

## Will Consumer Protections for Texas Medicaid Managed Care Survive to Become Law in the 86th?

*The Chance for Reforms may be Lost as the Legislative Clock Runs Down...*

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**Legislation to improve health care for Medicaid enrollees and improve insurer performance and accountability is at risk of failing to become law due to late-hour conflicts and legislative process delays. Extensive analysis, public hearings, and negotiations over the last 9 months to develop improved policies will have been wasted if this happens.**

Over 50 bills aimed at reforming Texas Medicaid Managed Care were filed in this legislative session, and [many had public hearings in April](#). Today, some clear frontrunners have emerged, but we remain a long way from final decisions about which bills will pass and which reforms will survive the process. Health care provider and health insurance industry associations have put in long hours lobbying for their respective goals and priorities, and the consumer advocates have added their two cents wherever possible.

Notably, several substantial agreed-to policy proposals emerged from a working group of physician, hospital, and insurer lobbyists. While disagreements on other important issues remain, some fundamental improvements have come out of this work, including the implementation of a new independent medical review option to which enrollees and providers can appeal denials and reductions of care made by Medicaid Managed Care plans (often referred to as MCOs); and robust new transparency and accountability requirements for MCO “Prior Authorization” requirements before a service can be accessed. If those two general concepts survive the hectic last month of this legislative session relatively intact, there will be meaningful progress. Advocates for Texans with disabilities and medically fragile children have made important expert contributions to the development of bills.

A number of important proposed consumer protections for Texas’ 4 million Medicaid enrollees in the bills that are “moving.” This post (and attached brief) looks at five bills. HB 2453 by Sarah Davis, HB 4178 by James Frank, and SB 1105 by Lois Kolkhorst are lengthier bills that cover multiple Medicaid Managed Care topics. HB 3721 by Joe Deshotel and SB 1140 by Kirk Watson (joint authors Hinojosa and West) are single-topic bills to create the new independent medical review option for of denials and reductions of care. However, HB 2453 and HB 4178 each also contain provisions to establish the independent medical review function. Below, proposals on (key) Medicaid Managed Care reform topics are summarized, beginning with the proposals for an independent medical review option.

***Put simply, to get the best protections for Texas Medicaid, the Legislature will need to incorporate provisions from several bills: no single bill currently delivers all of the needed consumer protections. The 86<sup>th</sup> Legislature has just a few short weeks to get the job done to protect 4 million Texans and the integrity of our public investment in Medicaid Managed Care.***

**Note:** “MCO” stands for Managed Care Organization. All Texas Medicaid Managed Care health plans are licensed as HMOs, but “MCO” is a term used nationally in Medicaid, in order to be inclusive in states where HMOs are not the only vehicle for Medicaid Managed Care delivery.

### **New Independent Medical Review option, to appeal denials or reductions of care by MCOs, or eligibility denials by HHSC based on medical necessity or functional need**

Federal Medicaid laws require that Medicaid enrollees and applicants must be able to request a “Fair Hearing” when a service is denied or reduced, or when eligibility is denied, but there is no requirement that state staff who make the decisions in those hearings have any medical or clinical expertise. This is a problem, because MCO denials are typically based on a dispute over whether a service is “medically necessary,” or when the Medicaid agency denies Medicaid eligibility for special levels of care based on the severity of a person’s medical condition or “functional need.” Only a handful of states have adopted policies to address this glaring loophole, and the proposals for independent review in these Texas bills resemble to solutions other states are using.

- **In multiple bills.** As noted, HB 3721 and SB 1140 are solely about creating this function, while HB 2453 and HB 4178 also contain provisions. Several other members filed bills on this topic.
- **The bills use different terms for essentially the same thing:** Independent Review Organizations (IROs) already exist and are used in commercial insurance denial disputes., third-party arbiter, independent medical review. All identify the IRO optional step as occurring after an MCO’s internal appeal has upheld an initial denial, but before a Medicaid fair hearing.

- **Number of IROs:** SB 1140 calls for 3 or more contractors; HB 2453, HB 4178 and HB 3721 call for HHSC to contract with “an” IRO.
- **Includes reductions in care, not just complete denials:** HB 2543 and HB 3721 clarify that reductions (not just complete denials) in care are included. HB 4178 and SB 1140 cite reductions only in their reference to eligibility denials made by the HHSC (see below) and not in MCO reductions of care, so their language may not be sufficient to ensure reductions are also protected by the IRO process.
- **Also includes HHSC eligibility denials based on medical necessity or functional need:** HB 2453, HB 4178, and SB 1140 include an IRO option for these eligibility denials.
- **Burden of proof is on MCO to establish that the care is not medically necessary.** HB 2453, SB 1140, and HB 3721 call for HHSC to establish external review procedures that include the presumption of medical necessity, , and provide for expedited reviews for urgent care. HB 2453 and HB 3721 require external reviews to have a basis in up-to-date peer-reviewed clinical evidence.
- **External review is optional for enrollee.** Both HB 2453 and HB 3721 clarify that enrollees may opt out of external review after an MCO denies or reduces care, and proceed to a Medicaid fair hearing if they choose.
- **Expertise of independent reviewer:** HB 2453 and SB 1140 require “same or similar” education and practice; HB 4178 and HB 3721 call for a less rigorous “appropriate expertise.” HB 2453 and HB 3721 call for expertise related to private duty nursing and long-term services and supports, which are needed by enrollees in STAR Health, STAR Kids, and STAR Plus. HB 2453 and HB 3721 also call for a qualified IRO to have a medical director licensed in Texas.
- **No Conflict of Interest or Reviewer Shopping.** HB 3721 and HB 4178 would require random assignment of reviewers and obligate HHSC and the IRO to monitor and avoid conflicts of interest; HB 2453 and HB 3721 require no financial relationship between and MCO and an IRO.
- **Online tracking system for enrollee.** HB 2453 and SB 1140 require the IRO(s) to have an online tracking system to allow enrollees to follow status of appeal.
- **Benefits continued pending outcome of appeals, external reviews, and fair hearings.** HB 2453 calls for unreduced benefits to be continued for a Medicaid enrollee until the various levels of appeal or review are complete, unless the enrollee opts out of continuation.
- **Special protections:** HB 2453 and HB 3721 include a provision that the outcome of an Independent Medical Review “sets the floor” for the enrollee; that is, a fair hearing afterwards cannot result in a less favorable outcome for the enrollee than the IRO decision. HB 4178 and HB 3721 indicate that HHSC will decide what recourse remains after an IRO (but federal law mandates access to the fair hearing).

### **MCO Accountability: tracking and creating public records of complaints, appeals, denials and corrective actions**

An over-arching concern raised in the media and Legislative hearings has been the lack of centralized data on Medicaid Managed Care problems, and the failure until now to leverage that track record to inform agency contracting and enrollee plan choices, or to use public reporting of MCO track records to simply encourage better performance by the health plans. Here are some of the major highlights and themes in the 5 bills.

- **Notices of denials of prior authorization or reductions in services** clearly state exactly what documentation is needed to get approval, and the reasons for a denial in both plain and medical terms (for both enrollee and care provider) are in SB 1105, HB 2453, and HB 4178.
- **Complaints and grievances from all sources will be aggregated into a centralized HHSC database** regardless of where they originated (e.g., including those coming for a Legislator’s office): a “no wrong door” tracking system: especially strong in HB 2453 and SB 1105. Along with track record on denials, appeals, and MCO decisions overturned, this data would be integrated into MCO report cards to help enrollees choose among plans (HB 2453). SB 1105 calls for verification of MCOs’ reported complaint data, and creating online public access to MCO quality and outcome performance data.
- **“Liquidated Damages” for MCO contract compliance failures.** HB 2453 specifically calls for liquidated damages (financial penalties) for MCOs failing to comply with contracts, and for transparent public HHSC records of all MCO enforcement actions.
- **External Quality Review Organization role in oversight and analysis of grievances, denials, appeals, etc.** HB 2453 calls for the federally mandated independent Medicaid Managed Care external review entity to look at the track record created from MCO inquiries, complaints about access, grievances, denial, appeals, overturned denials, and fair hearings, including comparing the track records of both for-profit and non-profit MCOs.
- **MCOs’ PA “Track Record” Analyzed and Reported to Public by HHSC.** HB 2453 calls for HHSC to consider Medicaid Managed Care grievances and HHSC outcome goals in performing internal agency reviews of MCO performance; MCOs must have an opportunity to review and respond before HHSC findings are posted for public.

## Issues for STAR Kids (children with disabilities and medically fragile kids) and STAR Health (kids in foster care, which includes some medically fragile children)

Problems—some life-threatening—for children with disabilities, medically fragile kids, and children in the Texas foster care system are a top concern being addressed in Medicaid Managed Care reform bills.

- **Annual Assessment for MDCP.** Both HB 2453 and SB 1105 call for a re-design, and HB 4178 for streamlining of the annual (and initial) needs assessment for the Medically Dependent Children’s Program (MDCP) waiver and STAR Kids, and require that parents be provided with the assessment, and a signature be obtained to ensure that. All three bills require that care for a child may not be delayed by the MCO related to this process. HB 2453 calls for special re-design of needs assessments for Private Duty Nursing.
- **Continuing the STAR Kids Advisory Committee.** SB 1105, HB 2453, and HB 4178 all provide for continuation, either specifically to December 2023 or subject to HHSC discretion.
- **Proposed Medicaid Buy-in for Children with Disabilities.** HB 4178 proposes HHSC seek a waiver to allow children with disabilities in higher income families to “buy in” to Medicaid coverage, subject to available state budget funding.
- **Add “Consumer-Directed” option to MDCP; study use of ACO or other innovative models.** SB 1105 calls for the creation of a “consumer-directed” option to MDCP. Presumably, this would be an alternative to STAR Kids, and similar to the previous fee-for-service model. HHSC is directed to study use of an Accountable Care Organization model or other model endorsed by the federal Center for Medicare and Medicaid Innovation and report in December 2022.
- **“Coordination of Benefits” for children who also have private insurance.** Both HB 2453 and HB 4178 include different provisions to streamline approval of care for children with both Medicaid and private coverage. HB 4178 includes allowing a child with complex needs to maintain established relationships with an out-of-MCO service area provider and to allow continued access to a medication without “prior authorization” if it was previously covered by their private insurer.
- **Study Single Statewide MCO contract for STAR Kids.** SB 1105 calls for HHSC to issue a request for information (RFI) to assess the concept of a having single statewide managed care plan contract for children with disabilities, as opposed to the current model of multiple options per region.
- **CONTESTED: Allow children to be assessed for therapy (PT/OT/ST) needs.** Currently foster care children in STAR Health must get prior authorization (PA, or permission from the MCO) before they can be assessed for their physical, occupational, or speech therapy needs. HB 2453 (Section 14. Sec. 533.0058) would require that any such PA policy must have a clinical basis. **This provision has been opposed by the Texas Association of Health Plans (TAHP).**
- **CONTESTED: Extended PA periods for certain medications, medical and mental health services, and treatments for certain chronic conditions and disabilities.** HB 2453 (Section 24. Sec. 533.0095) calls for HHSC to establish a list of these, for which MCOs would be required to grant longer authorizations, e.g., for conditions unlikely to change rapidly. **This provision has been opposed by the Texas Association of Health Plans (TAHP).**

## Care Coordination Transparency and Adequacy

STAR Plus, STAR Health, and STAR Kids all include varying kinds of care coordination for enrollees, but the titles used, the degree of services the MCO is obligated to provide, and the credentials and numbers of care coordinators vary. Enrollees and health care providers report confusion about what the coordinators’ roles are, as well as challenges accessing the care coordinators.

- **Consistent Terms and new options for delivery.** HB 2453 calls for HHSC to develop consistent terminology across the different Medicaid Managed Care programs, and development of HHSC rules to allow on-site care coordinators or virtual/online care coordination services. The bill also calls for care coordinators responsibilities to include assisting enrollees with prior authorization processes.
- **Accountability of MCOs for Care Coordination impact on potentially preventable hospital admissions or readmissions.** HB 2453 calls for the adequacy of MCO care coordination to be a factor in metrics related to hospital admissions, specifically including behavioral health related admissions.
- **Specific requirements for Long Term Services and Supports, and for the STAR Health, Kids, and Plus populations.** HB 2453 calls for detailed requirements for care coordination to meet the needs of children and adults with disabilities, foster children, and seniors, including non-medical long term and community based services and supports.
- **Minimum requirements for care coordinator response times after enrollee requests.** HB 2453 calls for specific contract performance standards for MCOs regarding timely response to enrollee requests.

**“Prior Authorization” (PA) Reforms: Reducing Barriers and Red Tape between enrollees and the care they need.**

Extensive negotiations among doctors, hospitals and health insurers have been devoted to streamlining PA processes to reduce delays and improve access to medically needed care. Consensus has been reached on some important issues, while other issues remain contentious.

- **Required elements of Notices.** Both HB 4178 and HB 2453 include specific requirements that notices of PA denial must specify precise reasons for denial, timelines involved, and documentation required to achieve authorization.
- **Annual Review of PA Requirements.** Both HB 4178 and HB 2453 call for an annual review by each MCO of all of their PA requirements, including the required documentation for approval and the related timelines. HB 2453 requires that each MCO's inventory be publicly posted online.
- **Ability to "fix" incomplete PA paperwork and confer with a medical peer.** Both HB 4178 and HB 2453 would require MCOs to allow health care providers or enrollees to provide any missing documents to complete a PA request before they can be denied, and require that health care providers be able to confer with a clinician with "same or similar" education and practice expertise.
- **Specific PA time frame standards for all MCOs.** HB 4178 includes important detailed timeline standards that have been negotiated, too detailed for this summary but will guarantee access on weekends and holidays.
- **Exempting Medicaid Managed Care from some Texas Insurance Laws.** HB 4178 exempts Texas Medicaid Managed Care plans from certain Texas Insurance law requirements (Texas Ins Code 4201.304) that govern utilization review and PA.
- **PA Track Record Analysis by HHSC.** HB 2453 requires HHSC to analyze the trends in each MCOs PAs, including the rates of appeals and rates of PA denials being overturned.
- **CONTESTED PA Provisions:** HB 2453 includes three additional PA-related provisions (**two more are listed** in the children's issues section) that the Texas Association of Health Plans (TAHP, Texas' health insurance industry lobby group) has said they oppose and are the reason for their opposition to HB 2453.
  - The first is section 9(e) of the bill, which requires HHSC to review the MCO annual inventory and make recommendations about needed changes, updates, or deletions.
  - The second is section 9(k) of the bill, which requires HHSC to "to the extent feasible," give "guidance" to MCOs on "aligning treatments and conditions subject to prior authorization to create uniformity among Medicaid managed care plans." Despite the moderating words (to the extent feasible, guidance), TAHP has stated that the language is a mandate for a requirement that all MCOs use the same PA policies.
  - The third is Section 18 of the bill, which permits (does not require) HHSC to develop incentive programs in Medicaid Managed Care in which providers who meet specified quality goals or who adhere to specific evidence-based medical practices could be granted reduced PA requirements. Though the language is permissive, TAHP asserts that this provision would force MCOs to use identical approaches to PA provider incentive programs.

### **Improved Benefits, Network Adequacy, and Quality**

Several provisions are included in Medicaid Managed Care bills to improve MCOs' are delivering enrollees access to the benefits and health care providers they need.

- HB 4178 would requires that the criteria for including an medication on the Texas Medicaid "preferred drug list" (PDL) must take into account a drug's impact on health outcomes and continuity of care (this is not currently the case).
- HB 4178 would require new policies to improve coordination and reduce delays for seniors and Texans with disabilities who have dual coverage under both Medicaid and Medicare.
- HB 2453 would require HHSC to validate MCOs' provider networks, including whether time and distance standards are met. HHSC would also be required to validate the MCO provider directory by comparing against the Texas Medicaid master provider file, to ensure that the master file is accurate and up to date, and report to the Legislature on findings by December 2020. HHSC would establish adequacy standards for Personal Attendant access (because attendants provide services in the enrollee's home, time and distance are not relevant), and the External Quality Review Organization (EQRO) would periodically assess adequacy of availability of Personal Attendant care. The EQRO would use MCO records of care provided as one factor in validating the accuracy of an MCO's provider directory. Providers listed incorrectly, who cannot be reached, or who do not actually accept Medicaid patients will be included in the denominator when directories are assessed for accuracy (this is not currently the case).
- HB 2453 provides that annual EQRO studies would study at least three quality measures, compare non-profit and for-profit performance measures, analyze how MCO polices may affect the acuity of their enrollee population. MCOs quality monitoring would incorporate measures for individuals with intellectual and developmental disabilities.

### **Provisions Designed to Improve the Medicaid Managed Care Provider Experience**

Several bills include provisions specifically designed to better meet the needs of health care providers in Texas' Medicaid Managed Care programs.

- SB 1105 calls for a study of the impact of the current limit on coverage of inpatient hospital days for adults (which is 30 days per spell of illness) in the STAR Plus program, which services seniors and adults with disabilities.
- SB 1105 calls for Texas Medicaid to use the National Provider Identifier (NPI) number, rather than any Texas-specific provider ID number. HHSC and MCOs would start by using the NPI for credentialing providers, and eventually use it exclusively for billing. HB 4178 also calls for streamlining of credentialing and conversion to using the NPI.
- SB 1105 calls for creation of a specific process to add to or amend Medicaid Managed Care benefits, to include stakeholder advisory committee input. It also calls for creation of a single, unified HHSC medical benefits policy manual that fully incorporates Medicaid Managed Care policies.
- HB 4178 would require new policy and process for making changes to provider rates which would include a formal process for provider notice and input, and 45 days for the Texas Medicaid claims processor and MCOs to make system changes needed to increase or reduce fees.
- HB 4178 would add 18 MCO representatives to the Medicaid Drug Utilization Review Board (up from current 2, to 5 for each STAR program); just 2 consumer representatives would be included and no more than one can be a voting member.
- HB 4178 would require that providers have access to online eligibility data that identifies patients with private coverage in addition to Medicaid, and if possible information on the benefit coverage and cost sharing provisions of the enrollee's private insurance plan.
- HB 2453 would establish a new Ombudsman for care providers, not within the HHSC Ombudsman's division but required to coordinate data with that division, and charged with using the data collected to make recommendations on how to improve provider experience with Medicaid and Medicaid Managed Care. The bill also calls for creating a system to track provider payment appeals, including detailed timeline information on claims paid.
- HB 2453 would require that EQRO studies collect provider opinions on MCO quality, and also analyze whether MCOs are disproportionately denying PA or benefits to specific providers.
- HB 2453 would require that MCOs must solicit input from care providers as part of its required annual review of PA processes.