teledentistry service. The same licensing requirements apply to teledentistry as for in-person services.

HB 2506 also mandates Medicaid coverage of teledentistry and requires HHSC to adopt rules requiring payment parity in the fee-for-service program (but not in managed care) and may not limit a dentist's choice of platform. The bill also adds teledentistry to the Insurance Code telehealth coverage mandate.

Effective September 1, 2021.

Insurance Code provisions effective January 1, 2022 (but not upon issuance or renewal of health plans after that date).

Telehealth for TDLR Health Professionals

SB 40 by Sen. Zaffirini

Recommended by the Texas Department of Licensing and Regulation (TDLR) based on strategic plans to protect public health in response to the COVID-19 pandemic, SB 40 eliminates regulatory barriers and allows health professionals regulated by TDLR to provide telehealth services in accordance with current telehealth law. The bill does not amend the Insurance Code or apply the current health plan coverage mandate to these additional providers.

Signed by the Governor. Effective immediately.

Consumer Protection Legislation

The COVID crisis exacerbated the predatory actions of many independent free-standing emergency rooms (FSERs). This session, the Legislature provided needed consumer protections by requiring HHSC to impose penalties on FSERs that price gouge Texans during a disaster. The Legislature also took steps to address some shortcomings of Texas's balance billing law by allowing county- and municipality-owned air and ground ambulances the option to not balance bill consumers.

Mental Health Parity Complaint Portal

HB 2595 by Reps. Price, Smith, Allison, Meza, and Rose

HB 2595 creates a portal for complaints by health benefit plan enrollees regarding mental health parity and requires the development of additional educational materials and training on parity laws for mental health conditions. The bill also designates October as Mental Health Condition and Substance Use Disorder Parity Awareness Month to increase awareness of and compliance with state and federal requirements regarding benefits for mental health conditions and substance use disorders.

Signed by the Governor. Effective September 1, 2021.

County and Municipal Ambulances

SB 790 by Sen. Zaffirini

Public entities may prefer to not balance bill consumers for STAR Flight and ground ambulance services. However, the interpretation of some counties and cities is that state law requires them to try recovering any and all monies owed. SB 790 allows county- and municipality-owned air and ground ambulances the option to accept health plan payments as payment in full and not balance bill enrollees. The bill also requires TDI to conduct a study on the balance billing practices of ground ambulance service providers, variations in prices, proportions of services that are in-network, trends in network inclusion, and factors contributing to the network status of ground ambulances. TDI must submit a report on the study to the legislature by Dec. 1, 2022.

Signed by the Governor. Effective September 1, 2021.

State Emergency Preparedness

SB 968 by Sen. Kolkhorst

The COVID-19 pandemic brought to light various challenges and opportunities to improve the state's preparedness to address a public health disaster. SB 968 seeks to ensure that Texas is better prepared for a future public health emergency or disaster by improving the public health disaster response and coordination between state agencies. The bill also seeks to protect the rights of individuals during a public health crisis and provides DSHS more timely medical information from physicians and healthcare professionals during a public health crisis.

Major provisions in the bill include:

- **Texas Medical Board (TMB):** Defines "nonelective medical procedure" and prohibits TMB during a declared state of disaster from issuing an order or adopting a regulation that limits or prohibits a nonelective medical procedure. The bill does authorize TMB during a declared state of disaster to issue an order or adopt a regulation imposing a temporary limitation or prohibition on a medical procedure other than a nonelective medical procedure only if the limitation or prohibition is reasonably necessary to conserve resources for disaster response. The bill prohibits an order issued or regulation adopted under this subsection from continuing for more than 15 days unless renewed by TMB and provides that a person subject to an order issued or regulation adopted under this section who in good faith acts or fails to act in accordance with that order or regulation is not civilly or criminally liable.
- **Personal protective equipment (PPE):** Requires the Texas Division of Emergency Management (TDEM) to enter into a contract with a manufacturer or wholesale distributor of PPE that guarantees a set amount and stocked supply of the equipment for use during a public health disaster. When entering into a contract for PPE, TDEM must pursue all available federal funding to cover the costs and must ensure that the manufacturer is located in the United States to the extent practicable.
- **Immunizations:** Requires DSHS to develop and implement a disease prevention information system for dissemination of immunization information during a declared state of disaster or local state of disaster.It requires that during a declared disaster, educational materials regarding immunizations are available to local health authorities for distribution. The bill also requires DSHS to maintain a registry of persons who receive an immunization or antiviral, and other medication, administered to prepare for a potential disaster, public health disaster, terrorist

attack, hostile military or paramilitary action, or extraordinary law enforcement and requires health care providers who administer an immunization or antiviral to provide the data elements to DSHS.

- **Vaccine Passport**: Prohibits a governmental entity in Texas from issuing a vaccine passport or other standardized documentation to certify an individual's COVID-19 vaccination status for a purpose other than health care. The bill also prohibits a business in Texas from requiring a customer to provide any documentation certifying the customer's COVID-19 vaccination or post transmission recovery to enter or gain access to, or to receive service from the business.
- **State Epidemiologist**: Establishs an Office of Chief State Epidemiologist within DSHS to provide expertise in public health activities and policy in this state by evaluating epidemiologic, medical, and health care information, and by identifying pertinent research and evidence-based best practices.

The bill outlines declarations of public health disasters and emergencies as follows:

- Authorizes the commissioner of DSHS to declare a statewide or regional public health disaster or order a statewide or regional public health emergency if the commissioner determines an occurrence or threat to public health is imminent and if the governor declares a state of disaster.
- Provides that a public health disaster or public health emergency expires on the 30th day after the date of declaration and authorizes renewal by the Legislature or by the commissioner with the approval of a designated legislative oversight board.
- Requires that a declaration or order issued under this section include certain information regarding the description, scope, and nature of the disaster or emergency and that the order issued be disseminated promptly.
- Requires the commissioner, after declaring a public health disaster or ordering a public health emergency, to consult with the Task Force on Infectious Disease Preparedness and Response, including any subcommittee the task force forms to aid in the rapid assessment of response efforts.

The bill also establishes requirements related to wellness checks for individuals designated as medically fragile, including:

- Requires TDEM, in collaboration with HHSC and DSHS, to adopt rules regarding which events require a wellness check and to adopt procedures for conducting wellness checks.
- Requires TDEM to develop a process for designating individuals who are included in the emergency assistance registry as medically fragile and requires TDEM to authorize the following persons to access the emergency assistance during an emergency event: HHSC; DSHS; first responders; local governments; and local health departments.
- Requires TDEM to collaborate with the persons authorized to access the emergency assistance registry and with applicable municipalities and counties to ensure that a wellness check is conducted on each medically fragile individual listed in the emergency assistance registry to ensure the individual has continuity of care and the ability to continue using electrically powered medical equipment, if applicable.
- Requires that a wellness check on a medically fragile individual includes: an automated telephone call and text to the individual; a personalized telephone call to the individual; and if the individual is unresponsive to a telephone call, an in-person wellness check.

Effective immediately.

Unauthorized Business of Insurance

SB 1809 by Sen. Hancock

Modern technology makes it possible for people who are not authorized to conduct the business of insurance in Texas to expand their reach and unlawfully collect millions of dollars in a short period of time. A combination of the high burden of proof, short timelines for administrative hearings, and limited administrative sanction options makes it difficult for TDI to stop these sellers before consumers are harmed.

SB 1809 strengthens TDI's enforcement authority over unauthorized insurance by revising emergency cease and desist order procedures, giving TDI more options to take action against a violator, and removing certain burdensome deadlines, among other changes. It increases the maximum penalty for unauthorized insurance from $10,000 to $25,000.

Signed by the Governor. Effective Sept. 1, 2021.

FSER Prices During Disaster

SB 2038 by Sen. Menéndez

During the height of the COVID-19 pandemic, many Texans went to FSERs for COVID testing because those FSERs advertised a quick turnaround time for results. Because these facilities are designed to treat patients experiencing medical emergencies, they have the ability to charge facility and physician fees that are exorbitantly high in comparison to other types of medical facilities. Many FSERs tacked these same fees onto bills for COVID tests. In one example, an FSER in Tarrant County billed more than $15,000 for a COVID test, including charges

for facility fees, routine supplies, and physician fees, even though the billed charge for the test itself was only $250. While the tests were provided at no direct cost to the consumer, many reporters and consumers expressed concerns about the high prices facilities charged insurance companies for COVID-19 tests, which will eventually be passed along to consumers through higher insurance premiums. SB 2038 creates new consumer protections, prohibiting FSERs from charging unconscionable prices during a declared state of disaster and establishing administrative penalties for violations.

An FSER that is subject to the bill and provides testing or vaccination for an infectious disease based on a declared state of disaster must disclose its prices for the test or vaccine. FSERs are also prohibited from charging a facility or observation fee related to services, including testing or vaccination, accessed from a patent's vehicle (this provision is not limited to during a declared disaster). The bill clarifies that these provisions may not be construed as expanding the type of health care services an FSER is authorized to provide.

During a state of disaster, FSERs are also prohibited from charging an individual an unconscionable price or knowingly or intentionally charging a third-party payor, including a health plan, a higher price than it charges individuals for the same product or service based on the coverage. This applies to a price more than 200% of the average price for the same or substantially similar service or product provided by facilities in the same or nearest county according to DSHS data. An FSER is not prohibited from offering an uninsured individual a cash discount or accepting full payment directly from an individual in lieu of submitting a claim to a health plan.

The bill requires HHSC to impose a $10,000 administrative penalty for the first violation and a $50,000 administrative penalty as well as a 30-day license ruspension for the second violation. A permanent license revocation is required for a third violation. The bill includes exceptions to these penalty amounts for good cause shown.

Effective September 1, 2021.

Provider Access Legislation

Texas has a provider access problem—our state does not yet have enough providers to meet the needs of a rapidly growing population nor enough providers in rural areas to meet the needs of our less well-connected populations. This session, the Legislature adopted a handful of measures to increase and facilitate patients' ability to access health care providers.

Treatment by a Physical Therapist Without a Referral

HB 1363 by Reps. Minjarez and Guillen

Legislation passed last session allowed a physical therapist to provide services to a patient for up to 15 days without a physician referral. This provision applied to physical therapists who have a doctoral degree and have completed residency or fellowship training. HB 1363 expands the types of physical therapists this provision applies to by adding "certified by an entity approved by the board" as an alternative to completion of a residency or fellowship. A doctoral degree is still required.

Signed by the Governor. Effective September 1, 2021.

Interstate Medical Licensure Compact

HB 1616 by Reps. Bonnen, A. Johnson, and Shaheen

Texas needs a robust supply of physicians to meet the demands of its growing population. The COVID-19 pandemic gave rise to dramatic progress in the use and acceptance of telemedicine by both health care providers and patients. Expansion of telemedicine provides opportunities for providers to reach out to patients and give care across state borders. The choice and ability to practice medicine in multiple states could help meet these demands and make quality health care more accessible. HB 1616 aims to create a voluntary, expedited pathway to licensure for qualified physicians who wish to practice in multiple states through the Interstate Medical Licensure Compact while ensuring that physicians are still subject to the laws and licensing regulations of each state in which they deliver care.

Signed by the Governor. Effective September 1, 2021.

Out-of-State MD Study

SB 284 by Seliger

During the COVID-19 pandemic, some state licensing requirements were waived for out-of-state licensed physicians, allowing them to temporarily practice in Texas during the pandemic. SB 284 requires the Texas Medical Board to complete a one-time report on the basic performance of these physicians, such as number of board disciplinary reviews and actions against them.

Signed by the Governor. Effective immediately.

Coverage Expansion and Alternative Coverage

With the intent to provide uninsured Texans with more options for health coverage, the Legislature passed several bills this session that expand the ability of entities to provide alternative coverage options and act as insurance providers without being subject to the same strict regulatory requirements as those companies licensed and regulated as insurers. Over the course of the session, TAHP and our members educated members on how these efforts to expand "insurance-like" coverage pose a threat to Texans with preexisting conditions, Texans that rely on comprehensive coverage in the individual market, and the stability of the Texas insurance market itself. Other forms of expansion include an extention of Medicaid postpartum care coverage and an innovative strategy to help uninsured Texans receive affordable prescription drugs.

"Texas Cares" Rx Coverage Program

HB 18 by Reps. Oliverso, Bonnen, Collier, Canales, and Burrows

HB 18 seeks to ensure that qualifying Texans without prescription drug benefits are not forced to go without prescribed medications due to cost. It establishes a program to provide uninsured Texans access to prescription drugs at a "post-rebate" price. The bill does not expand the Medicaid program.

Signed by the Governor. Effective September 1, 2021.

Postpartum Coverage Expansion and Healthy Texas Women's Program

HB 133 by Reps. Rose, S. Thompson, Walle, Tierry, and Reynolds

Medicaid plays a significant role in improving maternal health and helping to eliminate preventable maternal mortality. The most significant barrier preventing health plans from improving care for new mothers is the short timeframe for Medicaid eligibility before and after pregnancy. Texas Medicaid currently only covers women for 60 days past delivery, and research shows the majority of maternal deaths in Texas occur after the mother loses her Medicaid coverage. HB 133 extends Medicaid coverage for pregnant women by 4 months to allow for 6 months total of coverage postpartum.

The bill also transitions the Case Management Program for Children and Pregnant Women and the Healthy Texas Women's Program (HTW), currently administered by HHSC through fee-for-service, into managed care. The Case Management program was established when the majority of clients were served in fee-for-service because there was no mechanism for case management in that delivery model. Now that the majority of these clients are in managed care, this program will be carved-in and coordinated by MCOs, which provide case management to the majority of these clients today. The Healthy Texas Women's program offers family planning services and limited benefits for uninsured women in Texas through a 1115 demonstration waiver. Carving this program into managed care will allow a woman to be able to stay with her health plan and keep her doctors in between pregnancies.

The bill requires that HHSC consult with the State Medicaid Managed Care Advisory Committee on the transition into managed care and to identify barriers that prevent women from obtaining HTW services and seek opportunities to mitigate those barriers. The bill also requires that HHSC designate HTW providers as significant traditional providers until at least the third anniversary of the date of transition into managed care, which means the MCOs must offer these providers a contract to be in network with the plan. To help women identify coverage options, HHSC and each MCO must provide each woman in HTW a written notice containing information about enrollment in a health benefit plan for which an enrollee may receive a premium subsidy under the Affordable Care Act. The bill requires HHSC and TDI to coordinate on the development of the form and content of the notice.

The budget includes a contingency rider to fund both the 6 months coverage and the carve-in of the Healthy Texas Women's Program.

HHSC is only required to implement provisions in this bill if the Legislature appropriates money specifically for that purpose, and HHSC may delay implementation pending federal approval.

Signed by the Governor. Effective September 1, 2021.

Texas Mutual Alternate Coverage

HB 3752 by Reps. Frank, Oliverson, Raymond, and White

HB 3752 allows the Texas Mutual Insurance Company to create, own, or operate subsidiaries that offer "real" health insurance under a TDI certificate of authority or another type of health benefit coverage or plan that

is not an insurance policy or product subject to Texas workers' compensation law and may be offered to individuals, small businesses (no more than 250 full-time equivalent employees), or the company's policyholders and their employees.

A subsidiary of the company may not offer or issue an occupational policy for an employer or an employer's employees covering an occupational bodily injury, disease, or death that explicitly provides liability coverage to an employer that elects not to maintain workers' compensation coverage.

In developing health coverage or plan options to be offered through a subsidiary, the company must fully explore all options that may be offered and place emphasis on:

- increasing competition in the health insurance market
- utilizing innovations that improve the quality of health care while lowering costs
- ensuring adequacy of benefits and access to care for individuals with preexisting conditions
- issuing coverage in a manner that does not discriminate against individuals with preexisting conditions
- leveraging federal tax credits that may be available for private health benefit plans to the greatest extent possible to increase the affordability of coverage
- ensuring transparency and coherence of costs and coverage to inform shoppers
- reducing incidences of medical debt faced by individuals and uncompensated care faced by providers
- ensuring equitable costs regardless of gender or prospects of pregnancy or childbirth

The company must submit a report to the Legislature by September 1, 2022, explaining how any anticipated health benefit coverage offerings would comply with all considerations and guiding principles for developing health benefit coverage offerings. No coverage may be offered under the bill before September 1, 2023.

Other than the new chapter created by the bill, insurance code provisions that do not expressly mention alternative health benefit coverage do not apply. A subsidiary of the company that acts in accordance with the bill in offering alternative coverage is not an insurer and is not engaging in the business of insurance in this state. TDI may adopt rules as necessary to implement the bill, except with respect to alternative health benefit coverage.

Effective September 1, 2021.

Farm Bureau Alternate Coverage

HB 3924 by Reps. Oliverson, Anderson, Middleton, Frank, and T. King

HB 3924 allows a nonprofit agricultural organization to offer health "coverage" that is exempt from the regulatory authority of TDI. The bill requires that the organization provide a written notice to applicants for coverage and obtain acknowledgment that the coverage is not insurance subject to state regulation. A nonprofit agricultural organization acting in accordance with the law is not considered to be engaging in the business of health insurance.

The bill provides consumer balance billing protections for some services (the services included in commercial balance billing provisions). It prohibits balance billing by non-network providers, requiring the organization to pay a "usual and customary rate," defined as the relevant allowable amount as described by the applicable master benefit plan document, and subjects claims to the mediation and arbitration processes established under the Insurance Code.

Effective September 1, 2021.

High Risk Pool Coverage

SB 874 by Sen. Hancock

The 85th and 86th Texas Legislatures passed legislation to provide a "safety net" for Texas should federal action allow for or require state risk or reinsurance pools to cover individuals with high cost medical conditions or provide reinsurance, thus allowing carriers to reduce health insurance premiums. Federal action may be taken and/or federal funding may become available before the next Texas legislative session, so provisions must be made in state law this session to permit TDI to access the possible federal funds on an interim basis. SB 874 extends the provisions to August 31, 2023.

Signed by the Governor. Effective immediately.

Transparency Legislation

This session saw the Legislature pass significant transparency measures at the state level that closely mirror federal transparency efforts. TAHP and its members have always supported increased transparency, and TAHP worked closely with members and other stakeholders to ensure that the legislation was crafted in a manner that would be most useful for consumers and to mitigate the regulatory burdens that contribute to the overall cost of health care.

Health Care Cost Transparency

HB 2090 by Reps. Burrows, Oliverson, Frank, Bonnen, and Middleton

HB 2090 incorporates recent federal transparency rules into state law. It requires health plans and plan administrators (including for ERS and TRS) to provide detailed disclosures regarding an enrollee's cost-sharing for a service or supply. The bill also allows for the creation of an all-payors claim database.

Cost-Sharing Estimator Tool: Health plans and issuers must make personalized out-of-pocket cost information available to enrollees for covered items and services, including information on negotiated rates, through an internet-based self-service tool and in paper form upon request. Cost-sharing tools must allow enrollees to obtain real-time estimates of their cost-sharing liability that are personalized and accurate based on their plan and coverage. This includes estimated cost-sharing amounts, accumulated amounts, in-network rates, out-of-network allowed amounts, items and services included in bundled payment arrangements, notice of prerequisites to coverage, and several disclosure notices. The information must also be available to enrollees upon request in plain language in a physical form at no cost. Enrollee disclosure requirements apply to plans issued or renewed on or after January 1, 2024.

Machine Readable Files: For plan years beginning on or after January 1, 2022, plans and issuers must make detailed pricing information publicly available through three separate machine-readable files showing negotiated rates for all covered items and services between the plan or issuer and in-network providers, historical payments to and billed charges from out-of-network providers, and in-network negotiated rates and historical payment net prices for all covered prescription drugs by plan or issuer at the pharmacy location level.

These requirements do not apply to plans for which the federal reporting requirements (under 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 45 C.F.R. Parts 147 and 158) apply. Conversely, the requirements apply only to plans for which the federal requirements do not apply. These public disclosure requirements (through machine readable files) apply to plans issued or renewed on or after January 1, 2022.

All-Payor Claim Database (APCD): HB 2090 also authorizes TDI to establish an APCD to be administered by the Center for Healthcare Data at The University of Texas Health Science Center at Houston (the Center).

Payors: Payors that will be required to submit data include any of the following entities that pay, reimburse, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient:

- an insurance company providing health or dental insurance
- the sponsor or administrator of a health or dental plan
- an HMO operating under Chapter 843
- the state Medicaid program, including the Medicaid managed care program operating under Chapter 533, Government Code
- a health benefit plan offered or administered by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including TRS and ERS
- any other entity providing a health insurance or health benefit plan subject to regulation by TDI

Any sponsor or administrator of a health benefit plan subject to ERISA (29 U.S.C. Section 1001 et seq.) may elect or decline to participate in or submit data to the center for inclusion in the database as consistent with federal law.

Stakeholder Advisory Group: The center must establish a stakeholder advisory group by January 1, 2022, to provide assistance with establishing and updating the standards, requirements, policies, and procedures relating to the collection and use of data; evaluating and prioritizing the types of reports the center should publish; evaluating data requests from qualified research entities; and assisting the center in developing its recommendations to the Legislature.

The advisory group must be composed of the state Medicaid director or their designee, a member designated by the Teacher Retirement System of Texas, a member designated by the Employees Retirement System of Texas, and 12 members designated by the

center, including:

- two members representing the business community, with at least one of those members representing small businesses that purchase health benefits but are not involved in the provision of health care services, supplies, or devices or health benefit plans
- two members who represent consumers
- two members representing hospitals
- two members representing state-regulated health benefit plan issuers
- two members who are licensed physicians, one of whom is a primary care physician
- two members who are not professionally involved in health care services, supplies, or devices or health benefit plans and who have expertise in health planning or economics, provider quality assurance, statistics or health data management, or medical privacy laws

Any person serving on the stakeholder advisory group must disclose any conflict of interest. Members serve fixed terms as prescribed by TDI rule.

Database: TDI will collaborate with the center to help establish the APCD, and the center will serve as the administrator. In determining the information a payor is required to submit, the center must consider information useful to health policy makers, employers, and consumers for purposes of improving health care quality and outcomes, improving population health, and controlling health care costs. The information at a minimum must include the following for all health care services, supplies, and devices paid or otherwise adjudicated by the payor:

- the name and National Provider Identifier of each health care provider paid
- the claim line detail that documents the health care services or supplies provided
- the amount of charges billed and the payor's allowed amount or contracted rate and adjudicated claim amount
- the names of the payor and health benefit plan and type of health benefit plan, including a Medicaid or Medicare program, workers' compensation insurance, HMO plan, preferred provider benefit (PPO) plan, TRS or ERS plan, school employee uniform coverage, or a health benefit plan that is subject to ERISA
- claim level information that identifies the geozip

Each payor must submit the required data on a schedule determined by the center and adopted by TDI rule. Subject to the standards and requirements relating to the use of data and in consultation with the stakeholder advisory group, the center may use the data in the database for a noncommercial purpose to make consumer reports available through the public access portal that address population health and health care costs, quality, utilization, outcomes, disparities and access in a format that allows easy public access and navigation. Any information or data that is accessible through the portal may not identify a specific patient, health care provider, health benefit plan, health benefit plan issuer, or other payor.

Data Security and Privacy: Before making information or data accessible through the portal, the center shall remove any data or information that may identify a specific patient in accordance with the de-identification standards described in 45 C.F.R. Section 164.514.

Any information that may identify a patient, health care provider, health benefit plan, health benefit plan issuer, or other payor is confidential and subject to applicable state and federal law relating to records privacy and protected health information, including Chapter 181, Health and Safety Code, or "open records" disclosure.

A qualified research entity with access to data or information that is contained in the database but not accessible through the portal may use the information only for purposes consistent with the purposes of the bill and standards established by the center in consultation with the stakeholder advisory group and must execute an agreement relating to its compliance with these requirements. Researchers may not sell or share any information contained in the database or use the information for a commercial purpose.

TDI and the center may not disclose an individual's protected health information (PHI). The database may include only the minimum necessary amount of PHI identifiers necessary. The center must maintain PHI identifiers collected but excluded from the database in a separate database, which may not be aggregated with any other information and must use a proxy or encrypted record identifier for analysis.

Report to the Legislature: The center must submit to the Legislature no later than September 1 of each even-numbered year a written report containing an analysis of the data submitted for the database; information regarding the submission, maintenance, analysis, and use of the data; recommendations from the center, in consultation with the stakeholder advisory group, to further improve the transparency, cost-effectiveness, accessibility, and quality of health care in Texas; and an analysis of the trends of health care affordability, availability, quality, and utilization.

Rules: TDI, in consultation with the center, must adopt rules specifying the types of data, the schedule and and the method for submission of data to the center (at least quarterly) and that address data layout, data governance, historical data, use and sharing, information security, and privacy protection in data submissions.

The rules must establish oversight and enforcement mechanisms to ensure that payors submit data as required in the bill. In adopting rules governing methods for data submission, TDI must to the maximum extent practicable use methods that are reasonable and cost-effective for payors. TDI must adopt rules by June 1, 2022.

The bill requires the center to actively seek financial support from the federal grant program for development of state APCDs (Pub. L. No. 116-260) and any other federal financial support available for purposes of implementing an APCD.

Signed by the Governor. Effective September 1, 2021.

Hospital Price Transparency

SB 1137 by Sen. Kolkhorst

The federal Centers for Medicare and Medicaid Services (CMS) adopted a rule titled "Price Transparency Requirements for Hospitals to Make Standard Charges Public" that became effective on January 1, 2021. It is designed to increase market competition and lower healthcare costs by providing standard hospital pricing information to the public. SB 1137 codifies the CMS rule into Texas law, requiring hospitals to make a list of all standard charges publicly available in a machine-readable format and provide a consumer-friendly list of standard charges for a limited set of at least 300 shoppable services that must include payor-specific negotiated charges, the discounted cash price, and the de-identified minimum and maximum negotiated charges. The bill requires HHSC to monitor facility compliance and authorizes corrective action plans and enforcement of the bill's requirements.

Signed by the Governor. Effective September 1, 2021.

Key Legislation Affecting the Health Insurance Industry

TAHP and our member plans worked throughout the session to ensure bills adopted by the Legislature did not adversely affect the health insurance market and the Texans it serves. There was an unprecedented number of regulatory and benefit mandates filed this session that increase the cost of coverage. Overall, 108 benefit and regulatory bills were filed: 46 had a hearing, 36 passed out of a committee, 23 passed the house or the senate, and 8 ultimately passed both houses. TAHP worked with legislators and stakeholders onseveral bills throughout the session and amended several significant pieces of legislation to mitigate increased health care costs for Texas employers and families and undermining important patient protections.

Ovarian Cancer Screening Mandated Benefit

HB 428 by Reps. King, Leach, Kaca, Canales, and Guillen

HB 428 expands the current benefit mandate for ovarian cancer testing and screening to include "any other test or screening approved by the FDA for the detection of ovarian cancer."

Applies to commercial health plans issued or renewed on or after January 1, 2022.

Signed by the Governor. Effective September 1, 2021.

School District Participation in TRS

SB 1444 by Taylor

Certain school districts are currently required to participate in the uniform group coverage program established under the Texas School Employees Uniform Group Health Coverage Act. SB 1444 authorizes school districts to discontinue participation in the program effective Sept.1, 2022, or later by providing written notice to the Teacher Retirement System of Texas (TRS) by the preceding December 1.

Signed by the Governor. Effective September 1, 2021.

Applicability of Sales and Use Tax to Insurance Billing Services

HB 1445 by Reps. Oliverson, Meyer, Allison, and Swanson

The Texas Comptroller of Public Accounts determined that the preparation of a health insurance claim is an inherent part of the claim process and therefore constitutes a taxable service. The Comptroller adopted a rule scheduled to go into effect later this year subjecting medical billing services to taxation. HB 1445 amends the Tax Code to exclude both medical and dental billing services performed before the submission of a claim, including a claim under certain government-funded programs, from insurance services subject to taxation.

Signed by the Governor. Effective January 1, 2022.

TRS Notice of Appeals

HB 1585 by Reps. Lambert, Canales, Paddie, Goldman and Cyrier

This bill requires TRS to develop and distribute informational materials to enrollees regarding their rights to appeal denials of adverse determinations to an independent review organization.

Signed by the Governor. Effective immediately.

Credit for Reinsurance

HB 1689 by Reps. Oliverson, Metcalf, Button, Murr, and Romero, Jr.

This legislation updates legislation that passed overwhelmingly in the previous two sessions. Like its predecessors, it will prevent federal preemption of state insurance regulation of collateral requirements for certain insurers. It expands eligibility for assuming insurers relating to allowed credit for ceded reinsurance. Credit must be allowed when reinsurance is ceded to an assuming insurer that meets specific minimum capital and surplus requirements and agrees to provide adequate assurances in a form required by TDI rule.

These technical revisions have been endorsed by the Texas Department of Insurance (TDI), the National Conference of Insurance Legislators (NCOIL), and the National Association of Insurance Commissioners (NAIC).

Signed by the Governor. Effective January 1, 2022.

Medicare-Eligible TRS Enrollees

HB 2022 by Rep. Darby

Based on prior legislative changes to the Texas Public School Employees Group Insurance Program (TRS-Care), TRS retirees faced higher premiums and only one plan option based on their Medicare eligibility, and some retirees gave up TRS-Care health benefits to purchase a less expensive alternative. HB 2022 allows Medicare-eligible TRS retirees who voluntarily terminated membership in TRS-Care on or after January 1, 2017, and on or before December 31, 2019, a one-time opportunity to re-enroll in TRS-Care before on or before December 31, 2023.

Signed by the Governor. Effective immediately.

Health Care Cost Transparency and APCD

HB 2090 by Reps. Burrows, Oliverson, Frank, Bonnen, and Middleton

HB 2090 incorporates recent federal transparency rules into state law. It requires health plans and plan administrators (including for ERS and TRS) to provide detailed disclosures regarding an enrollee's cost-sharing for a service or supply. The bill also allows for the creation of an all-payors claim database.

Cost-Sharing Estimator Tool: Health plans and issuers must make personalized out-of-pocket cost information available to enrollees for covered items and services, including information on negotiated rates, through an internet-based self-service tool and in paper form upon request. Cost-sharing tools must allow enrollees to obtain real-time estimates of their cost-sharing liability that are personalized and accurate based on their plan and coverage. This includes estimated cost-sharing amounts, accumulated amounts, in-network rates, out-of-network allowed amounts, items and services included in bundled payment arrangements, notice of prerequisites to coverage, and several disclosure notices. The information must also be available to enrollees upon request in plain language in a physical form at no cost. Enrollee disclosure requirements apply to plans issued or renewed on or after January 1, 2024.

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These requirements do not apply to plans for which the federal reporting requirements (under 26 C.F.R. Part 54, 29 C.F.R. Part 2590, and 45 C.F.R. Parts 147 and 158) apply. Conversely, the requirements apply only to plans for which the federal requirements do not apply. These public disclosure requirements (through machine readable files) apply to plans issued or renewed on or after January 1, 2022.

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- the sponsor or administrator of a health or dental plan
- an HMO operating under Chapter 843
- the state Medicaid program, including the Medicaid managed care program operating under Chapter 533, Government Code
- a health benefit plan offered or administered by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including TRS and ERS
- any other entity providing a health insurance or health benefit plan subject to regulation by TDI

Any sponsor or administrator of a health benefit plan subject to ERISA (29 U.S.C. Section 1001 et seq.) may elect or decline to participate in or submit data to the center for inclusion in the database as consistent with federal law.

Stakeholder Advisory Group: The center must establish a stakeholder advisory group by January 1, 2022, to provide assistance with establishing and updating the standards, requirements, policies, and procedures relating to the collection and use of data; evaluating and prioritizing the types of reports the center should publish; evaluating data requests from qualified research entities; and assisting the center in developing its recommendations to the legislature.

The advisory group must be composed of the state Medicaid director or their designee, a member designated by the Teacher Retirement System of Texas, a member designated by the Employees Retirement System of Texas, and 12 members designated by the center, including:

- two members representing the business community, with at least one of those members

representing small businesses that purchase health benefits but are not involved in the provision of health care services, supplies, or devices or health benefit plans

- two members who represent consumers
- two members representing hospitals
- two members representing state-regulated health benefit plan issuers
- two members who are licensed physicians, one of whom is a primary care physician
- two members who are not professionally involved in health care services, supplies, or devices or health benefit plans and who have expertise in health planning or economics, provider quality assurance, statistics or health data management, or medical privacy laws

Any person serving on the stakeholder advisory group must disclose any conflict of interest. Members serve fixed terms as prescribed by TDI rule.

Database: TDI will collaborate with the center to help establish the APCD, and the center will serve as the administrator. In determining the information a payor is required to submit, the center must consider information useful to health policy makers, employers, and consumers for purposes of improving health care quality and outcomes, improving population health, and controlling health care costs. The information at a minimum must include the following for all health care services, supplies, and devices paid or otherwise adjudicated by the payor:

- the name and National Provider Identifier of each health care provider paid
- the claim line detail that documents the health care services or supplies provided
- the amount of charges billed and the payor's allowed amount or contracted rate and adjudicated claim amount
- the names of the payor and health benefit plan and type of health benefit plan, including a Medicaid or Medicare program, workers' compensation insurance, HMO plan, preferred provider benefit (PPO) plan, TRS or ERS plan, school employee uniform coverage, or a health benefit plan that is subject ERISA
- claim level information that identifies the geozip

Each payor must submit the required data on a schedule determined by the center and adopted by TDI rule. Subject to the standards and requirements relating to the use of data and in consultation with the stakeholder advisory group, the center may use the data in the database for a noncommercial purpose to make consumer reports available through the public access portal that address population health and health care costs, quality, utilization, outcomes, disparities and access in a format that allows easy public access and navigation. Any information or data that is accessible through the portal may not identify a specific patient, health care provider, health benefit plan, health benefit plan issuer, or other payor.

Data Security and Privacy: Before making information or data accessible through the portal, the center shall remove any data or information that may identify a specific patient in accordance with the de-identification standards described in 45 C.F.R. Section 164.514.

Any information that may identify a patient, health care provider, health benefit plan, health benefit plan issuer, or other payor is confidential and subject to applicable state and federal law relating to records privacy and protected health information, including Chapter 181, Health and Safety Code, or "open records" disclosure.

A qualified research entity with access to data or information that is contained in the database but not accessible through the portal may use the information only for purposes consistent with the purposes of the bill and standards established by the center in consultation with the stakeholder advisory group and must execute an agreement relating to its compliance with these requirements. Researchers may not sell or share any information contained in the database or use the information for a commercial purpose.

TDI and the center may not disclose an individual's protected health information (PHI). The database may include only the minimum necessary amount of PHI identifiers necessary. The center must maintain PHI identifiers collected but excluded from the database in a separate database, which may not be aggregated with any other information and must use a proxy or encrypted record identifier for analysis.

Report to the Legislature: The center must submit to the Legislature no later than September 1 of each even-numbered year a written report containing an analysis of the data submitted for the database; information regarding the submission, maintenance, analysis, and use of the data; recommendations from the center, in consultation with the stakeholder advisory group, to further improve the transparency, cost-effectiveness, accessibility, and quality of health care in Texas; and an analysis of the trends of health care affordability, availability, quality, and utilization.

Rules: TDI, in consultation with the center, must adopt rules specifying the types of data, the schedule and and method for submission of data to the center (at least quarterly) and address data layout, data governance, historical data, use and sharing, information security, and privacy protection in data submissions. The rules must establish oversight and enforcement mechanisms to ensure that payors submit data as required in the bill. In adopting rules governing methods for data

submission, TDI must to the maximum extent practicable use methods that are reasonable and cost-effective for payors. TDI must adopt rules by June 1, 2022.

The bill requires the center to actively seek financial support from the federal grant program for development of state APCDs (Pub. L. No. 116-260) and any other federal financial support available for purposes of implementing an APCD.

Signed by the Governor. Effective September 1, 2021.

Prior Authorization "Gold-Carding" Transparency

HB 3459 by Rep. Bonnen

TAHP was able to negotiate minor improvements to HB 3459, which prohibits a health plan from applying PA medical criteria to most health care services. Unfortunately, this lack of PAs will likely create risks for patients and an inappropriate "guarantee of payment" for potentially inappropriate or even harmful care.

PA Exemption Requirement: The bill prohibits an HMO or insurer (health plan) that uses a PA process from requiring a physician or provider to obtain a PA for a particular health care service if the health plan approved or would have approved at least 90% of the PA requests submitted by the physician or provider for the service in the most recent six-month evaluation period. This is not limited to network providers. The bill initially included only 80% of approvals for the PA exemption.

Health plans that require PA must evaluate whether a physician or provider qualifies for a PA exemption once every six months. Within 5 days of a physician or provider meeting the qualification for an exemption, the health plan must provide a notice of the exemption for each health care service and how long it will last. A physician or provider is not required to request an exemption. If a PA is requested when an exemption applies, the health plan must promptly provide a notice of the exemption and payment requirements.

Rescission of Exemption: A health plan may rescind an exemption from PA requirements only during January or June of each year. To rescind an exemption, the health plan must review a random sample of 5 to 20 claims submitted by the physician or provider during the most recent evaluation period and find that less than 90% met the applicable medical necessity criteria. The health plan must notify the physician or provider at least 25 days in advance of a rescission and provide the sample used and a plain language explanation of how to appeal and seek an independent review. An exemption from PA requirements remains in effect until the 30th day after the health plan notifies the physician or provider of its decision to rescind and no appeal is made. If the physician or provider appeals, the exemption remains in place until the 5th day after an independent review organization (IRO) affirms the determination to rescind the exemption. A determination to rescind the exemption can only be made by a Texas-licensed physician who has the same or similar specialty.

A physician or provider has a right to a review of an adverse determination regarding a PA exemption by an IRO. A health plan may not require an internal appeal first and must pay for the IRO review and a reasonable fee (determined by the Texas Medical Board) for any copies of medical records or other documents requested during a rescission review. If a physician or provider requests, the IRO must also consider another random sample of 5 to 20 claims. The IRO review must be completed within 30 days and is binding on the health plan. A health plan may not retroactively deny a health care service on the basis of an exemption rescission, even if its determination is affirmed by an IRO.

If an IRO overturns a PA exemption determined by the health plan, the health plan may not rescind the exemption before the end of the next evaluation period. A physician or provider is eligible for consideration of an exemption for the same health care service following a rescission after the six-month evaluation period.

Payment Mandate: A health plan may not deny or reduce payment for an "exempted" health care service based on medical necessity or appropriateness of care unless the physician or provider knowingly and materially misrepresented the health care service in a claim with the specific intent to deceive and obtain an unlawful payment or failed to substantially perform the service. A health plan can conduct a retrospective review of an exempted service only to determine if the physician or provider still qualifies for an exemption or if there is reasonable cause to suspect fraud.

Peer-to-Peer Requirements: HB 3459 also amends the provisions requiring an opportunity for a peer-to-peer discussion before an adverse determination (medical necessity denial) is issued. Under HB 3459 the peer must be licensed to practice medicine in Texas. If the health care service is to be provided by a physician, the review must be with a physician licensed to practice medicine in Texas who has the same or similar specialty.

The requirements of the bill apply to ERS and TRS plans. Medicaid and CHIP are explicitly exempt.

Effective September 1, 2021. Exemption provisions apply only to a request for PA made on or after January 1, 2022. The peer-to-peer discussion provisions apply to a PA or utilization review requested on or after the effective date.

Applicability of "Not Workers' Comp" Policy Notice

HB 3769 by Rep. Smithee

A current TDI property and casualty insurance rule relating to the sale of alternatives to workers'

compensation is broadly written to require all individual and group policies providing benefits to employees to include a prominent disclosure on the applicable policy stating it is not a workers' compensation policy. TDI interprets this to apply to any policy sold through an employer, including policies that specifically exclude occupational injuries and policies that could not reasonably be confused with workers' compensation. The bill clarifies what types of coverages are considered "occupational" policies requiring the notice, including an accident or health policy that explicitly provides coverage or benefits for an employer or its employees for an employee's occupational bodily injury, disease, or death; an accident, health, or liability policy that does not expressly include coverage for occupational injuries, disease, or death, but is marketed or sold to or through an employer as an alternative to workers' compensation coverage; and a policy that includes occupational accident and health and liability coverage in the same policy.

The bill requires TDI to adopt rules as soon as practicable after the effective date.

Applies to an occupational insurance policy delivered, issued for delivery, or renewed after January 1, 2022.

Signed by the Governor. Effective September 1, 2021.

Colorectal Cancer Screening Mandated Benefit

SB 1028 by Huffman and Zaffirini

SB 1028 expands the current colorectal screening mandated benefit to include all colorectal cancer examinations, preventive services and laboratory tests assigned either a grade of "A" or a grade of "B" by the United States Preventive Services Task Force for average-risk individuals, including as assigned either a grade of "A" or a grade of "B" in the future. The bill expands applicability of the mandate to include small employer groups and to exclude multiple employer welfare arrangement (MEWA) plans holding a certificate of authority under ch. 846 and limited benefit policies.

Applies to commercial health plans issued or renewed on or after January 1, 2022.

Signed by the Governor. Effective September 1, 2021.

Diagnostic Imaging for Breast Cancer Mandated Benefit

SB 1065 by Sen. Alvarado

SB 1065 expands the current "diagnostic mammogram" (now "diagnostic imaging") mandated benefit to add ultrasound imaging and MRI designed to evaluate (among others) an individual with a personal history of dense breast tissue.

This benefit mandate also applies to ERS, TRS, and Medicaid. Implementation by a state agency or institution is mandatory only if a specific appropriation is made for that purpose.

Applies to commercial health plans issued or renewed on or after January 1, 2022.

Signed by the Governor. Effective September 1, 2021.

TDI Premium Rate Review

SB 1296 by Sen. Johnson

Federal law requires federal regulators to review certain health insurance rate increases if states do not. Texas ceded its authority to federal regulators in 2013. SB 1296 requires TDI to adopt rules establishing a process under which it reviews health benefit plan rates and rate changes for compliance with applicable state and federal law. This focused rate review at the state level will allow Texas, rather than federal regulators, to ensure that rate increases are reasonable and also remedy a misalignment in premiums across the different tiers of coverage in the health insurance marketplace, resulting in more affordable coverage.

The bill requires TDI to seek all available federal funding to cover its cost for reviewing rates. Implementation by TDI is mandatory only if a specific appropriation is made for that purpose.

Applies to health plans issued or renewed on or after January 1, 2023.

Signed by the Governor. Effective September 1, 2021.

Electronic Communications

SB 2124 by Sen. Blanco

Health plan enrollees have the ability to opt in to receiving certain communications electronically, but some are unaware of this option that would provide greater convenience. SB 2124 gives employer health plan sponsors the authority to opt in employees to electronic delivery if employees are given the ability to opt out of this paperless option.

Applies to health plans delivered, issued for delivery, or renewed after January 1, 2022. Effective September 1, 2021.

Key Legislation Affecting Drug Coverage and PBMs

TAHP
The Texas Association of Health Plans

Prescription drug affordability is a major issue in Texas and across the country. Drug costs have risen at an astronomical rate in recent years and now amount to about $350 billion annually. Almost 25 cents of every health care dollar goes to prescription drugs—more than any other health care cost. PBMs provide a check on Big Pharma manufacturers' constant price hikes, helping patients save more at the pharmacy counter. PBMs negotiate for lower prescription drug costs and pass those savings directly on to patients and employers. Unfortunately, the Texas Legislature passed several mandates this session that severely restrict a PBM's ability to manage drug costs for Texans and endanger patient safety. TAHP and our members spent the session opposing these measures and advocating for the use of private market solutions and competition to negotiate lower drug prices for Texas patients and employers.

Drug Price Transparency

HB 1033 by Reps. Oliverson and Shaheen

Last session, the Texas Legislature adopted a drug cost transparency bill that requires pharmaceutical drug manufacturers to disclose certain drug price increases along with reasons for those increases. There have since been suggestions for improvements to that disclosure process that would help improve efficiency, streamline information gathering, and increase compliance with the disclosure requirements. HB 1033 makes the drug manufacturer reporting annual rather than within 30 days of a price increase, moves the reporting program from HHSC to DSHS, and sets an administration fee for manufacturers. The annual reports must include a prescription drug with a wholesale acquisition cost (WAC) of at least $100 for a 30-day supply that increased 40% or more over the preceding three calendar years or 15% or more in the prior calendar year. It requires a fee to be submitted by the manufacturer with each report, allows a right to correct failed submissions, and provides for an administrative penalty for violations. The bill also changes the submission deadline for health plans and PBMS to submit drug data to TDI from February 1 to March 1 and exempts Medicaid and CHIP data from both health plan and PBM reporting.

Signed by the governor. Effective September 1, 2021.

Pharmacy Contract Mandates

HB 1763 by Reps. Oliverson, Hefter, Lucio III, Bell, and Raymond

HB 1763 creates a number of new government mandates for privately negotiated pharmacy agreements.

Prohibition of Value Based Contracting: Prohibits health plans and PBMs from directly or indirectly reducing the amount of a claim payment to a pharmacy through the use of an aggregated effective rate, quality assurance program, other direct or indirect remuneration fee.

Limitation on Affiliated Pharmacies: Prohibits a health plan or PBM from paying an affiliated pharmacy more than a nonaffiliated pharmacy for the same pharmacist service

Prohibition on Limiting Pharmacy Mail-Order: Except in a case of a credible allegation of fraud, mandates that a health plan or PBM network agreement may not prohibit a pharmacy from mailing or delivering a drug to a patient upon request (to the extent permitted by law) or from charging a shipping and handling fee if the fee is disclosed with a notice that it may not be reimbursable by the health plan or PBM—a pharmacy may not charge a health plan or PBM for delivery of a prescription drug unless it is specifically agreed to.

Prohibition on Requiring Accreditation for Specialty Pharmacies: Prohibits a health plan or PBM from requiring any specialty accreditation unless required by state or federal law or by the drug manufacturer

Retaliation Prohibition: Prohibits retaliation by a PBM against a pharmacy for pursuing rights under the law—prohibited retaliation includes terminating or refusing to renew a contract, subjecting the pharmacist or pharmacy to increased audits, or failing to promptly pay any money owed. An action is not considered retaliation if it is taken in response to a credible allegation of fraud for which reasonable notice has been given.

Fee Schedule: Requires PBMs to share a "fee schedule" with network pharmacies

PSAOs: Provides that a pharmacist or pharmacy that is a member of a pharmacy services administrative organization (PSAO) that enters into a contract with a health plan or PBM on their behalf is entitled to receive from the PSAO a copy of the contract provisions applicable to the pharmacist or pharmacy, including each provision relating to the pharmacist's or pharmacy's rights and obligations under the contract

The provisions of the bill may not be waived or voided by contract. The bill does not specifically exempt Medicaid and CHIP, but HHSC has indicated that it does not apply since the administration of the Medicaid and CHIP programs are outside the jurisdiction of the Texas Department of Insurance and this bill amends the Insurance Code.

The changes apply only to a contract entered into or renewed on or after the effective date.

Signed by the Governor. Effective September 1, 2021.

Prohibition on Pharmacy Steerage

HB 1919 by Rep. Harris

HB 1919 introduces new government mandates into privately negotiated pharmacy agreements. It limits employer and consumer choice, prohibiting health plans and PBMs from steering a member to an affiliated provider.

A health plan issuer or PBM could not offer a plan that requires or induces a patient to use an affiliated provider, including by providing for reduced cost-sharing. Further, a health plan issuer or PBM could not use oral or written communication, including online messaging, to direct a patient to an affiliated prescription provider. It also requires written enrollee consent to transfer a prescription to an affiliated pharmacy or DME provider.

Steerage provisions apply to benefit plans issued or renewed on or after the effective date.

Effective September 1, 2021.

Emergency Refills of Insulin and Diabetes Supplies

HB 1935 by Reps. Bucy, Price, Guillen, and Talarico

HB 1935 amends current law, which allows for only a three-day emergency refill of insulin and insulin-related equipment and supplies. The bill gives pharmacists the authority to dispense a 30-day emergency supply of insulin and insulin-related equipment and supplies if specific criteria are met. Equipment and supplies include needles, syringes, cartridge systems, prefilled pen systems, glucose meters, continuous glucose monitor supplies, and test strips, but excludes insulin pumps. The bill requires the Texas State Board of Pharmacy to adopt rules as soon as practicable after the effective date.

Applies to health plans issued or renewed on or after January 1, 2022.

Effective September 1, 2021.

Insulin Copay Cap

SB 827 by Sens. Kolkhorst et al.

SB 827 prohibits a health plan from imposing a cost-sharing provision for insulin in the benefit plan's formulary exceeding $25 per prescription for a 30-day supply, regardless of the amount or type of insulin needed to fill the enrollee's prescription. Benefit plans must include at least one insulin from each therapeutic class in its formulary.

In addition to commercial plans, HB 827 applies to ERS and TRS plans and CHIP.

Applies to health plans issued or renewed on or after January 1, 2022.

Signed by the Governor. Effective September 1, 2021.

Key Legislation Affecting Medicaid/CHIP and Managed Care

Medicaid has played a key role in providing coverage during this economic and health care crisis. The crisis has also highlighted the power of the public and private sectors working together to lower costs, improve efficiencies, and provide the high-quality health care that Texans deserve.

Today's Texas Medicaid covers medical expenses, coordinates complex medical care, and helps Texans stay as healthy and active as possible—all while providing caring, compassionate one-on-one support. The focus on prevention, wellness, and care coordination—getting Texans the care they need to get healthy, stay healthy, and live in their communities—has translated into better care and lower costs. As a result, millions of Texans—including children and pregnant moms—have seen improved outcomes, and Texas taxpayers have saved over $5 billion.

TAHP and the Texas Medicaid managed care plans worked closely with legislators, HHSC, and the health care community to pass legislation that helps continue to strengthen and modernize Texas' Medicaid and CHIP programs and to ensure all low-income Texans have access to affordable, high-quality health coverage. TAHP also worked closely with the Medicaid managed care plans to ensure health plans maintained the flexibility needed to continue to innovate and improve quality and access to cost effective care.

Expanding Telemedicine Access in Medicaid

HB 4 by Reps. Price, Oliverson, Coleman, Ashby, and Guillen

The COVID-19 crisis demonstrated the importance of telehealth in the Texas Medicaid program.

These temporary telehealth solutions improved the program and proved to be popular among Texas Medicaid families. House Bill 4 makes many of these solutions permanent and improves greater access to health care by ensuring that telehealth can continue to address patients' needs beyond the crisis.

The bill requires HHSC to establish policies and procedures by rule to allow an MCO to conduct assessments and care coordination services using telecommunications or information technology to the extent the MCO determines is appropriate for the client and the client requests and consents (either verbally or written). If an MCO conducts an assessment of or provides care coordination services to a recipient using telecommunications or information technology, the MCO must monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse and determine whether additional social services or supports are needed.

The bill requires HHSC to determine categories of recipients of home and community-based services who must receive in-person visits and requires an MCO to provide those persons at least one in-person visit, except during emergency circumstances, to make an initial waiver eligibility determination and conduct additional in-person visits with the recipient if necessary as determined by the MCO. HHSC may on a case-by-case basis require MCOs to discontinue the use of telecommunications or information technology for assessment or service coordination services if it determines that the discontinuation is in the best interest of the recipient.

Additional provisions in the bill include:

- HHSC must ensure by rule that rural health clinics may be reimbursed as both the patient and the distant site (where the provider is delivering service) for telemedicine and telehealth services.
- To the extent permitted by federal law and to the extent that it is cost-effective and clinically effective, HHSC must ensure clients have the option to receive preventive health and wellness services, case management services, behavioral health services, therapy services (PT, OT, ST), nutritional counseling services assessment services, outpatient chemical dependency treatment services via telemedicine or telehealth delivery modes.

- To the extent permitted by federal law and to the extent that it is cost-effective and clinically effective, HHSC by rule must develop a system that ensures behavioral health services may be provided via audio-only communication.
- MCOs may reimburse providers for home telemonitoring services for conditions or risk factors other than those that are currently in law, as long as the reimbursement for the service is cost-effective and clinically effective.
- HHSC must consider the availability of telehealth and telemedicine services for MCO network adequacy requirements.
- HHSC must develop guidelines to allow an MCO to communicate with clients via text message.
- Requires changes to a Medicaid recipient's enrollment application to allow them to select their preferred method of contact and for that information to be shared with their MCO. The application will also allow the client to provide consent for MCOs to communicate with the client via their preferred method, including via text message.

Signed by the Governor. Effective immediately but allows HHSC to delay implementation pending federal approval.

Postpartum Coverage Expansion and Healthy Texas Women's Program

HB 133 by Reps. Rose, S. Thompson, Wallee, Thierry, and Reynolds

Medicaid plays a significant role in improving maternal health and helping to eliminate preventable maternal mortality. The most significant barrier preventing health plans from improving care for new mothers is the short timeframe for Medicaid eligibility before and after pregnancy. Texas Medicaid currently only covers women for 60 days past delivery, and research shows the majority of maternal deaths in Texas occur after the mother loses her Medicaid coverage. HB 133 extends Medicaid coverage for pregnant women by 4 months to allow for 6 months total of coverage postpartum.

The bill also transitions the Case Management Program for Children and Pregnant Women and the Healthy Texas Women's Program (HTW), currently administered by HHSC through fee-for-service, into managed care. The Case Management program was established when the majority of clients were served in fee-for-service because there was no mechanism for case management in that delivery model. Now that the majority of these clients are in managed care, this program will be carved-in and coordinated by MCOs, which provide case management to the majority of these clients today. The Healthy Texas Women's program offers family planning services and limited benefits for uninsured women in Texas through a 1115 demonstration waiver. Carving this program into managed care will allow a woman to be able to stay with her health plan and keep her doctors in between pregnancies.

The bill requires that HHSC consult with the State Medicaid Managed Care Advisory Committee on the transition into managed care and to identify barriers that prevent women from obtaining HTW services and seek opportunities to mitigate those barriers. The bill also requires that HHSC designate HTW providers as significant traditional providers until at least the third anniversary of the date of transition into managed care, which means the MCOs must offer these providers a contract to be in network with the plan. To help women identify coverage options, HHSC and each MCO must provide each woman in HTW a written notice containing information about enrollment in a health benefit plan for which an enrollee may receive a premium subsidy under the Affordable Care Act. The bill requires HHSC and TDI to coordinate on the development of the form and content of the notice.

The budget includes a contingency rider to fund both the 6 months coverage and the carve-in of the Healthy Texas Women's Program.

HHSC is only required to implement provisions in this bill if the Legislature appropriates money specifically for that purpose, and HHSC may delay implementation pending federal approval.

Signed by the Governor. Effective September 1, 2021.

Eligibility for Children in Juvenile Facilities

HB 1664 by Reps. White and Guillen

Several bills passed this session to improve eligibility processes including HB 1644. This bill requires that if, during the period a child is placed in a juvenile facility, the child is hospitalized or becomes an inpatient in another type of medical facility, HHSC shall reinstate the child 's eligibility for medical assistance during the period of the child 's inpatient stay.

Effective September 1, 2021.

Teledentistry

HB 2056 by Klick

This bill allows dentists and dental professionals to communicate and share patient information, which will expand access to dental care professionals. It amends the current telehealth statute to include teledentistry, dentists, and dental hygienists. It additionally gives the Texas State Board of Dental Examiners authority to promulgate rules to ensure that appropriate

quality care is provided, prevent fraud and abuse, ensure adequate supervision of non-dentist health professionals, and establish the maximum number of non-dentist health professionals that a dentist may supervise through a teledentistry service. The same licensing requirements apply to teledentistry as for in-person services.

HB 2506 also mandates Medicaid coverage of teledentistry and requires HHSC to adopt rules requiring payment parity in the fee-for-service program (but not in managed care) and may not limit a dentist's choice of platform.

Signed by the Governor. Effective September 1, 2021.

Health Care Transparency

HB 2090 by Reps. Burrows, Oliverson, Frank, Bonnen, and Middleton

HB 2090 incorporates recent federal transparency rules into state law. It requires health plans and plan administrators (including for ERS and TRS) to provide detailed disclosures regarding an enrollee's cost-sharing for a service or supply. The bill also allows for the creation of an all-payors claim database.

All-Payor Claim Database (APCD): HB 2090 also authorizes TDI to establish an APCD to be administered by the Center for Healthcare Data at The University of Texas Health Science Center at Houston (the Center).

Payors: Payors that will be required to submit data include any of the following entities that pay, reimburse, or otherwise contract with a health care provider for the provision of health care services, supplies, or devices to a patient:

- an insurance company providing health or dental insurance
- the sponsor or administrator of a health or dental plan
- an HMO operating under Chapter 843
- the state Medicaid program, including the Medicaid managed care program operating under Chapter 533, Government Code
- a health benefit plan offered or administered by or on behalf of this state or a political subdivision of this state or an agency or instrumentality of the state or a political subdivision of this state, including TRS and ERS
- any other entity providing a health insurance or health benefit plan subject to regulation by TDI

Any sponsor or administrator of a health benefit plan subject to ERISA (29 U.S.C. Section 1001 et seq.) may elect or decline to participate in or submit data to the center for inclusion in the database as consistent with federal law.

Stakeholder Advisory Group: The center must establish a stakeholder advisory group by January 1, 2022, to provide assistance with establishing and updating the standards, requirements, policies, and procedures relating to the collection and use of data; evaluating and prioritizing the types of reports the center should publish; evaluating data requests from qualified research entities; and assisting the center in developing its recommendations to the legislature.

The advisory group must be composed of the state Medicaid director or their designee, a member designated by the Teacher Retirement System of Texas, a member designated by the Employees Retirement System of Texas, and 12 members designated by the center, including:

- two members representing the business community, with at least one of those members representing small businesses that purchase health benefits but are not involved in the provision of health care services, supplies, or devices or health benefit plans
- two members who represent consumers
- two members representing hospitals
- two members representing state-regulated health benefit plan issuers
- two members who are licensed physicians, one of whom is a primary care physician
- two members who are not professionally involved in health care services, supplies, or devices or health benefit plans and who have expertise in health planning or economics, provider quality assurance, statistics or health data management, or medical privacy laws

Any person serving on the stakeholder advisory group must disclose any conflict of interest. Members serve fixed terms as prescribed by TDI rule.

Database: TDI will collaborate with the center to help establish the APCD, and the center will serve as the administrator. In determining the information a payor is required to submit, the center must consider information useful to health policy makers, employers, and consumers for purposes of improving health care quality and outcomes, improving population health, and controlling health care costs. The information at a minimum must include the following for all health care services, supplies, and devices paid or otherwise adjudicated by the payor:

- the name and National Provider Identifier of each health care provider paid
- the claim line detail that documents the health care services or supplies provided
- the amount of charges billed and the payor's

allowed amount or contracted rate and adjudicated claim amount

- the names of the payor and health benefit plan and type of health benefit plan, including a Medicaid or Medicare program, workers' compensation insurance, HMO plan, preferred provider benefit (PPO) plan, TRS or ERS plan, school employee uniform coverage, or a health benefit plan that is subject ERISA
- claim level information that identifies the geozip

Each payor must submit the required data on a schedule determined by the center and adopted by TDI rule. Subject to the standards and requirements relating to the use of data and in consultation with the stakeholder advisory group, the center may use the data in the database for a noncommercial purpose to make consumer reports available through the public access portal that address population health and health care costs, quality, utilization, outcomes, disparities and access in a format that allows easy public access and navigation. Any information or data that is accessible through the portal may not identify a specific patient, health care provider, health benefit plan, health benefit plan issuer, or other payor.

Data Security and Privacy: Before making information or data accessible through the portal, the center shall remove any data or information that may identify a specific patient in accordance with the de-identification standards described in 45 C.F.R. Section 164.514.

Any information that may identify a patient, health care provider, health benefit plan, health benefit plan issuer, or other payor is confidential and subject to applicable state and federal law relating to records privacy and protected health information, including Chapter 181, Health and Safety Code, or "open records" disclosure.

A qualified research entity with access to data or information that is contained in the database but not accessible through the portal may use the information only for purposes consistent with the purposes of the bill and standards established by the center in consultation with the stakeholder advisory group and must execute an agreement relating to its compliance with these requirements. Researchers may not sell or share any information contained in the database or use the information for a commercial purpose.

TDI and the center may not disclose an individual's protected health information (PHI). The database may include only the minimum necessary amount of PHI identifiers necessary. The center must maintain PHI identifiers collected but excluded from the database in a separate database, which may not be aggregated with any other information and must use a proxy or encrypted record identifier for analysis.

Report to the Legislature: The center must submit to the Legislature no later than September 1 of each even-numbered year a written report containing an analysis of the data submitted for the database; information regarding the submission, maintenance, analysis, and use of the data; recommendations from the center, in consultation with the stakeholder advisory group, to further improve the transparency, cost-effectiveness, accessibility, and quality of health care in Texas; and an analysis of the trends of health care affordability, availability, quality, and utilization.

Rules: TDI, in consultation with the center, must adopt rules specifying the types of data, the schedule and and the method for submission of data to the center (at least quarterly) and that address data layout, data governance, historical data, use and sharing, information security, and privacy protection in data submissions. The rules must establish oversight and enforcement mechanisms to ensure that payors submit data as required in the bill. In adopting rules governing methods for data submission, TDI must to the maximum extent practicable use methods that are reasonable and cost-effective for payors. TDI must adopt rules by June 1, 2022.

The bill requires the center to actively seek financial support from the federal grant program for development of state APCDs (Pub. L. No. 116-260) and any other federal financial support available for purposes of implementing an APCD.

Signed by the Governor. Effective Sept. 1, 2021.

New Medicaid Provider: Military Medical Treatment Facilities

HB 2365 by Rep. Lopez

HB 2365 requires HHSC to allow military medical treatment facilities to be recognized as a Medicaid provider type and be reimbursed for inpatient emergency services and related outpatient services. These facilities are not reimbursed today for services provided to a Medicaid client.

Signed by the Governor. Effective September 1, 2021 but allows HHSC to delay implementation pending federal approval.

Medicaid Cost Containment Reforms

HB 2658 by Rep. Frank

The majority of clients in the Medicaid program receive their coverage through managed care but many processes are still operating through fee-for-service, creating opportunities to find efficiencies and improve the program. HB 2658 includes many provisions that create efficiencies and improve the Medicaid program, including:

- Requires HHSC to provide two consecutive periods

of eligibility for a child and authorizes HHSC to conduct an eligibility review only once during the child's two conservative periods of eligibility. Provides that a child remains eligible for medical assistance during the first of the two consecutive periods of eligibility, without additional review by HHSC and regardless of changes in the child's household income, until the end of the six-month period following the date on which the child's eligibility was determined.

- Requires HHSC to study the feasibility of creating an online portal for individuals to request to be placed and check the individual 's placement on a Medicaid waiver program interest list. As part of the study, HHSC must also determine the most appropriate and cost-effective automated method for determining the level of need of an individual seeking services through a Medicaid waiver program. HHSC must submit a study by January 1, 2023.
- Requires HHSC to develop a procedure to verify that a Medicaid recipient or the recipient 's parent or legal guardian is informed regarding the consumer direction services (CDS) model and provided the option to choose to receive care under that model and if the individual declines the CDS option the MCO must document the declination.
- Requires HHSC to establish rules in addition to existing nursing facility minimum performance standards in the STAR+PLUS program. The bill directs HHSC to monitor provider performance and corrective actions for providers not meeting standards and ensure they share that information with MCOs.
- Requires HHSC when developing MCO premiums to include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services.
- Directs HHSC to collaborate with MCOs to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.
- Requires that if a disease management program provided by a MCO has low active participation rates, HHSC must identify why there is low participation and develop an approach to increase participation for high-risk recipients.
- Adds at least one preventive dental care visit per year, for an adult recipient with a disability who is enrolled in the STAR+PLUS Medicaid managed care program.
- Directs HHSC to adopt rules requiring parental consent for services provided under the school health and related services programs (SHARS) in order for the school to receive reimbursement for the services.
- Requires HHSC to review nursing facility staff rate enhancement programs to identify and evaluate methods for improving administration of those programs to reduce administrative barriers that prevent an increase in direct care staffing and direct care wages and benefits in NFs and develop recommendations for increasing participation. The bill also requires HHSC to revise their policies regarding the NF Quality In Payment Program (QIPP) to require improvements to staff-to-patient ratios in NFs participating in the program.
- Allows the executive commissioner to approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model
- Requires HHSC to conduct a study to determine the cost-effectiveness and feasibility of providing Medicaid recipients who have been diagnosed with diabetes, including Type 1 diabetes, Type 2 diabetes, and gestational diabetes with diabetes self-management education and support services that follow the National Standards for Diabetes Self-Management Education and Support and that may be delivered by a certified diabetes educator. If HHSC determines providing these services would improve health outcomes for Medicaid recipients and lower Medicaid costs they can develop a program to provide the benefits.
- Requires HHSC to study and identify benefits and services, provided under Medicaid that are not provided in this state under the Medicaid managed care model and evaluate the feasibility, cost-effectiveness, and impact on Medicaid recipients of providing the benefits and services through managed care.
- Requires HHSC to conduct a study regarding dually eligible individuals who are enrolled in managed care including the evaluation of: (1) Medicare cost-sharing requirements for those individuals; (2) the cost-effectiveness for a MCO to provide all Medicaid-eligible services not covered under Medicare and require cost-sharing for those services; and (3) the impact on clients and providers if HHSC implemented cost sharing for the services.

HHSC is only required to implement provisions in this bill if the Legislature appropriates money specifically for that purpose, and HHSC may delay implementation pending federal approval.

Signed by the Governor. Effective September 1, 2021.

Antipsychotics Access

HB 2822 by Reps. Hull, Oliverson, and Guillen

While Medicaid MCOs are responsible for the administration of prescription drugs, it is HHSC and the Vendor Drug Program that determines which drugs require prior authorization and those that do not. With the legislature's continued focus on mental health coverage, HB 2822 was filed to help address concerns regarding access to antipsychotic drugs.

HB 2822 prohibits HHSC or a MCO from requiring prior authorization for a non-preferred antipsychotic drug if during the preceding year the patient was prescribed and unsuccessfully treated with a 14-day trial of a preferred antipsychotic. For safety reasons, the MCO or HHSC can still require prior authorization if the prescription is outside of federal maximum dosage limits or HHSC rules on quantity limits and can still implement clinical edits which are used to ensure safe dispensing. The bill also requires MCOs, to the extent possible, to ensure that if a prescription drug is denied the pharmacist receives an automated point of sale message specifying the contact and other information necessary to submit a prior authorization request for the prescription; and instructs the pharmacist to dispense a 72-hour supply of the prescription only if clinically appropriate.

Signed by the Governor. Effective September 1, 2021, but allows HHSC to delay implementation pending federal approval if needed and recognizes implementation will require a change to the managed care contracts and until the contract is updated, the contract prevails.

Improvements to Medicaid Interest Lists

HB 3720 by Reps. Frank, González, Noble, Guillen, and Capriglione

Texas has several home and community based waiver programs that provide necessary services and supports to allow clients to live independently in the community. The wait to obtain access to several of these programs can be long and in an effort to address stakeholders concerns with the interest lists HB 3720 was filed. HB 3720 requires HHSC in coordination with stakeholders to develop a questionnaire for an individual who requests to be placed on or is currently on an interest list for a waiver program to include contact information, general demographic information, the individual's living arrangement, the types of assistance the individual requires, the individual 's current caregiver supports and circumstances. If the questionnaire is not responded to, HHSC shall designate the individual's status on the interest list as inactive until the individual notifies HHSC that the individual is still interested in receiving services under the waiver program. At the time the individual provides notice, the individual's status on the interest list will be restored with the date the individual was initially placed on the list.

HHSC is only required to implement provisions in this bill if the legislature appropriates money specifically for that purpose, and HHSC may delay implementation pending federal approval.

Effective September 1, 2021.

Competitive and Integrated Employment

SB 50 by Sen. Zaffirini

Clients in the Medicaid program have access to services to help them gain employment but the uptake of these services still tends to be low. SB 50 requires HHSC to develop by rule a uniform process to assess the goals and available opportunities for competitive and integrated employment opportunities and related employment services available to individuals in waiver programs including the STAR+PLUS home and community-based services (HCBS) waiver program. The process should include incorporating those goals, opportunities, and services into the client's plan of care. HHSC must also identify strategies to increase the number of individuals who are receiving employment services from the Texas Workforce Commission, determine a reasonable number of individuals who indicate a desire to work to receive employment services and ensure those individuals have received employment services or are receiving employment services on December 31, 2023. HHSC must submit a report no later than December 31 of each even-numbered year.

Effective September 1, 2021 but includes the provision that HHSC is only required to implement provisions in this bill if the Legislature appropriates money specifically for that purpose.

New Medicaid Provider: Texas Health Departments

SB 73 by Sen. Miles

Medicaid MCOs contract with local health departments today but the services that these entities provide can vary, resulting in local health departments enrolling as various different types of providers. SB 73 requires HHSC to establish a unique provider type for enrollment and reimbursement of local public health departments.

HHSC is only required to implement provisions in this bill if the legislature appropriates money specifically for that purpose, and HHSC may delay implementation pending federal approval.

Effective September 1, 2021.

Study on Behavioral Health Interoperability

SB 640 by Sen. Menèndez

The federal government has been focusing on the need to create better interoperability within healthcare systems to help improve client care, reduce burdens and track impacts of care on client overall health. SB 640 focuses specifically on the interoperatiliby of behavioral health service providers in Texas. SB 640 creates a study that reviews the technology readiness, interoperability and gaps in technology in Texas, including within behavioral health organizations, managed care, and other key stakeholders, to assist the state in understanding the behavioral health technology landscape.

Signed by the Governor. Effective September 1, 2021.

Collaborative Care Model

SB 672 by Sens. Buckingham, Campbell, Nelson, and Schwertner

Over the past decade, the integration of behavioral health and general medical services has been shown to improve patient outcomes, save money, and reduce stigma related to mental health. The Collaborative Care Model has been found to be effective and efficient in delivering integrated care. SB 672 requires HHSC to add reimbursement for collaborative care management services for children and adults receiving behavioral health services. The Collaborative Care team is led by a primary care provider and includes behavioral health care managers, psychiatrists and other mental health professionals all empowered to work at the top of their license. The team implements a measurement-guided care plan based on evidence-based practice guidelines and focuses particular attention on ensuring patients meet their clinical goals.

Signed by the Governor. Effective September 1, 2021, but allows delay of implementation pending federal approval.

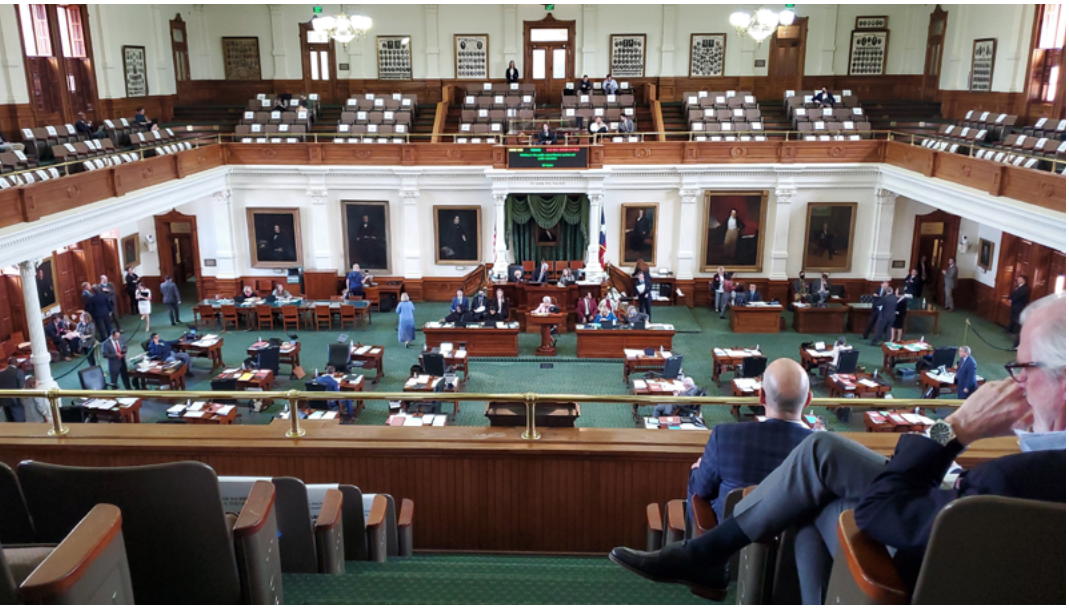
State Agency Procurement Reforms

SB 799 by Sen. Nelson

During the past three legislative sessions, the Legislature passed reforms to the procurement processes, and this session SB 799 amends current law relating to contracting procedures and requirements for governmental entities, including HHSC.

Reforms in SB 799 include:

- **Major Information Resources Projects:** Requires additional monitoring if the project exceeds $5 million and requires that the award notice be on a form prescribed by the LBB and filed not later than the 30th day, rather than the 10th day, after the date the agency enters into the contract. The bill also requires additional oversight, including risk management, quality assurance services, independent project monitoring, and project management, for major information resources projects.
- **Best Value Statute:** Amends the best value contracting statute as follows:
  - Provides that, in determining the best value for the state, the purchase price and whether the goods or services meet specifications are principal considerations that are required to be balanced with other relevant factors, rather than prioritizing just the purchase price and whether the goods or services meet specifications.
  - Requires a state agency to consult with and receive approval from the comptroller before considering factors other than price when procuring goods or services through competitive bidding and requires the state agency to specify in the request for bids the proposal criteria the agency will use when considering factors other than price.
  - Requires agencies to consider the impact of a purchase on the agency's administrative resources.
- **Goods and Services:** Provides that a state agency is delegated the authority to purchase goods and services if the purchase does not exceed $50,000, rather than $15,000. If HHSC does not receive any responsive bids on a competitive solicitation for goods



or services for a state hospital or a state supported living center they must negotiate with and award the contract to any qualified vendor who meets the requirements of the original solicitation.

- **Purchasing a Commodity:** Prohibits a state agency from entering into a contract to purchase a commodity item if the value of the contract exceeds $10 million, rather than $5 million and to purchase a commodity item using a purchasing method designated by the comptroller.
- **Competitive Bidding:** Provides that competitive bidding is required for a purchase by a state agency if the purchase meets certain criteria, including if the purchase exceeds $10,000, rather than $5,000.
- **Professional and Consulting Services:** Requires a state agency to provide written notice to the LBB of a contract for professional or contracting services, other than a contract for physician or optometric services, if the amount of the contract, including an amendment, modification, renewal, or extension of the contract, exceeds $50,000, rather than $14,000 and requires that the notice be on a form prescribed by the LBB and filed not later than the 30th day, rather than the 10th day, after the date the agency enters into the contract.
- **Contract Management Guide:** Requires that the comptroller's contract management guide include: (1) instructions to assist a state agency in identifying procurements that require an additional or secondary agency employee to serve as a contact and establishing procedures for notifying vendors when to contact the additional or secondary agency employee; (2) a general outline for the training required to provide to the agency's procurement evaluators, including training on the implementation of best value standards; (3) for a procurement in an amount that exceeds $20 million, the information a state agency is required to include in a contract file on the evaluator for that procurement, including the reasons the person was selected and the person's relevant qualifications; and (4) a model communications procedure for vendors and agency employees. Requires that for a procurement in an amount that exceeds $20 million the agency must notify interested parties at least two months before the date the agency issues the solicitation for the procurement.

Effective September 1, 2021.

Clients Aging Out of Foster Care

SB 1059 by Sen. Paxton

Youth who age out of foster care are eligible for Medicaid coverage up to age 26 through the Former Foster Care Children program. However, many experience a disruption in coverage because they have difficulty renewing their benefits annually with the state. SB 1059 increases the time that a former foster care youth shall be eligible to recertify themselves for medical assistance, streamlines the process of determining former foster care youths' eligibility for Medicaid, and allows them to recertify online.

Effective September 1, 2021

Medicaid Quality Initiatives

SB 1136 by Sen. Kolkhorst

In August 2020, the Centers for Medicare and Medicaid Services (CMS) approved the Delivery System Reform Incentive Payment (DSRIP) Transition Plan. According to the transition plan, the DSRIP program and funding will end on September 30, 2021. SB 1136 recognizes the end of DSRIP funding and finds ways to develop programs and initiatives to continue the work of DSRIP and reduce unnecessary hospital emergency room visits. The bill requires HHSC to coordinate with hospitals and other providers that receive supplemental payments to identify and implement initiatives based on best practices and models that are designed to reduce use of hospital emergency room services and to improve recipients ' access to primary care. The bill also requires HHSC to encourage Medicaid providers to continue implementing effective interventions and best practices associated with improvements in the health outcomes of Medicaid recipients that were developed and achieved under DSRIP, including through: provider incentive programs; the terms included in MCO contracts; implementation of alternative payment models; or adoption of other cost-effective measures. HHSC must biannually report to the legislature on the efforts under this legislation.

Signed by the Governor. Effective September 1, 2021, but allows delay of implementation pending federal approval if needed.

Safety Net Program Study

SB 1138 by Sen. Hughes

The goal of SB 1138 is to help the state better understand how it is utilizing taxpayer money for safety net programs as well as identifying areas to improve outcomes for beneficiaries. SB 1138 would provide this information by way of a study of programs, such as the Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP), Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Medicaid, and others. The bill requires the study to include recommendations on how safety net programs can be simplified and streamlined to improve outcomes and lower costs to taxpayers.The bill also requires that the study include

information on the amount of taxpayer revenue spent, state money appropriated, and federal money received per program and a measure of key variables for specific demographic and socioeconomic statuses of recipients, and a cost benefit analysis to measure the effectiveness of these programs.

Effective immediately.

Medicaid MCO Mandatory Contract Requirements

SB 1244 by Sen. Perry

Over the next several years, HHSC will begin the re-procurement process for the Medicaid managed care programs. There were multiple bills filed this session that addressed procurement including SB 1244. The bill requires HHSC before awarding a contract to a MCO to evaluate and certify that the health plan is reasonably able to fulfill the terms of the contract, including all requirements of applicable federal and state law. Notwithstanding any other law, HHSC may not award a contract under this chapter to a MCO that does not receive the certification.

Signed by the Governor. Effective September 1, 2021 but allows HHSC to delay implementation pending federal approval if needed.

Continuity of Care for Children with Complex Medical Needs and Omnibus Medicaid Bill

SB 1648 by Sen. Perry

Texas rolled out the STAR Kids program in 2016 and last session the Legislature passed SB 1207 to help address some of the concerns from families being transitioned into managed care. SB 1648 clarifies provisions from SB 1207 from the 86th Legislative Session by ensuring that children with complex medical needs can access out of network care from a specialty physician if they have an established relationship with the physician, even if they do not also have commercial coverage. The bill requires MCOs to develop a simple, timely, and efficient process to negotiate a single-case agreement with the specialty physician. Until an agreement can be reached, the MCO must pay the out of network rate. The bill also clarifies that this provision does not count against a health plan as out of network care for network adequacy requirements.

The bill also includes several additional provisions, including:

- Requires HHSC and DFPS to coordinate to develop a process to review denials for services for children in the foster care program. HHSC must submit a report on summary of the process developed and implemented by December 1, 2022.
- Allows a provider to submit a variable schedule into the electronic visit verification system.
- Requires HHSC to study the feasibility of creating an online portal for individuals to request to be placed and check the individual 's placement on a Medicaid waiver program interest list. As part of the study, HHSC must also determine the most appropriate and cost-effective automated method for determining the level of need of an individual seeking services through a Medicaid waiver program. HHSC must submit a study by January 1, 2023.
- Requires HHSC to develop a procedure to verify that a Medicaid recipient or the recipient 's parent or legal guardian is informed regarding the consumer direction services (CDS) model and provided the option to choose to receive care under that model and if the individual declines the CDS option the MCO must document the declination.
- Requires HHSC to consult with stakeholders to develop and implement the Exceptional Kids Act pilot program which provides coordinated care through a health home to children with complex medical conditions (Section 3, Medicaid Services Investment and Accountability Act of 2019). The bill authorizes HHSC to actively seek and apply for federal funding to implement the program. HHSC must submit a report by December 31, 2024 on the pilot. The pilot program terminates September 1, 2025.
- Adds one preventive dental care visit per year, for an adult recipient with a disability who is enrolled in STAR+PLUS.

HHSC is only required to implement provisions in this bill if the legislature appropriates money specifically for that purpose, and HHSC may delay implementation pending federal approval.

Effective September 1, 2021.

Medicaid Provider and Client Directories

SB 1829 by Sen. Hinojosa

Recently the amount of data elements required in printed provider directories drastically increased based on federal managed care rules, resulting in increases to the size of paper directories and increases in cost for both health plans and the state to print and mail directories. The changes in federal law combined with state law requirements to provide a paper copy to every client has resulted in unintended financial and administrative burdens. SB 1829 makes statutory changes to streamline the provider directory

requirements to require a health plan to send a printed copy of a provider directory to a member only if requested. This will align requirements for all product lines and require a client to opt-in to receiving a hard copy of the provider directory. This change is also in line with recent guidance from CMS encouraging states to move toward electronic directories rather than printed directories because they are more up to date.

The bill also requires HHSC to establish a client directory that will be the single source of information for client contact information. The bill requires HHSC to allow Maximus, HHSC and the MCOs access to update the directory in real-time to the extent feasible.

Signed by the Governor. Effective immediately but the legislation recognizes implementation will require changes to the managed care contracts and until the contract is updated, the contract prevails.

Modernization of Client Communications

SB 1911 by Sen. Blanco

Client engagement, especially in the Medicaid program, is crucial to maintaining healthy behaviors and ensuring clients go to important health care appointments. Unlike phone calls, text messages present information in a more digestible, timely manner, and are more successful at grabbing a client's attention. SB 1911 adds changes to a Medicaid recipient's enrollment application to allow them to select their preferred method of contract and for that information to be shared with their MCO. The application will also allow the client to provide consent for MCOs to communicate with the client via their preferred method, including text message.

Signed by the Governor. Effective immediately.

Budget Highlights

Leading into the 87th Session, numerous questions arose regarding the state of the economy due to the economic impact of the public health crisis. To manage anticipated budget shortfalls, Governor Abbott directed state agencies to submit a 5% reduction plan in May 2020 and the Comptroller made various changes to revenue estimates based on the constantly changing state of the economy in 2020 and 2021.

Budget discussions during the session centered around federal relief funding and how to account for new dollars that would come in after the session. To address relief funding, the Governor has indicated that he will call a special session in the Fall to allow the legislature to provide input on how to appropriate federal relief funding.

This session was unique in that there was not a Medicaid shortfall that needed to be funded via HB 2, mostly due to the enhanced federal matching funds (FMAP) and reduced spending in the program in the 2020 and 2021 biennium. The 87th Legislature eventually passed a $163 billion in General Revenue funds and $248 billion in All Funds General Appropriations budget for 2022-2023 (SB 1).

Medicaid Funding — General Appropriations Act

General Appropriations Act for 2022-2023
SB 1 by Sen. Nelson

SB 1 includes $64 billion in All Funds, including $23.5 billion in General Revenue for the 2022-23 biennium for Medicaid client services. Compared to the 2020-21 base without supplemental appropriations, this is a decrease of $0.3 billion in All Funds, including an increase of $1 billion in General Revenue.

SB 1 does not assume the 6.2 percentage point increase in federal matching funds (FMAP) for the 2022-23 biennium due to COVID relief funds. It does account for residual effects from the public health emergency, such as increased unemployment into the 2022-23 biennium. The bill does not fund projected biennial cost growth, which, based on HHSC's most recent forecast, was projected to be approximately $5 billion in All Funds, including $1.9 billion in General Revenue.

While SB 1 does include increases for Medicaid client services and caseload growth, the increases are offset by two primary decreases, $0.9 billion in All Funds, including $0.5 billion in General Revenue for cost containment and $4.7 billion in All Funds, including $1.9 billion in General Revenue in other decreases.

SB 1 includes:

- $123,462,974 All Funds ($47,576,677 GR) for rural hospital rate increases
- $500 Medicaid add-on payment for labor and delivery services provided at rural hospitals
- $76.9 million in All Funds to decrease the community waiver interest lists
- Funding to expand access to direct-acting antiviral medications for Medicaid enrollees diagnosed with chronic Hepatitis C
- Funding for computer system updates needed to implement the pilot of the carve in of the IDD waivers into managed care
- Funds for an additional 25 FTEs in each fiscal year of the 2022-23 biennium if needed for negotiating and implementing the 1115 waiver

Legislative Budget Board Summary of Conference Committee Report for SB 1

Article II — HHSC Budget Riders

Texas Medicaid and Healthcare Partnership (TMHP)
Rider 6

Requies HHSC to maintain an executive steering Committee for the Texas Medicaid and Healthcare Partnership (TMHP) contract and Texas Medicaid Management Information System (MMIS) capital project. The TMHP executive steering committee shall provide executive-level strategic direction including review of contract terms prior to execution of a new contract or amendment and reports from third-party quality assurance and independent verification and validation vendors. In addition, the rider requires the committee to report any anticipated contract or project cost overruns or delays to the Legislative Budget Board.

Increase Consumer Directed Services
Rider 9

Requires MCOs to educate STAR+PLUS clients about the CDS option, and seek to increase the percentage of clients who choose CDS. Requires HHSC to collect information annually from each MCO on the percent of clients enrolled in CDS and shall establish incremental benchmarks for improvement and include the information on their website

Therapy Reporting
Rider 10

Requires HHSC to continue reporting on therapy services access but changes frequency to biannual instead of quarterly.

Evaluation of Medicaid Data
Rider 11

Requires HHSC to annually evaluate data submitted by managed care organizations to determine whether the data continues to be useful or if additional data, such as measurements of recipient services, is needed to oversee contracts or evaluate the effectiveness of Medicaid.

HHSC Cost Containment
Rider 24

Requires HHSC to find $350 million GR in cost containment through reducing fraud, waste and abuse, implement Medicaid efficiencies, increasing utilization of telemedicine, and applying for an IMD waiver.

Improving Dental TMPPM
Rider 26

Requires a workgroup to be established at HHSC to review and update the dental policies in the Texas Medicaid Provider Procedures Manual and requires certain stakeholders participate including OIG and DMOs.

Medicaid Efficiency Rider
Rider 27

Directs HHSC to develop and implement initiatives to create program efficiencies, including:

- Medicaid provider enrollment and credentialing data sharing
- Automatic enrollment into managed care
- Promotion of electronic provider directories and reductions in paper waste
- Modernization of electronic communication (texting)

Applied Behavioral Analysis
Rider 28

Includes funding for applied behavioral analysis (ABA) services for autism for children in the Medicaid program and clarifies that it is the intent of the legislature that HHSC implement ABA services as soon as practicable, but not later than February 1, 2022.

Pediatric Services Study
Rider 29

Requires HHSC to study whether rate increases for services to children ages 0 to 3 result in savings. The study will also look at the feasibility of determining an actuarially sound basis for cost and savings — if HHSC's recommendations include a possibility that rate increases can be implemented in a cost neutral manner and is actuarial sound, HHSC may implement the recommendation as a pilot beginning on March 1, 2023.

Behavioral Health Services
Rider 33

Extends reimbursement of behavioral health telehealth or telephone into 2022-23.

Institute for Mendat Disease (IMD)
Rider 34

Authorizes HHSC to submit an IMD exclusion waiver to allow the state to receive federal funds for Medicaid-eligible individuals during short-term stays for acute care in psychiatric hospitals or residential treatment settings that qualify as institutions of mental disease.

Dialysis Services
Rider 35

Directs HHSC to study cost-effective and clinically-appropriate methods to provide dialysis services in Medicaid.

Managed Care Denials and Appeals
Rider 36

Requires HHSC to study Medicaid denials, appeals processes, and implementation of the independent review organization.

Medicaid Provider Rate Increases
Rider 39

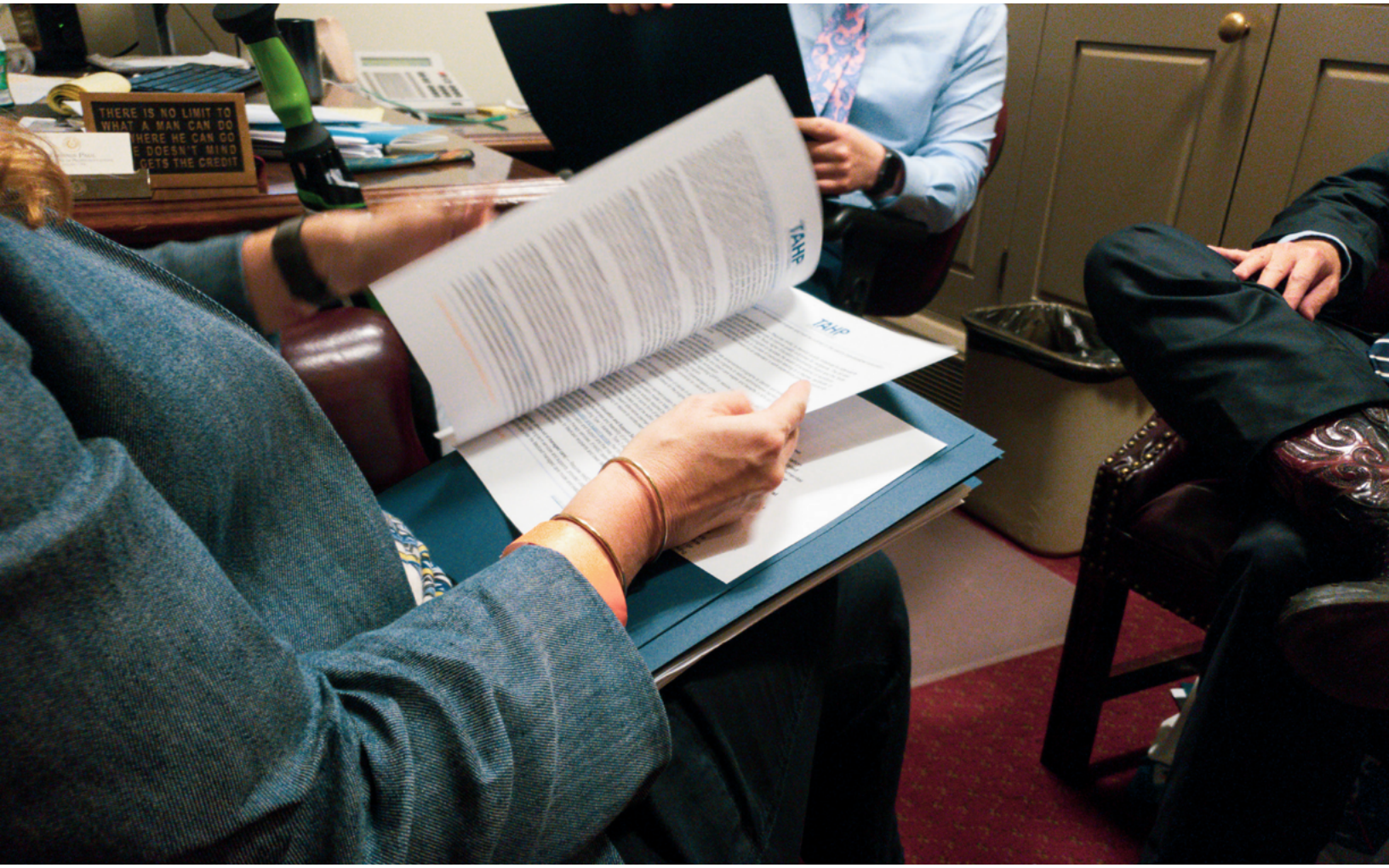
Directs HHSC, to the extent allowable under federal law, to require MCOs to reimburse providers the full amount of funds appropriated for rate increases.

Pediatric Long-term Care Facility Rate Increase
Rider 40

Includes funds to revise the reimbursement methodology for pediatric long-term care facilities to mirror that of Medicare reimbursement.

Emergency Triage, Treat, And Transport Demonstration Payment Model
Rider 42

Directs HHSC to implement the ET3 model that allows ambulance providers to treat clients in place via telemedicine and transport to the most appropriate setting. The rider reduces appropriations by $4,253,772 in All Funds in anticipated cost savings from implementing the model.



Article X — HHSC Budget Riders

The Governor did a line-item veto of Strategies in Article X which includes funding for the Legislature, LBB, Sunset and the SAO, but the Riders in Article X were not vetoed including the managed care rates study.

SAO Audit of Managed Care Rates

Rider 5

Requires the State Auditor's Office (SAO) to conduct an actuarial analysis of the fiscal year 2023 and fiscal year 2024 rates for Medicaid managed care at HHSC. No later than November 1, 2022, the SAO will provide an audit report on the rate making process used by HHSC. The report should identify improvements to the rate-making process (including identifying significant cost drivers in the rate-setting process) and to the process of communicating rates with oversight entities. In evaluating the rate-making process, the SAO will determine if the HHSC followed appropriate procurement processes in obtaining actuarial vendors.

Medicaid Funding — Supplemental Budget

Supplemental Budget for 2022-2023

HB 2 by Sen. Nelson

Each year, the Texas Legislature passes a bill that helps finalize the budget for the current biennium, includes both supplemental appropriations and reductions in appropriations, and provides direction and adjustment authority regarding appropriations. This session was unique in that there was not a Medicaid shortfall that needed to be funded via HB 2, mostly due to the enhanced FMAP and reduced spending in the program in the 2020 and 2021 biennium.

The 2020-21 base for Medicaid client services includes $70.3 billion in All Funds, including $24.8 billion in General Revenue, for Medicaid client services. However, $6 billion in All Funds (including $2.3 billion in General Revenue) was assumed supplemental appropriations which HHSC did not end up needing. If the supplemental appropriations are removed, the 2020-21 base for Medicaid client services is $64.3 billion in All Funds, including $22.5 billion in General Revenue.

There were no impacts to the Medicaid program or HHSC in the supplemental budget, and HB 1 included $431.8 million for information technology, including projects to update and modernize legacy systems at HHSC.

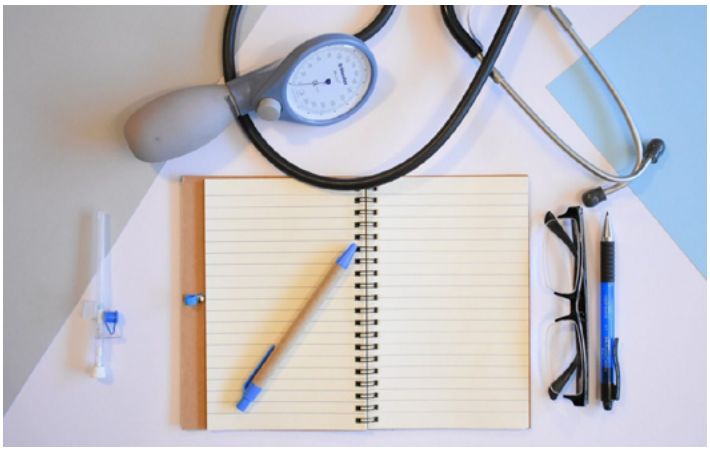
Legislative Budget Board Summary of Senate Committee Substitute for HB 2

TAHP in the News

In fight over prior authorization from insurance, Texas patients must come first

Houston Chronicle | February 4, 2021

"We're the only ones that have that 360° view of what is going on with the patient to know that there was going to be an adverse reaction between two or three drugs, or between a surgery and another drug," said Jamie Dudensing, CEO for the Texas Association of Health Plans.



Texas stakeholders disagree on prior authorization rules

State of Reform | March 9, 2021

Dudensing emphasized that PAs must be evidence-based. She said services like these should only be covered for patients whose health depends on them and not for individuals pursuing the service for other reasons. This would be "inappropriate coverage" and would increase the cost of coverage.

Lawmakers Considering Cap on Monthly Price of Insulin

Texas Scorecard | April 6, 2021

"Eli Lilly, Novo Nordisk, and Sanofi Aventis control 90% of the insulin market and have increased prices in lockstep for several years. Copay cap mandates will not stop these unjustified price hikes or lower the cost of insulin."

Texas State Rep. Talarico shares he has diabetes while announcing insulin price cap legislation

KTSM | April 6, 2021

Opponents of [HB 40], like the Texas Association of Health Plans, say the fix should target the drug manufacturers rather than the insurance companies.

State of Texas: 'We're facing a lot of challenges' in search of funds to prevent the next power crisis

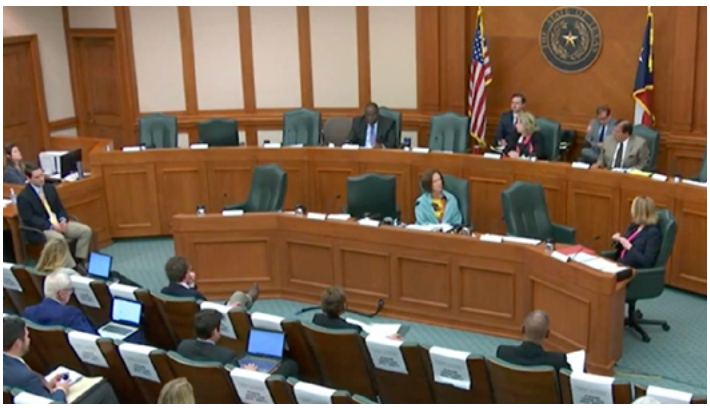
KXAN | April 11, 2021

Insurers, like Dudensing, are backing House Bill 18, which has state and health insurance companies leverage their influence with drug manufacturers to negotiate lower prices.

Texas Farm Bureau could sell health coverage to its members exempt from insurance laws if bill passes

KWTX | May 12, 2021

"Farm bureau plans raise premiums for everyone else in the individual market because they cherry pick the healthier and leave sicker populations in the regulated market," said Jason Baxter, the director of government relations at the Texas Association of Health Plans, at a committee hearing for the Senate version of the bill.



House OKs bill letting Texas Farm Bureau sell health coverage exempt from insurance laws

Dallas Morning News | May 4, 2021

TAHP has warned the changes could destabilize the insurance market if younger, healthier people begin to depart for new unregulated plans, potentially leaving the risk pool with a sicker population.

'A bigger hit than the cancer itself': How some states are working to help cancer patients with infertility

The 19th News | May 13, 2021

Lawmakers in states including Utah and Texas introduced legislation this year aimed at requiring insurance companies to cover the costs of fertility preservation. [...] Pushback on legislation has come from some businesses and insurance firms.

Preauthorization for health care takes Tuesday's spotlight in Texas Senate Finance Committee

KTSM | May 18, 2021

"It should have some accountability on the back end. You should have some accountability for fraud, waste, and abuse. You should have some accountability for that quality of care, and you should have some accountability for those metrics that have been developed by the medical community to follow," said Dudensing, CEO of the Texas Association of Health Plans.

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tahp.org/page/Advocacy

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Freestanding Emergency Rooms	Expanding Access (APRNs)
Prescription Drug Coverage	High Insulin Costs
Reducing Health Care Mandates	Eliminating Social Barriers to Care
Lowernig Health Care Costs	Smart Care & Appropriate Utilization