BILL ANALYSIS

Senate Research Center
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H.B. 1771
By: Delisi (Nelson)
Finance
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Engrossed

AUTHOR'S/SPONSOR'S STATEMENT OF INTENT

Texas is trying to identify innovative approaches for reducing health care costs while promoting better quality and patient outcomes. A longstanding goal of the legislature is to develop a comprehensive care management system that meets the needs of Medicaid recipients, constrains health care expenditures, and targets health care dollars to improved patient outcomes.

Currently, Medicaid services are offered under several different models. Although there are several capitated managed care models being piloted throughout the state, it is not clear that the those models are able to contain costs without impinging on patient access and restricting federal funding streams.

Current managed care programs offer either intense utilization, case, and disease management, along with a capitated fee structure, or minimal utilization, case, and disease management, along with a rate-based fee structure.

A new model of Medicaid managed care, integrated care management (ICM), may offer effective utilization, case, and disease management, along with a rate-based fee structure that maintains patient access and does not restrict funds. This new model is a non-capitated system of care that lowers costs by utilizing a wide array of clinically-based utilization management strategies.

H.B. 1771 establishes an ICM pilot project that allows eligible Medicaid patients to select a medical home – a care provider that manages and coordinates all aspects of a recipient's healthcare, provides preventative and primary care services, and coordinates specialty and ancillary services, including long-term care.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 5 (Section 533.061, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 553.001, Government Code, by amending Subdivisions (2) and (5) and adding Subdivisions (8), (9), and (10), to define "executive commissioner," rather than "commissioner," redefine "managed care plan," and define "case management," "medical home," and "service coordination."

SECTION 2. Amends Section 533.002, Government Code, as follows:

> Sec. 533.002. PURPOSE. Amends Subdivision (1) and adds Subdivisions (7), (8), (9), and (10) to require the Health and Human Services Commission (commission) to implement the Medicaid managed care program, as part of the health care delivery system developed under Chapter 532 [sic], by contracting with managed care organizations in a manner that, to the extent possible:
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> > (1) improves the health of Texans not only by emphasizing prevention, promoting continuity of care, and providing a medical home for recipients, but also by providing long-term services and supports in the most integrated setting possible,

and promoting consumer control and self-determination through consumer-directed services;

(7) reduces administrative, financial, and nonfinancial barriers for recipients and physicians and health care providers participating in the state Medicaid program;

(8) minimizes expenditures not related to the provision of direct care, unless those expenditures will result in better care provided to and improved outcomes for recipients;

(9) ensures that each recipient who needs community and long-term services and supports receives those services and supports in the recipient's local community in accordance with Section 531.0244 or 531.043, to the extent applicable; and

(10) promotes the integration, inclusion, and independence of recipients by providing home and community-based services.

SECTION 3. Amends Section 533.0025, Government Code, by amending Subsections (b), (c), and (d), and adding Subsections (b-1), (c-1), (c-2), (f), (g), and (h), as follows:

(b) Requires the commission, except as otherwise provided by this section and notwithstanding any other law, to provide medical assistance for health care and long-term services and supports, rather than for acute care, through the most cost-effective model of Medicaid managed care as determined by the commission. Authorizes the commission, if it determines that it is more cost-effective, to provide medical assistance for health care and long-term services and support, rather than for acute care, in a certain part of this state or to a certain population of recipients using certain models, including a health maintenance organization (HMO) model, but not an HMO model including the acute care portion of Medicaid Star Plus pilot programs.

(b-1) Prohibits the executive commissioner of the commission (executive commissioner) from using a capitated risk model for health care and long-term services and supports for recipients who are aged, blind, or disabled, except in the acute and long-term care integration pilot operating in Harris County on August 31, 2005.

(c) Includes among those issues that the executive commissioner, rather than the commissioner, must consider in determining whether a model or arrangement describes by Subsection (b) is more cost-effective:

(5) the impact, including fiscal impact, to the medical delivery infrastructure of political subdivisions of this state that provide medical assistance, health care, or health care services to recipients or indigent populations; and

(6) the long-term impact to the provider network of the state Medicaid program, including participation in the network by privately practicing physicians, home and community support services agencies, mental health providers, providers of assisted living services, and day activity health providers.

(c-1) Requires the commission to maintain any primary care case management model implemented on or before January 1, 2005, until the model is replaced by the integrated care management model as provided by Subchapter D.

(c-2) Requires the commission, if after January 1, 2005, the commission begins initially providing medical assistance to recipients using a Medicaid managed care model or arrangement, other than an integrated care management model as provided by Subchapter D, to provide an option for those recipients to receive medical assistance through a primary care case management model of managed care.

(d) Makes conforming changes.

(f) Requires the commission, before it begins initially providing medical assistance through a Medicaid managed care model or arrangement to recipients residing in a certain area of this state, or begins providing medical assistance through a different model or arrangement to recipients in an area served by a Medicaid managed care model or arrangement, to seek public comments and hold a public hearing in the affected area at least six months before the date the commission intends to begin providing medical assistance through that model or arrangement.

(g) Requires the executive commissioner, before the commission begins initially providing medical assistance to recipients through a Medicaid managed care model or arrangement or begins providing medical assistance to recipients through a different model or arrangement, to provide to the governor, lieutenant governor, and speaker of the house of representatives a report containing certain information. Requires a report submitted under this subsection be made available to the public on the commission's Internet website.

(h) Provides that the implementation of any Medicaid managed care model or arrangement does not preclude the operation of any program of all-inclusive care for the elderly (PACE) site under Section 32.053, Human Resources Code.

SECTION 4. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.019, as follows:

Sec. 533.019. MEDICAL HOME FOR CERTAIN RECIPIENTS. Authorizes a recipient who is a child with special health care needs or who is a child or adult with a disability to select a physician who is a subspecialist to act as the recipient's medical home if the subspecialist agrees to serve in that role.

SECTION 5. Amends Chapter 533, Government Code, by adding Subchapter D, as follows:

SUBCHAPTER D. INTEGRATED CARE MANAGEMENT MODEL

Sec. 533.061. ESTABLISHMENT OF AN INTEGRATED CARE MANAGEMENT MODEL; PILOT PROJECT. (a) Requires the executive commissioner, by rule, to establish, and the commission to conduct and evaluate, a pilot project to determine the cost savings, health benefits, and effectiveness of providing medical assistance through an integrated care management model to certain populations of recipients.

(b) Defines "integrated care management."

(c) Provides that the Department of Aging and Disability Services is responsible for the development of policies for the long-term care provisions of the integrated care management model.

(d) Requires the commission, in establishing the integrated care management model, to implement the pilot project in the eight Medicaid managed care service delivery areas of this state where Star Plus would have otherwise been implemented.

Sec. 533.062. CONTRACTING FOR INTEGRATED CARE MANAGEMENT. (a) Requires the commission to contract with a managed care organization or other qualified organization to perform the components of the integrated care management model specified in Section 533.061(b) to achieve certain goals.

(b) Sets forth specific requirements of the commission in contracting under this section.

(c) Authorizes the commission to amend contracts to the extent allowed by law.

Sec. 533.063. COST-EFFECTIVENESS OF THE INTEGRATED CARE MANAGEMENT MODEL. (a) Requires the commission, in determining whether the integrated care management model achieves cost savings, to consider certain factors.

(b) Requires the comptroller of public accounts to verify the findings of the commission in evaluating the cost savings of the integrated care management model.

(c) Prohibits projected cost savings from being achieved by reducing eligibility for long-term services below what is currently available in the existing integrated managed care long-term service system.

Sec. 533.064. STATEWIDE INTEGRATED CARE MANAGEMENT ADVISORY COMMITTEE. (a) Requires the executive commissioner to appoint an advisory committee to assist the executive commissioner in developing the integrated care management model. Requires the executive commissioner to consult the advisory committee throughout the development of the model, including in relation to the development of proposed rules regarding the components of the integrated care management model specified in Section 533.061(b).

(b) Sets forth the composition of the advisory committee.

(c) Requires the advisory committee to establish certain subcommittees composed of one or more members of the advisory committee and one or more persons who do not serve on the advisory committee.

(d) Requires the advisory committee, in making appointments to the subcommittees under Subsection (c), to assure that each subcommittee provides representation of the broad range of appropriate acute care providers, long-term care providers, and consumers to assure inclusive and diverse input into the development and design of the integrated care management model.

(e) Requires the advisory committee to meet as necessary to perform the duties required by this section.

(f) Prohibits any member of the advisory committee from receiving compensation for serving on the committee, but entitles the member to reimbursement for reasonable and necessary travel expenses incurred by the member while conducting the business of the committee, as provided by the General Appropriations Act.

(g) Provides that the advisory committee is not subject to Chapter 551 (Open Meetings).

Sec. 533.065. REPORT REGARDING INTEGRATED CARE MANAGEMENT MODEL. Requires the commission, not later than January 5, 2007, to submit to the Legislative Budget Board, the lieutenant governor, and the speaker of the house of representatives, a preliminary report containing the commission's findings regarding the implementation of the integrated care management model developed under Section 533.061. Requires the report to include certain information and recommendations.

Sec. 533.066. EXPIRATION OF SUBCHAPTER. Provides that this subchapter expires September 1, 2009.

SECTION 6. Amends Section 32.0212, Human Resources Code, to make a conforming change.

SECTION 7. (a) Requires the executive commissioner to adopt rules to implement the integrated care management model pilot project established under Section 533.061, Government Code, as added by this Act, by December 1, 2005.

(b) Requires the commission to implement that pilot project by September 1, 2006.

SECTION 8. Requires the executive commissioner to appoint the members of the statewide integrated care management advisory committee created under Section 533.064, Government Code, as added by this Act, by September 2, 2005.

SECTION 9. Authorizes delay of implementation until any necessary federal waivers or authorizations are obtained.

SECTION 10. Effective date: upon passage or September 1, 2005.