Coming September 1: New Texas Health Care Laws

Description

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The 87th Regular Session of the Texas Legislature began in the midst of a pandemic that made health care and health care policy a central part of almost every debate. Not only did we see creation policies responding to the COVID pandemic, but we also saw greater emphasis on all areas of health care policy and what it means for Texans.

While some health care legislation went into effect as soon as it was signed by the Governor, many bills do not take effect until the state begins a new fiscal year on September 1. Below is a guide for legislation going into effect next week.

For a more comprehensive overview of legislation, check out our 87th Session Highlights Guide or watch our Food for Thought webinar on the topic.

Pandemic Response

HB 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.

SB 2038 was passed in response to severe **price gouging for COVID-19 tests administered by free-standing ERs** across the state, including many tests billed for more than $10,000. During a state of disaster this bill prohibits free-standing ERs from charging an unconscionable price or knowingly or intentionally charging a third-party payor, including a health plan, a higher price than it charges individuals.

Prescription Drugs

HB 18, also known as the **Texas Cares Rx Program**, will help Texans without prescription drug benefits obtain more affordable prescriptions. It establishes a program to provide uninsured Texans access to prescription drugs at a “post-rebate” price that is negotiated by the state using the buying power of the Medicaid program. While the bill authorizes the state to set up the program as of September 1, the actual implementation and enrollment will take more time.

HB 1033 streamlines the process for pharmaceutical drug manufacturers to disclose certain drug price increases along with reasons for those increases. It 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 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.

HB 1763 effectively **eliminates the ability of health plans and pharmacy benefit managers to negotiate lower prices on drugs**

by prohibiting discounted payments to affiliated pharmacies. The bill also mandates that a health plan or pharmacy benefit manager network agreement **may not prohibit a pharmacy from mailing or delivering a drug** to a patient upon request, and it prohibits a health plan or PBM from requiring any specialty accreditation unless required by law or by the drug manufacturer.

HB 1919 **prohibits a health plan or pharmacy benefit manager from encouraging a patient to use an affiliated provider**, including through reduced copays or deductibles or through most marketing materials. The bill also requires written consent from the enrollee to transfer a prescription to an affiliated pharmacy or provider.

HB 1935 gives pharmacists the **authority to dispense a 30-day emergency supply of insulin** and insulin-related equipment and supplies if specific criteria are met. While the bill goes into effect on September 1, it applies to health plans issued or renewed on or after January 1, 2022.

SB 827 **prohibits a health plan from imposing a cost sharing provision for insulin 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. Applies to commercial health plans issued or renewed on or after January 1, 2022.

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. The bill preserves safety measures such as dosage limits and gives pharmacists the **ability to dispense a 3-day emergency dosage** if clinically appropriate. The bill is effective September 1, but allows HHSC to delay implementation pending federal approval and contract updates.

Benefit and Coverage Mandates

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

SB 1065 **expands mandated breast cancer screening** to include ultrasound and MRI imaging for an individual with a personal history of dense breast tissue. Applies to commercial health plans issued or renewed on or after January 1, 2022.

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.

HB 1363 **expands the types of physical therapists a patient may see without a referral**. This provision applies to by adding “certified by an entity approved by the board” as an alternative to the requiring completion of a residency or fellowship. A doctoral degree is still required. Requires the Texas Board of Physical Therapy Examiners to adopt rules by November 1, 2021.

HB 3459 prohibits an HMO or health plan from requiring a physician or provider to obtain prior authorization for a particular service if the health plan approved 90% of the prior authorization requests submitted in the most recent six-month evaluation period.

Medicaid

Please Note: *while these medicaid bills are technically effective September 1, the Legislature recognizes that changes to the Medicaid program usually require negotiations with CMS and changes to the managed care contract. Where applicable, HHSC is provided flexibility on implementation dates.*

HB 2658 includes provisions to create efficiencies in the Medicaid program. The majority of Medicaid clients receive coverage through managed care, but many processes are still operating through fee-for-service.

Provisions include requiring HHSC to:

- provide two consecutive periods of eligibility for a child with a single eligibility check
- study the feasibility of creating an online portal for individuals to request placement on a Medicaid waiver program interest list
- develop a procedure to verify a Medicaid recipient is informed about consumer direction services and provided the option to choose to receive care
- establish rules in addition to existing nursing facility minimum performance standards in the STAR+PLUS program
- 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
- collaborate with MCOs to implement medication therapy management services to lower costs and improve quality outcomes for recipients
- identify why there is low participation in a disease management program and develop an approach to increase participation
- add 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
- 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
- review nursing facility staff rate enhancement programs

- 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
- 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
- identify benefits and services, provided under Medicaid that are not provided in this state under the Medicaid managed care model and evaluate the impact of providing the benefits and services through Medicaid managed care
- conduct a study regarding dually eligible individuals who are enrolled in managed care

The majority of these changes will require HHSC to adopt contract amendments, rules and negotiate changes with CMS so while they are technically effective September 1, HHSC will need additional time to implement.

HB 133 **extends Medicaid coverage for pregnant women by 4 months** to allow for 6 months total of coverage postpartum. 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. The bill also **transitions the Case Management Program for Children and Pregnant Women and the Healthy Texas Women's (HTW) Program into managed care**. By putting these programs into managed care, women in these programs will have continuity of coverage and providers. This will help make any program transitions seamless and avoid disruption of care. While the bill is technically effective on September 1, HHSC needs CMS approval to extend coverage for pregnant women to implement. HHSC has indicated the HTW carve-in will be part of the new STAR contracts scheduled for 2024 and the case management program will be carved-in via a September 1, 2022 managed care contract amendment.

HB 3720 **requires HHSC to work with stakeholders to develop a more comprehensive questionnaire for interest lists** in order to address concerns related to the often long wait list for home and community waiver programs. Additionally, the bill sets out that 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 differently. At that time, the individual's status on the interest list will be restored to the date they were initially placed on the interest list.

SB 50 requires HHSC to **develop a uniform process to assess the goals and available opportunities for competitive and integrated employment opportunities and related employment services in waiver programs** including the STAR+PLUS home and community-based services (HCBS) waiver program. HHSC must also identify strategies to increase the number of individuals who are receiving employment services from the Texas Workforce Commission and ensure those individuals receive services.

SB 73 requires HHSC to establish a **unique provider type for enrollment and reimbursement of local public health departments**. HHSC has not indicated when the new provider type will be effective as it will require system changes to implement.

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.

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.

SB 1244 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.

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. HHSC will need to update the rules that are in the process of being adopted to implement SB 1207 with the clarification from SB 1648.

Non-insurance

HB 3752 allows the **Texas Mutual Insurance Company to offer a type of health "coverage" that is not an insurance policy** or product subject to Texas workers' compensation law and may be offered to individuals, small businesses, or the company's policyholders and their employees. The company **must submit a report to the Legislature** by September 1, 2022 and coverage may be offered before September 1, 2023.

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.

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.

Transparency

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.

HB 2090 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.

Rates and Regulations

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.

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.

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**.

HB 2056 allows dentists and dental professionals to communicate and share patient information, which will **allow access to dental care professionals through telehealth**. 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. Teledentistry is also added to the Insurance Code telehealth coverage mandate.

Contracting

SB 799 **amends current law relating to contracting procedures and requirements for governmental entities, including HHSC**. Reforms in SB 799 include changes to:

- Major Information Resources Projects
- Best Value Statute
- Purchasing a Commodity
- Contract Management Guide

Behavioral and Mental Health

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

SB 640 focuses specifically on the **interoperatiliby of behavioral health service providers** in Texas. The bill creates a study reviewing the technology readiness, interoperability and gaps in technology in Texas, including within behavioral health organizations, managed care, and other key stakeholders.

SB 672 requires HHSC to add Medicaid **reimbursement for collaborative care management services for children and adults receiving behavioral health services**

. HHSC has indicated they are working on the policy and will hold a rate hearing in November.

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