BILL ANALYSIS

Senate Research Center
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S.B. 1105
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Health & Human Services
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

STAR Kids is a Texas Medicaid managed care program that provides Medicaid benefits to children and adults 20 and younger who have disabilities. The Medically Dependent Children's Program (MDCP) is a 1915(c) waiver program within STAR Kids that provides respite, minor home modifications, and adaptive aids as an alternative to nursing facility care.

The 2018 Texas Medicaid Managed Care STAR Kids Program Focus Study Report found that problems in the STAR Kids program implementation included: Resistance to the program on the part of families and providers, changes or reductions in services, medical necessity denials, and issues with scheduling and completing the STAR Kids Screening and Assessment Instrument (SK-SAI).

S.B. 1105 seeks to address these concerns and provide needed reforms and modernization to the STAR-Kids program by ensuring efficiencies in provider enrollment, public access to Medicaid data and health outcomes, a standardized process for complaints, improvement of the SK-SAI assessment process, managed care accountability, new options for delivery of care in STAR-Kids, and other additional reforms to the current program.

As proposed, S.B. 1105 amends current law relating to administration and operation of Medicaid, including Medicaid managed care.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 3 (Section 531.073, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.02118, Government Code, by adding Subsections (e) and (f), as follows:

> (e) Requires the Health and Human Services Commission (HHSC) to enroll a provider as a Medicaid provider, without requiring the provider to separately apply for enrollment through the entity serving as the state's Medicaid claims administrator, if the provider is credentialed by a managed care organization that contracts with HHSC under Chapter 533 (Medicaid Managed Care Program) or is enrolled as a Medicare provider.
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> (f) Requires HHSC and the entity serving as the state's Medicaid claims administrator to use a provider's national provider identifier number issued by the Centers for Medicare and Medicaid Services to identify an enrolled provider and prohibits them from issuing a separate state provider identifier number.

SECTION 2. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.02131, 531.02142, and 531.0511, as follows:

> Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) Requires HHSC, to ensure all grievances are managed consistently, to ensure the definition of a grievance related to Medicaid is consistent among divisions within HHSC.

(b) Requires HHSC to standardize Medicaid grievance data reporting and tracking among divisions within HHSC.

(c) Requires HHSC to implement a no-wrong-door system for Medicaid grievances reported to HHSC.

(d) Requires HHSC to establish a procedure for expedited resolution of a grievance related to Medicaid that allows HHSC to identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution and to resolve the grievance within a specified period.

(e) Requires HHSC to verify grievance data reported by a managed care organization that contracts with HHSC under Chapter 533 to provide health care services to Medicaid recipients.

(f) Requires HHSC to aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances and make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider.

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) Requires HHSC, to the extent permitted by federal law, to make available to the public on its Internet website in an easy-to-read format data relating to the quality of health care received by Medicaid recipients and the health outcomes of those recipients. Requires data made available to the public under this section to be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) Authorizes HHSC, in performing its duties under this section, to collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data.

Sec. 531.0511. MEDICALLY DEPENDENT CHILDREN WAIVER PROGRAM: CONSUMER DIRECTION OF SERVICES. Requires a consumer direction model implemented under Section 531.051 (Definitions), including the consumer-directed service option, for the delivery of services under the medically dependent children (MDCP) waiver program, notwithstanding Sections 531.051(c)(1) and (d), to allow for the delivery of all services and supports available under that program through consumer direction.

SECTION 3. Amends Section 531.073, Government Code, by adding Subsection (i), as follows:

(i) Prohibits prior authorization, notwithstanding Subsection (a), from being required under Medicaid vendor drug program for low-cost generic drugs. Requires the executive commissioner of HHSC (executive commissioner) to adopt rules defining "low-cost" for purposes of this subsection.

SECTION 4. Amends Section 533.00253, Government Code, by amending Subsection (c) and adding Subsections (c-1), (f), (g), (h), and (i), as follows:

(c) Authorizes HHSC to require that care management services made available as provided by Subsection (b)(7) (relating to requiring the managed care program to reduce the incidence of unnecessary institutionalizations and events), provide a care needs assessment for a recipient, rather than provide a care needs assessment for a recipient that is comprehensive, holistic, consumer-directed, evidence-based, and takes into consideration social and medical issues, for purposes of prioritizing the recipient's needs that threaten independent living.

(c-1) Authorizes a care needs assessment provided as a component of care management services made available as provided by Subsection (b)(7) to be conducted using any nationally recognized screening tool the assessor chooses to use.

(f) Requires a STAR Kids managed care organization to, after conducting a care needs assessment for a recipient, report to HHSC any significant change in condition the recipient experiences, including a change in condition resulting in the recipient no longer meeting an institutional level of care requirement. Requires HHSC, after receiving the report, to redetermine the recipient's eligibility for the STAR Kids managed care program.

(g) Requires the executive commissioner to develop and implement a pilot program through which Medicaid benefits are provided to children enrolled in the STAR Kids managed care program under an accountable care organization model in accordance with guidelines established by the Centers for Medicare and Medicaid Services. Provides that a child's participation in the pilot program is optional.

(h) Requires HHSC, not later than December 1, 2022, to prepare and submit a written report to the legislature evaluating the outcomes of the pilot program and recommending whether the pilot program should be continued, expanded, or terminated.

(i) Provides that Subsections (g) and (h) and this subsection expire September 1, 2023.

SECTION 5. Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.0031, 533.029, and 533.030, as follows:

Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) Authorizes HHSC, notwithstanding Section 533.004 or any other law requiring HHSC to contract with a managed care organization to provide health care services to recipients, to contract with a managed care organization to provide those services only if the managed care plan offered by the organization is accredited by a nationally recognized accrediting entity.

(b) Requires HHSC, as required by 42 C.F.R. Section 438.360, to provide information from the accrediting entity's review of a managed care plan offered by a managed care organization that contracts with HHSC under this chapter to the external quality review organization, as defined by Section 533.051.

Sec. 533.029. HEALTH INSURANCE PREMIUM PAYMENT REIMBURSEMENT PROGRAM PROCEDURES. (a) Requires HHSC to adopt uniform policies and procedures applicable to a managed care organization that contracts with HHSC to provide health care services to a recipient who is also enrolled in a group health benefit plan as provided by Section 32.0422 (Health Insurance Premium Payment Reimbursement Program For Medical Assistance Recipients), Human Resources Code, that require the managed care organization to pay any deductible, copayment, coinsurance, or other cost-sharing obligation imposed on the recipient for a benefit covered under the group health benefit plan without requiring prior authorization.

(b) Requires the policies and procedures to also include a process to streamline the Medicaid enrollment of a provider who treats a recipient described by Subsection (a) and is enrolled as a provider in the group health benefit plan in which the recipient is enrolled as provided by Section 32.0422, Human Resources Code.

Sec. 533.030. STATEWIDE MANAGED CARE PLANS. (a) Requires HHSC to contract with a managed care organization to arrange for or provide managed care plans to recipients in certain Medicaid managed care programs throughout the state instead of on a regional basis. Requires the executive commissioner to determine the managed care programs or categories of recipients for which to arrange for or provide statewide managed care plans. Requires HHSC, in contracting with a managed care organization

under this section, to consider regional variations in the cost of and access to health care services, recipient access to and choice of providers, the potential impact on providers, including safety net providers, and public input.

(b) Requires HHSC, not later than December 1, 2022, to prepare and submit a written report to the legislature evaluating the outcomes of the statewide managed care plans and recommending whether offering the plans on a statewide basis should be continued, expanded, or terminated.

(c) Provides that Subsection (b) and this subsection expire September 1, 2023.

SECTION 6. (a) Requires HHSC, using available resources, to conduct a study to evaluate the 30-day limitation on reimbursement for inpatient hospital care provided to Medicaid recipients enrolled in the STAR+PLUS Medicaid managed care program under 1 T.A.C. Section 354.1072(a)(1) and other applicable law. Requires HHSC, in evaluating the limitation and to the extent data is available on the subject, to consider the number of Medicaid recipients affected by the limitation and their clinical outcomes and the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days and any cost savings achieved by the limitation under Medicaid.

(b) Requires HHSC, not later than December 1, 2020, to submit a report containing the results of the study conducted under Subsection (a) of this section to the governor, the legislature, and the Legislative Budget Board. Authorizes the report required under this subsection to be combined with any other report required by this Act or other law.

SECTION 7. Makes application of Section 533.0031, Government Code, prospective.

SECTION 8. Requires a state agency affected by a provision of this Act to request a waiver or authorization from a federal agency if the state agency determines that such waiver or authorization is necessary for implementation of the provision, and authorizes the agency to delay implementation until the waiver or authorization is granted.

SECTION 9. Effective date: September 1, 2019.