By: Ortega H.B. No. 1378

A BILL TO BE ENTITLED

AN ACT

relating to a report regarding Medicaid reimbursement rates, supplemental payment amounts, and access to care.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. (a) In this section:

(1) "Commission" means the Health and Human Services Commission.

(2) "Supplemental payment amount" includes a payment made to a Medicaid provider under:

(A) the Texas Healthcare Transformation and Quality Improvement Program waiver issued under Section 1115 of the Social Security Act (42 U.S.C. Section 1315);

(B) another program operating under a waiver to the state Medicaid plan that provides a payment in excess of the Medicaid reimbursement rate; or

(C) the Medicaid disproportionate share hospital payment program.

(b) The commission shall prepare a written report on provider reimbursement rates, supplemental payment amounts paid to providers, and access to care under Medicaid. The commission shall collaborate with the state Medicaid managed care advisory committee to develop and define the scope of the research for the report. The report must:

(1) review the provider reimbursement rates and

supplemental payment amounts for at least 20 Medicaid-covered services;

(2) outline factors of the reimbursement rate and supplemental payment amount methodologies used by Medicaid managed care organizations;

(3) propose alternative reimbursement and supplemental payment amount methodologies;

(4) evaluate the impact of Medicaid provider reimbursement rates and supplemental payment amounts on access to care for Medicaid recipients, including specifically evaluating the impact of Medicaid provider reimbursement rates and supplemental payment amounts for mental health and substance use disorder services on that access to care;

(5) compare the reimbursement rates and supplemental payment amounts paid to mental health and substance use disorder providers to the rates and amounts paid to other Medicaid providers;

(6) compare provider participation in Medicaid by region, particularly increases or decreases in the number of participating providers per year beginning with the state fiscal year ending August 31, 2012, categorized by provider specialty and subspecialty;

(7) list to the extent the information is available, for each state fiscal quarter beginning with the first quarter of the state fiscal year ending August 31, 2017:

(A) counties in which provider access standards relating to distance have not been met; and

(B) counties in which provider access standards relating to travel time have not been met;

(8) examine Medicaid directed provider payments and their effect on incentivizing providers to participate or continue participating in Medicaid, including:

(A) the uniform hospital rate increase program described by 1 T.A.C. Section 353.1305; and

(B) the quality incentive payment program (QIPP); and

(9) determine the feasibility and cost of establishing:

(A) a minimum fee schedule for Medicaid providers in counties where provider access standards are not being met; and

(B) a different reimbursement rate or supplemental payment amount for classes of providers who provide care in a county:

(i) located on an international border; or

(ii) with a Medicaid population at least 10 percent higher than the statewide average Medicaid population.

(c) Not later than December 1, 2024, the commission shall prepare and submit to the legislature the report described by Subsection (b) of this section. Notwithstanding that subsection, the commission is not required to include in the report any information the commission determines is proprietary.

SECTION 2. This Act takes effect September 1, 2023.