TO: Medical Care Advisory Committee

DATE: February 11, 2021

FROM: Michelle Erwin, Deputy Associate Commissioner, Policy and Program

SUBJECT: Coordination of Benefits and Specialty Providers

Agenda Item No.: 11

Amendments to: §353.4, concerning Managed Care Organization Requirements Concerning Out-of-Network Providers and new §353.7, concerning Coordination of Benefits with Primary Health Insurance Coverage, in the Texas Administrative Code, Title 1, Chapter 353 Medicaid Managed Care.

BACKGROUND: ☐ Federal Requirement ☒ Legislative Requirement ☐ Other:

The purpose of the proposal is to implement Texas Government Code, Section 533.038(g), added by Senate Bill 1207, 86th Legislature, Regular Session, 2019. Section 533.038(g) requires HHSC to establish a process for a Medicaid health care managed care organization (MCO) to allow a member with complex medical needs, who has established a relationship with a specialty provider through the member's primary health benefit plan, to continue receiving care from that specialty provider, whether or not that provider is in the health care MCO's network.

The proposed rules require a health care MCO to allow a member to remain under the care of a Medicaid enrolled specialty provider with which the member currently receives care through a primary health benefit plan—even if the specialty provider is an out-of-network provider for the health care MCO—if at the time of enrollment into the health care MCO, the member: (1) has complex medical needs, and (2) has and maintains healthcare coverage under a primary benefit health plan.

In reimbursing an out-of-network specialty provider acting within the scope of new Section 353.7, the proposed rules require a health care MCO to utilize the existing reimbursement methodology for authorized services performed by an out-of-network provider in renumbered Section 353.4(f)(2) (previously Section 353.4(e)(2)), until: (1) an alternate reimbursement agreement is reached with the member's specialty provider; (2) the member is no longer enrolled in a primary health benefit plan; (3) the member or the member's legally authorized representative agrees to select an alternate specialty provider; or (4) the member is no longer enrolled in the health care MCO.

Proposed new Section 353.7 also defines "primary health benefit plan," "complex medical needs," and "specialty provider" when used in the proposed new rule.

ISSUES AND ALTERNATIVES:

Some stakeholders have commented that the rules should apply to any Medicaid member, not only to certain Medicaid enrolled children with third party insurance. Additionally, some provider types who consider themselves to be a "specialty provider" have requested that they be included in the rule as a "specialty provider."

HHSC drafted the proposed rule after thorough review of the statutory language, its context, and the legislative intent of Section 533.038 of the Texas Government Code. In addition to general comments regarding the proposed rule, HHSC is requesting comments on how to distinguish a subset of durable medical equipment suppliers or of other provider types that might possibly be considered specialty providers based on the services they provide. HHSC staff will continue to review and consider any public comments received to decide if any changes should be made.

STAKEHOLDER INVOLVEMENT:

Providers, family members, and advocates have provided public comment regarding Texas Government Code, Section 533.038(g) at the STAR Kids Managed Care Advisory Committee (STAR Kids MCAC) and State Medicaid Managed Care Advisory Committee (SMMCAC). HHSC solicited written comments on draft contract language from the STAR Kids MCAC, SMMCAC, and the Texas Association of Health Plans (TAHP). The STAR Kids MCAC requested HHSC apply the change to all STAR Kids members, not to limit "specialty provider" to physicians, and not to limit the application of the change to the date of enrollment with the MCO. TAHP requested HHSC limit the change only to new members, limit "specialty provider" to physicians, have the change go into effect as of the date of the contract change, and have the change apply only at a member's initial selection of a plan. The SMMCAC expressed support for the proposed language and two commenters recommended the change be limited to STAR Kids and asked HHSC to make corresponding changes so MCOs are not penalized for increased out-of-network utilization. This feedback was taken into consideration during the development of the rules.

Additionally, HHSC provided an overview of the timeline for development of the contract language and rules at the November 2020 Medical Care Advisory Committee and the SMMCAC meetings. During the SMMCAC meeting, HHSC received one public comment from Parent to Parent who asked HHSC to apply the rule to adults and to involve their organization in the draft rule development.

FISCAL IMPACT:

☒ None

RULE DEVELOPMENT SCHEDULE:

February 11, 2021	Present to the Medical Care Advisory Committee
February 18, 2021	Present to HHSC Executive Council
February 2021	Publish proposed rules in Texas Register
April 2021	Publish adopted rules in *Texas Register*

April 2021 Effective date

REQUESTED ACTION:

☐ The MCAC recommends approval of the proposed rules for publication.

☒ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER A GENERAL PROVISIONS

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes an amendment to §353.4, concerning Managed Care Organization Requirements Concerning Out-of-Network Providers; and new §353.7, concerning Coordination of Benefits with Primary Health Insurance Coverage.

BACKGROUND AND PURPOSE

The purpose of the proposal is to implement Texas Government Code, §533.038(g), added by Senate Bill (S.B.) 1207, 86th Legislature, Regular Session, 2019. Senate Bill 1207 requires HHSC to establish a process for a Medicaid health care managed care organization (MCO) to allow a member with complex medical needs, who has established a relationship with a specialty provider through the member's primary health benefit plan, to continue receiving care from that specialty provider, whether or not that provider is in the health care MCO's network.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.4 adds new subsection (d) which sets forth the reimbursement methodology for a Medicaid health care MCO to pay out-of-network specialty providers performing services in accordance with proposed new §353.7. The proposed amendment also reformats the section and updates references.

Proposed new §353.7 sets forth the requirements imposed on Medicaid health care MCOs relating to certain out-of-network specialty providers. Subsection (a) clarifies that the rule applies to a member age 20 or younger who has complex medical needs and who has and maintains healthcare coverage under a primary health benefit plan. Subsection (b) defines "primary health benefit plan" in a manner consistent with Texas Human Resources Code, §32.0422(a). Subsection (c) defines "complex medical needs." Subsection (d) defines "specialty provider" in a manner consistent with the specialty provider list already established in Chapter 3.1 of the Uniform Managed Care Manual (UMCM). Subsection (e) requires a health care MCO to utilize the reasonable reimbursement methodology for authorized services performed by out-of-network providers described in renumbered §353.4(f)(2) (previously §353.4(d)(2)), until: (1) an alternate reimbursement agreement is reached with the member's specialty provider; (2) the member is no longer enrolled in a primary health benefit plan; (3) the member or the member's legally authorized representative agree to select an alternate specialty provider; or (4) the member is no longer enrolled in the health care MCO.

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer, has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:
(1) the proposed rules will not create or eliminate a government program;
(2) implementation of the proposed rules will not affect the number of HHSC employee positions;
(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;
(4) the proposed rules will not affect fees paid to HHSC;
(5) the proposed rules will create a new rule;
(6) the proposed rules will expand an existing rule;
(7) the proposed rules will not change the number of individuals subject to the rules; and
(8) the proposed rules will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. The rules apply to health care MCOs, which are not small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Stephanie Stephens, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public benefit will be that a member with complex medical needs who has established a relationship with a specialty provider will be able to continue receiving care from that provider when the criteria outlined in the rules are met.

Trey Wood has also determined that for the first five years the rules are in effect, there may be an economic cost to persons who are required to comply with the proposed rules. A health care MCO may need to train staff to implement the requirement to allow a member to continue seeing a specialty provider as described in the new rule. However, HHSC lacks sufficient information to determine cost to comply.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC HEARING

A public hearing is scheduled for February 26, 2021 starting at 3:00 pm (central time) to be held virtually. You can register for the meeting at:

https://attendee.gotowebinar.com/register/8673928896775152139

The webinar ID is: 273-729-803.

Persons requiring further information, special assistance, or accommodations should contact Mary Valente at (512) 438-4387.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or e-mailed to HHSRulesCoordinationOffice@hhs.texas.gov.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 21R032" in the subject line.

In addition to general comments regarding the proposed rule, HHSC is requesting comments on how to distinguish a subset of durable medical equipment suppliers or of other provider types that might possibly be considered specialty providers based on the services they provide.

STATUTORY AUTHORITY

The amendment and new section are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Texas Human Resources Code §32.021, which provides HHSC with the authority to administer the federal medical assistance (Medicaid) program in Texas and to adopt rules and standards for program administration; and Section 8 of S.B. 1207, in implementing Texas Government Code, §533.038.

The amendment and new section implement Texas Government Code §531.0055 and Texas Government Code, §533.038.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 221-6857.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language
(No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER A GENERAL PROVISIONS

§353.4. Managed Care Organization Requirements Concerning Out-of-Network Providers.

(a) Network adequacy. HHSC is the state agency responsible for overseeing and monitoring the Medicaid managed care program. Each managed care organization (MCO) participating in the Medicaid managed care program must offer a network of providers that is sufficient to meet the needs of the Medicaid population who are MCO members. HHSC monitors MCO members' access to an adequate provider network through reports from the MCOs and complaints received from providers and members. Certain reporting requirements are discussed in subsection (g) [~~(f)~~] of this section.

(b) MCO requirements concerning coverage for treatment of members by out-of-network providers for non-emergency services.

(1) Nursing facility services. A health care MCO must reimburse an out-of-network nursing facility for medically necessary services authorized by HHSC [~~the Texas Department of Aging and Disability Services (DADS)~~], using the reasonable reimbursement methodology in subsection (f) [~~(e)~~] of this section. Nursing facility add-on services are considered "other authorized services" under paragraph (2) of this subsection, and are authorized by STAR+PLUS MCOs.

(2) Other authorized services. The MCO must allow referral of its member(s) to an out-of-network provider, must timely issue the proper authorization for such referral, and must timely reimburse the out-of-network provider for authorized services provided if the criteria in this paragraph are met. If all of the following criteria are not met, an out-of-network provider is not entitled to Medicaid reimbursement for non-emergency services:

(A) Medicaid covered services are medically necessary and these services are not available through an in-network provider;

(B) a participating provider currently providing authorized services to the member requests authorization for such services to be provided to the member by an out-of-network provider; and

(C) the authorized services are provided within the time period specified in the MCO's authorization. If the services are not provided within the required time

period, a new request for referral from the requesting provider must be submitted to the MCO prior to the provision of services.

(c) MCO requirements concerning coverage for treatment of members by out-of-network providers for emergency services.

(1) An MCO may not refuse to reimburse an out-of-network provider for medically necessary emergency services.

(2) Health care MCO requirements concerning emergency services.

(A) A health care MCO may not refuse to reimburse an out-of-network provider for post-stabilization care services provided as a result of the MCO's failure to authorize a timely transfer of a member.

(B) A health care MCO must allow its members to be treated by any emergency services provider for emergency services, and services to determine if an emergency condition exists. The health care MCO must pay for such services.

(C) A health care MCO must reimburse for transport provided by an ambulance provider for a Medicaid recipient whose condition meets the definition of an emergency medical condition. Facility-to-facility transports are considered emergencies if the required treatment for the emergency medical condition, as defined in §353.2 of this subchapter (relating to Definitions), is not available at the first facility and the MCO has not included payment for such transports in the hospital reimbursement.

(D) A health care MCO is prohibited from requiring an authorization for emergency services or for services to determine if an emergency condition exists.

(3) Dental MCO requirements concerning emergency services.

(A) A dental MCO must allow its members to be treated for covered emergency services that are provided outside of a hospital or ambulatory surgical center setting, and for covered services provided outside of such settings to determine if an emergency condition exists. The dental MCO must pay for such services.

(B) A dental MCO is prohibited from requiring an authorization for the services described in subparagraph (A) of this paragraph.

(C) A dental MCO is not responsible for payment of non-capitated emergency services and post-stabilization care provided in a hospital or ambulatory surgical center setting, or devices for craniofacial anomalies. A dental MCO is not responsible for hospital and physician services, anesthesia, drugs related to treatment, and post-stabilization care for:

(i) a dislocated jaw, traumatic damage to a tooth, and removal of a cyst;

(ii) an oral abscess of tooth or gum origin; and

(iii) craniofacial anomalies.

(D) The services and benefits described in subparagraph (C) of this paragraph are reimbursed:

(i) by a health care MCO, if the member is enrolled in a managed care program; or

(ii) by HHSC's claims administrator, if the member is not enrolled in a managed care program.

(d) Health care MCO requirements concerning coverage for services provided to certain members by an out-of-network "specialty provider" as that term is defined in §353.7(d) of this subchapter (relating to Coordination of Benefits with Primary Health Insurance Coverage).

(1) A health care MCO may not refuse to reimburse an out-of-network "specialty provider" enrolled as a provider in the Texas Medicaid program for services provided to a member under the circumstances set forth in §353.7 of this subchapter.

(2) In reimbursing a provider for the services described in paragraph (1) of this subsection, a health care MCO must use the reasonable reimbursement methodology in subsection (f)(2) of this section.

(e) [~~(d)~~] An MCO may be required by contract with HHSC to allow members to obtain services from out-of-network providers in circumstances other than those described in subsections (b) - (d) [~~(c)~~] of this section.

(f) [~~(e)~~] Reasonable reimbursement methodology.

(1) Out-of-network nursing facilities.

(A) Out-of-network nursing facilities must be reimbursed:

(i) at or above ninety-five percent of the nursing facility unit rate established by HHSC for the dates of service for services provided inside of the MCO's service area; and

(ii) at or above one hundred percent of the nursing facility unit rate for the date of services for services provided outside of the MCO's service area.

(B) The nursing facility unit rate refers to the Medicaid fee-for-service (FFS) daily rate for nursing facility providers as determined by HHSC. The rate includes items such as room and board, medical supplies and equipment, personal needs items, social services, and over-the-counter drugs. The nursing facility unit rate also includes professional and general liability insurance and applicable nursing facility rate enhancements. The nursing facility unit rate excludes nursing facility add-on services.

(2) Emergency and authorized services performed by out-of-network providers.

(A) Except as provided in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services) or subsection (j)(2) [~~(i)(2)~~] of this section, the MCO must reimburse an out-of-network, in-area service provider the Medicaid FFS rate in effect on the date of service less five percent, unless the parties agree to a different reimbursement amount.

(B) Except as provided in §353.913 of this chapter, an MCO must reimburse an out-of-network, out-of-area service provider at 100 percent of the Medicaid FFS rate in effect on the date of service, unless the parties agree to a different reimbursement amount, until the MCO arranges for the timely transfer of the member, as determined by the member's attending physician, to a provider in the MCO's network.

(3) For purposes of this subsection, the Medicaid FFS rates are defined as those rates for providers of services in the Texas Medicaid program for which reimbursement methodologies are specified in Chapter 355 of this title (relating to Reimbursement Rates), exclusive of the rates and payment structures in Medicaid managed care.

(g) [~~(f)~~] Reporting requirements.

(1) Each MCO that contracts with HHSC to provide health care services or dental services to members in a service area must submit quarterly information in its Out-of-Network quarterly report to HHSC.

(2) Each report submitted by an MCO must contain information about members enrolled in each HHSC Medicaid managed care program provided by the MCO. The report must include the following information:

(A) the types of services provided by out-of-network providers for the MCO's members;

(B) the scope of services provided by out-of-network providers to the MCO's members;

(C) for a health care MCO, the total number of hospital admissions, as well as the number of admissions that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(D) for a health care MCO, the total number of emergency room visits, as well as the total number of emergency room visits that occur at each out-of-network hospital. Each out-of-network hospital must be identified;

(E) total dollars for paid claims by MCOs, other than those described in subparagraphs (C) and (D) of this paragraph, as well as total dollars billed by out-of-network providers for other services; and

(F) any additional information required by HHSC.

(3) HHSC determines the specific form of the report described in this subsection

and includes the report form as part of the Medicaid managed care contract between HHSC and the MCOs.

(h) [~~(g)~~] Utilization.

(1) Upon review of the reports described in subsection (g) [~~(f)~~] of this section that are submitted to HHSC by the MCOs, HHSC may determine that an MCO exceeded maximum out-of-network usage standards set by HHSC for out-of-network access to health care services and dental services during the reporting period.

(2) Out-of-network usage standards.

(A) Inpatient admissions: No more than 15 percent of a health care MCO's total hospital admissions, by service area, may occur in out-of-network facilities.

(B) Emergency room visits: No more than 20 percent of a health care MCO's total emergency room visits, by service area, may occur in out-of-network facilities.

(C) Other services: For services that are not included in subparagraph (A) or (B) of this paragraph, no more than 20 percent of total dollars for paid claims by the MCO for services provided may be provided by out-of-network providers.

(3) Special considerations in calculating a health care MCO's out-of-network usage of inpatient admissions and emergency room visits.

(A) In the event that a health care MCO exceeds the maximum out-of-network usage standard set by HHSC for inpatient admissions or emergency room visits, HHSC may modify the calculation of that health care MCO's out-of-network usage for that standard if:

(i) the admissions or visits to a single out-of-network facility account for 25 percent or more of the health care MCO's admissions or visits in a reporting period; and

(ii) HHSC determines that the health care MCO has made all reasonable efforts to contract with that out-of-network facility as a network provider without success.

(B) In determining whether the health care MCO has made all reasonable efforts to contract with the single out-of-network facility described in subparagraph (A) of this paragraph, HHSC considers at least the following information:

(i) how long the health care MCO has been trying to negotiate a contract with the out-of-network facility;

(ii) the in-network payment rates the health care MCO has offered to the out-of-network facility;

(iii) the other, non-financial contractual terms the health care MCO has offered to the out-of-network facility, particularly those relating to prior

authorization and other utilization management policies and procedures;

(iv) the health care MCO's history with respect to claims payment timeliness, overturned claims denials, and provider complaints;

(v) the health care MCO's solvency status; and

(vi) the out-of-network facility's reasons for not contracting with the health care MCO.

(C) If the conditions described in subparagraph (A) of this paragraph are met, HHSC may modify the calculation of the health care MCO's out-of-network usage for the relevant reporting period and standard by excluding from the calculation the inpatient admissions or emergency room visits to that single out-of-network facility.

(i) [~~(h)~~] Provider complaints.

(1) HHSC accepts provider complaints regarding reimbursement for or overuse of out-of-network providers and conducts investigations into any such complaints.

(2) When a provider files a complaint regarding out-of-network payment, HHSC requires the relevant MCO to submit data to support its position on the adequacy of the payment to the provider. The data includes a copy of the claim for services rendered and an explanation of the amount paid and of any amounts denied.

(3) Not later than the 60th day after HHSC receives a provider complaint, HHSC notifies the provider who initiated the complaint of the conclusions of HHSC's investigation regarding the complaint. The notification to the complaining provider includes:

(A) a description of the corrective actions, if any, required of the MCO in order to resolve the complaint; and

(B) if applicable, a conclusion regarding the amount of reimbursement owed to an out-of-network provider.

(4) If HHSC determines through investigation that an MCO did not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (f) [~~(e)~~] of this section, HHSC initiates a corrective action plan. Refer to subsection (j) [~~(i)~~] of this section for information about the contents of the corrective action plan.

(5) If, after an investigation, HHSC determines that additional reimbursement is owed to an out-of-network provider, the MCO must:

(A) pay the additional reimbursement owed to the out-of-network provider within 90 days from the date the complaint was received by HHSC or 30 days from the date the clean claim, or information required that makes the claim clean, is received by the MCO, whichever comes first; or

(B) submit a reimbursement payment plan to the out-of-network provider within 90 days from the date the complaint was received by HHSC. The reimbursement payment plan provided by the MCO must provide for the entire amount of the additional reimbursement to be paid within 120 days from the date the complaint was received by HHSC.

(6) If the MCO does not pay the entire amount of the additional reimbursement within 90 days from the date the complaint was received by HHSC, HHSC may require the MCO to pay interest on the unpaid amount. If required by HHSC, interest accrues at a rate of 18 percent simple interest per year on the unpaid amount from the 90th day after the date the complaint was received by HHSC, until the date the entire amount of the additional reimbursement is paid.

(7) HHSC pursues any appropriate remedy authorized in the contract between the MCO and HHSC if the MCO fails to comply with a corrective action plan under subsection (j) [~~(i)~~] of this section.

(j) [~~(i)~~] Corrective action plan.

(1) HHSC requires a corrective action plan in the following situations:

(A) the MCO exceeds a maximum standard established by HHSC for out-of-network access to health care services and dental services described in subsection (h) [~~(g)~~] of this section; or

(B) the MCO does not reimburse an out-of-network provider based on a reasonable reimbursement methodology as described in subsection (f) [~~(e)~~] of this section.

(2) A corrective action plan imposed by HHSC requires one of the following:

(A) reimbursements by the MCO to out-of-network providers at rates that equal the allowable rates for the health care services as determined under §32.028 and §32.0281, Texas Human Resources Code, for all health care services provided during the period:

(i) the MCO is not in compliance with a utilization standard established by HHSC; or

(ii) the MCO is not reimbursing out-of-network providers based on a reasonable reimbursement methodology, as described in subsection (f) [~~(e)~~] of this section;

(B) initiation of an immediate freeze by HHSC on the enrollment of additional recipients in the MCO's managed care plan until HHSC determines that the provider network under the managed care plan can adequately meet the needs of the additional recipients;

(C) education by the MCO of members enrolled in the MCO regarding the proper use of the MCO's provider network; or

(D) any other actions HHSC determines are necessary to ensure that Medicaid recipients enrolled in managed care plans provided by the MCO have access to appropriate health care services or dental services, and that providers are properly reimbursed by the MCO for providing medically necessary health care services or dental services to those recipients.

(k) [~~(j)~~] Application to Pharmacy Providers. The requirements of this section do not apply to providers of outpatient pharmacy benefits, except as noted in §353.913 of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Outpatient Pharmacy Services).

§353.7. Coordination of Benefits with Primary Health Insurance Coverage.

(a) A health care MCO must allow a member age 20 or younger, who at the time of the member's enrollment into the health care MCO has complex medical needs and has and maintains healthcare coverage under a primary health benefit plan, to remain under the care of a Medicaid enrolled specialty provider with which the member is receiving care through the primary health benefit plan, even if the specialty provider is an out-of-network provider.

(b) For the purpose of this section "primary health benefit plan" has the meaning assigned by Texas Human Resources Code, §32.0422(a) but does not include a Medicaid plan.

(c) For the purpose of this section "complex medical needs" means a member receiving:

(1) Level 1 Service Coordination as authorized in the STAR Kids managed care contract; or

(2) Service Management as authorized in the STAR Health managed care contract.

(d) For the purpose of this section "specialty provider" means one of the following provider types:

(1) a physician licensed under the Texas Occupations Code, Chapter 155, who has and maintains a specialty in:

(A) Adolescent Medicine (Teenagers);

(B) Allergist (Allergies);

(C) Ambulatory Medicine (General Non-Emergency Care);

(D) Cardiology, Cardiovascular (Heart, Blood Vessels);

(E) Colon/Rectal (Bowels);

(F) Dermatology (Skin);

(G) Endocrinology (Glands);

(H) Family Medicine (General Family Medical Care);

(I) Gastroenterology (Stomach, Digestion);

(J) Genetics (Inherited Diseases, Birth Defects);

(K) Hematology (Blood);

(L) Hepatology (Liver);

(M) Immunology (Immune System);

(N) Infectious Diseases (Viral/Bacterial Infections);

(O) Internal Medicine (General Medical Care);

(P) Neonatology/Perinatology (Fetus and Newborns);

(Q) Nephrology (Kidney);

(R) Neurology (Brain, Nervous System);

(S) Neurosurgery (Operations of the Brain, Spinal Cord);

(T) Nuclear Medicine (Testing, e.g., MRI, CAT scan);

(U) Obstetrics/Gynecology (Pregnancy, Women's Health);

(V) Occupational Medicine (Work-Related Injuries);

(W) Oncology (Cancer);

(X) Ophthalmology (Eyes);

(Y) Oral-Maxillofacial Surgery (Jaw and Mouth);

(Z) Orthopedics (Bones and Joints);

(AA) Otolaryngology (Ear, Nose, and Throat);

(BB) Otology (Ears);

(CC) Pediatrician (Babies, Children);

(DD) Perinatology (Fetus);

(EE) Physical Medicine (Rehabilitation);

(FF) Plastic Surgery (Corrective Surgery);

(GG) Psychiatry (Mental Illness);

(HH) Pulmonology (Lungs, Breathing);

(II) Radiology (X-Rays);

(JJ) Reproductive Endocrinology (Reproductive System Diseases);

(KK) Rheumatologist (Joints, Muscles, Tendons);

(LL) Sports Medicine (Sports Injuries);

(MM) Surgery (Operations);

(NN) Thoracic Surgery (Chest Surgery);

(OO) Urology (Urinary Tract); or

(PP) Vascular Surgery (Operations of the Blood Vessels);

(2) an audiologist, as that term is defined in Texas Occupations Code, §401.001(1-a), licensed under the Texas Occupations Code, Chapter 401;

(3) a chiropractor that holds a license issued by the board created under the Texas Occupations Code, Chapter 201;

(4) a dietitian licensed under the Texas Occupations Code, Chapter 701;

(5) an optometrist licensed under the Texas Occupations Code, Chapter 351; or

(6) a podiatrist licensed under the Texas Occupations Code, Chapter 202.

(e) A health care MCO must comply with the reasonable reimbursement methodology for authorized services performed by out-of-network providers as described in §353.4(f)(2) of this chapter (relating to Managed Care Organization Requirements Concerning Out-of-Network Providers) until:

(1) an alternate reimbursement agreement is reached with the member's specialty provider;

(2) the member is no longer enrolled in a primary health benefit plan;

(3) the member or the member's LAR agree to select an alternate specialty provider; or

(4) the member is no longer enrolled in the health care MCO.