TO: Medical Care Advisory Committee

DATE: May 12, 2022

FROM: Jennie Costilow, Director, Policy and Program Development

SUBJECT: Continuity of Specialty Care for Certain Medicaid Members

Agenda Item No.: #6ai

Amendments to: §353.4, Managed Care Organization Requirements Concerning Out-of-Network Providers and §353.7, Specialty Providers in the Texas Administrative Code, Title 1, Chapter 353.

BACKGROUND: ☐ Federal Requirement ☒ Legislative Requirement ☐ Other: (e.g., Program Initiative)

The purpose of the proposal is to implement Senate Bill (S.B.) 1648, 87th Legislature, Regular Session, 2021, that amended Texas Government Code §533.038(g) and added new subsections (h) and (i) to §533.038.

To implement §533.038(g), which clarified a member does not need to have primary health benefit plan coverage in addition to Medicaid coverage to utilize the continuity of care with a specialty provider benefit, the proposed amendment to §353.7(a) removes the requirement for a member to have and maintain healthcare coverage under a primary health benefit plan. The proposed amendment to §353.7 revises the title of the section from "Coordination of Benefits with Primary Health Insurance Coverage" to "Continuity of Care with Out-of-Network Specialty Providers" because of the clarification in §533.038(g) regarding primary health benefit plan coverage.

To implement §533.038(h), which requires a managed care organization (MCO) to develop a simple, timely and efficient process and make a good faith effort to negotiate a single-case agreement with a specialty provider that is serving a STAR Kids or STAR Health member with complex medical needs but is not already in its network, the proposed amendment to §353.7, in renumbered subsection (d)(1), adds a single-case agreement as an example of an alternate reimbursement agreement that an MCO may reach with a member's specialty provider. In addition, the proposed amendment to §353.7 adds new subsection (e) to require an MCO to make a good-faith effort to negotiate a single-case agreement with the out-of-network specialty provider using a simple, timely, and efficient process developed by the MCO, if a member wants to remain under the care of a Medicaid enrolled specialty provider that is not in the health care MCO's provider network.

To implement §533.038(i), that clarifies that a single-case agreement with a specialty provider is not considered accessing an out-of-network provider for the purposes of Medicaid MCO network adequacy requirements, the proposed amendment to §353.7 adds new subsection (f) to clarify a single-case agreement

with a specialty provider entered into pursuant to §353.7 is not considered accessing an out-of-network provider for the purposes of Medicaid MCO network adequacy requirements.

The proposed amendment to §353.7 makes editorial changes in subsection (a) because of the removal of the requirement for a member to have and maintain healthcare coverage under a primary health benefit plan. The proposed amendment to §353.7(b) deletes the subsection in its entirety as the definition of "primary health benefit plan" is no longer necessary. The proposed amendment to §353.7(c) - (e) renumber the subsections to (b), (c), and (d). The proposed amendment to §353.4 updates a reference to §353.7 to align with the proposed amendment to §353.7.

ISSUES AND ALTERNATIVES:

HHSC anticipates that many external stakeholders will respond positively to the proposed amendments required to implement S.B. 1648. HHSC also anticipates that certain stakeholders will have negative feedback because the proposed amendments do not include the changes that those stakeholders previously requested in §353.4 and §353.7 that implemented S.B. 1207, 86th Legislature, Regular Session, 2019. For example, stakeholders requested HHSC add durable medical equipment and therapy providers to the list of specialty providers and to include individuals not receiving STAR Kids level 1 coordination, including adults. Overall, HHSC anticipates that the volume of feedback will be high and primarily negative. The proposed amendments only make changes specified in S.B. 1648.

STAKEHOLDER INVOLVEMENT:

Texas Government Code, §533.038(g) requires HHSC to implement the changes required by §533.038(g), (h), and (i) through the managed care contracts. HHSC is working to implement contract changes as soon as practicable through an off-cycle contract amendment effective March 1, 2022.

To make the proposed rules effective as early as possible, HHSC published the proposed rules in the *Texas Register* before presenting them to the Medical Care Advisory Committee (MCAC) on May 12, 2022, and to the HHSC Executive Council on May 19, 2022.

HHSC will consider any comments received during the public comment period and a public hearing that will be held during the public comment period. HHSC will also consider any comments received during MCAC and HHSC Executive Council meetings.

FISCAL IMPACT:

There may be an increase in costs to HHSC if HHSC increases health care MCO capitation rates to offset the potential costs incurred as a result of reimbursing a specialty provider at the 95-100% fee-for-service rate until the MCO and the specialty provider enter into a single-case agreement. HHSC does not have sufficient information to estimate the potential cost to HHSC.

RULE DEVELOPMENT SCHEDULE:

May 2022	Publish proposed rules in *Texas Register*
May 12, 2022	Present to the Medical Care Advisory Committee
May 19, 2022	Present to HHSC Executive Council
August 2022	Publish adopted rules in *Texas Register*
August 2022	Effective date

REQUESTED ACTION: ***(Check appropriate box)***

☐ 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 amendments to §353.4, concerning Managed Care Organization Requirements Concerning Out-of-Network Providers; and §353.7, concerning Coordination of Benefits with Primary Health Insurance Coverage.

BACKGROUND AND PURPOSE

The purpose of this proposal is to implement Senate Bill (S.B.) 1648, 87th Legislature, Regular Session, 2021 that amended Texas Government Code §533.038(g) and added new subsections (h) and (i) to §533.038.

The amendment to §533.038(g) removed the requirement for a member to have and maintain primary health benefit plan coverage in addition to Medicaid coverage to utilize the specialty provider provision in §533.038(g).

Section 533.038(h) requires a managed care organization (MCO) to develop a simple, timely and efficient process and make a good faith effort to negotiate a single-case agreement with a specialty provider.

Section 533.038(i) clarifies that a single-case agreement with a specialty provider is not considered accessing an out-of-network provider for the purposes of Medicaid MCO network adequacy requirements.

SECTION-BY-SECTION SUMMARY

The proposed amendment to §353.4 updates a reference to §353.7 to align with the proposed amendment to §353.7.

The proposed amendment to §353.7 revises the title of the section from "Coordination of Benefits with Primary Health Insurance Coverage" to "Continuity of Care with Out-of-Network Specialty Providers." HHSC revised the title of the section to align with amended Texas Government Code §533.038(g) that removed the requirement for a member to have and maintain primary health benefit plan coverage to utilize the specialty provider provision in §533.038(g).

The proposed amendment to §353.7(a) deletes "and has and maintains healthcare coverage under a primary health benefit plan." The proposed amendment deletes "with which the member is receiving care through the primary health benefit plan" and replaces it with "from whom the member is receiving care" and moves "at the time of the member's enrollment into the health care MCO" directly after "from

whom the member is receiving care." These changes align the rule with amended §533.038(g).

The proposed amendment to §353.7(b) deletes the subsection in its entirety as the definition of "primary health benefit plan" is no longer necessary.

The proposed amendment to §353.7(c) renumbers the subsection to (b).

The proposed amendment to §353.7(d) renumbers the subsection to (c).

The proposed amendment to §353.7(e) renumbers the subsection to (d). Renumbered subsection (d), concerning the qualifying reasons an MCO no longer has to comply with the reasonable reimbursement methodology for authorized services performed by out-of-network providers as described in §353.4(f)(2), is amended by: (1) inserting "including a single-case agreement" as an example of an agreement an MCO may reach under the alternate-reimbursement-agreement qualifying reason, (2) striking "the member is no longer enrolled in a primary health benefit plan" as a qualifying reason, and (3) striking "alternate" and inserting "in-network" so that a member or member's legally authorized representative selecting an in-network (not alternate) specialty provider is now a qualifying reason. The last qualifying reason—a member who is no longer enrolled in the health care MCO—is unchanged.

The proposed amendment to §353.7 adds new subsection (e) to implement §533.038(h). This new subsection requires an MCO to make a good-faith effort to negotiate a single-case agreement with the out-of-network specialty provider using a simple, timely, and efficient process developed by the MCO, if a member wants to remain under the care of a Medicaid enrolled specialty provider that is not in the health care MCO's provider network.

The proposed amendment to §353.7 adds new subsection (f) to implement §533.038(i). This new subsection clarifies a single-case agreement with a specialty provider pursuant to §353.7 is not considered accessing an out-of-network provider for the purposes of Medicaid MCO network adequacy requirements.

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, there may be an additional cost to state government as a result of enforcing and administering the rules as proposed. HHSC may need to increase health care MCO capitation rates to offset costs incurred. The MCOs would incur additional costs by applying the proposed amendment to §353.7 to more members and by reimbursing a specialty provider at the 95-100% fee-for-service rate until the MCO and the specialty provider enter into a single-case agreement.

The fiscal effect on state government cannot be estimated at this time because HHSC does not have data to determine the number of members the rules will apply

to or how long it will take an MCO and provider to enter into a single-case agreement.

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

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years 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 not create a new rule;
(6) the proposed rules will expand an existing rule;
(7) the proposed rules will increase 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. No Texas Medicaid health care MCO qualifies as a small business, micro-business, or rural community under Texas Government Code §2006.001.

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 regardless of if the member has primary health benefit plan coverage in addition to Medicaid.

Trey Wood has also determined that for the first five years the rules are in effect, there may be an economic cost to health care MCOs who are required to comply with the proposed rules. An MCO may be required to apply §353.7 to more members. In addition, MCOs will be required to reimburse a specialty provider at the 95-100% fee-for-service rate until the MCO and the specialty provider enter into a single-case agreement. HHSC lacks information to determine the 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 to receive comments on the proposal is scheduled for May 10, 2022 at 9:00 a.m. (central time) to be held virtually. You can register for the meeting at:
https://attendee.gotowebinar.com/register/5699627906607234829

The webinar ID is:
195-070-731

Persons requiring further information, special assistance, or accommodations should contact Heather Kuhlman at heather.kuhlman@hhs.texas.gov.

PUBLIC COMMENT

Written comments on the proposal may be submitted to the Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 701 W. 51st Street, Austin, Texas 78751, 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 the 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 22R017" in the subject line.

STATUTORY AUTHORITY

The amendments 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; and 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.

The amendments 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: (737) 243-5936.

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) 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, using the reasonable reimbursement methodology in subsection (f) 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(c) [~~§353.7(d)~~] of this subchapter (relating to Continuity of Care with Out-Of-Network Specialty Providers [~~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) 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) of this section.

(f) 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) 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) 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) Utilization.

(1) Upon review of the reports described in subsection (g) 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) 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) of this section, HHSC initiates a corrective action plan. Refer to subsection (j) 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) of this section.

(j) 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) 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) 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) 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) 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. Continuity of Care with Out-of-Network Specialty Providers [~~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 from whom the member is receiving care at the time of the member's enrollment into the health care MCO [~~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.~~]

(b) [~~(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.

(c) [~~(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.

(d) [~~(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, including a single-case agreement, is reached with the member's specialty provider;

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

(2) [~~(3)~~] the member or the member's LAR agree to select an in-network [~~alternate~~] specialty provider; or

(3) [~~(4)~~] the member is no longer enrolled in the health care MCO.

(e) If a member wants to remain under the care of a Medicaid enrolled specialty provider that is not in the health care MCO's provider network, the MCO must make a good-faith effort to negotiate a single-case agreement with the out-of-network specialty provider using a simple, timely, and efficient process developed by the MCO.

(f) A single-case agreement entered into under subsection (d)(1) of this section is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements.