BILL ANALYSIS

Senate Research Center

C.S.H.B. 1771
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Finance
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Committee Report (Substituted)

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, 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 noncapitated system of care that lowers costs by utilizing a wide array of clinically-based utilization management strategies.

C.S.H.B. 1771 establishes an integrated care management model of Medicaid managed care to improve patient health and social outcomes, improve access to care, constrain health care costs, and integrate the spectrum of acute care and long-term care services and supports.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Section 533.061, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 533, Government Code, by adding Subchapter D, as follows:

SUBCHAPTER D. INTEGRATED CARE MANAGEMENT MODEL

Sec. 533.061. INTEGRATED CARE MANAGEMENT MODEL. (a) Requires the executive commissioner of the health and human services commission (executive commissioner) (HHSC), by rule, to develop an integrated care management model of Medicaid managed care (model). Provides that the model is a noncapitated primary care case management model of Medicaid managed care with enhanced components to achieve certain results.

(b) Requires the executive commissioner, in developing the model, to ensure that the model utilizes managed care principles and strategies to assure proper utilization of acute care and long-term care services and supports. Sets forth component requirements of the model.

(c) Provides that for the purposes of this chapter, the model is a managed care plan.

Sec. 533.062. CONTRACTING FOR INTEGRATED CARE MANAGEMENT. (a) Authorizes HHSC to contract with one or more administrative services organizations (organization) to perform the coordination of care and other services and functions of the integrated care management model developed under Section 533.061.

(b) Authorizes HHSC to require that each organization contracting with HHSC under this section assume responsibility for exceeding administrative costs and not meeting performance standards in connection with the provision of acute care and long-term care services and supports under the terms of the contract.

(c) Authorizes HHSC to include in a contract awarded under this section a written guarantee of state savings on Medicaid expenditures for recipients receiving services provided under the model developed under Section 533.061.

(d) Authorizes HHSC to require that each organization contracting with HHSC under this section to establish pay-for-performance incentives for providers to improve patient outcomes.

(e) Defines "administrative services organization."

Sec. 533.063. STATEWIDE INTEGRATED CARE MANAGEMENT ADVISORY COMMITTEE. Authorizes the executive commissioner to appoint an advisory committee to assist the executive commissioner in the development and implementation of the model. Provides that the advisory committee is subject to Chapter 551 (Open Meetings).

SECTION 2. (a) Requires HHSC to require each organization contracting with HHSC to perform services under Section 533.062. Government Code, as added by this Act, to coordinate with, use, and otherwise interface with the fee-for-service claims payment contractor operating in this state on August 31, 2005, until the date the claims payment contract expires, subject to renewal of the contract.

(b) Authorizes HHSC to require each organization contracting with HHSC to perform services under Section 533.062, Government Code, as added by this Act, to incorporate disease management into the model established under Section 533.061, Government Code, as added by this Act, utilizing the Medicaid disease management contractor operating in this state on November 1, 2004, until the date the disease management contract expires, subject to renewal of the contract.

SECTION 3. Authorizes delay of implementation until any necessary federal waivers or authorizations are obtained.

SECTION 4. Provides that if any provision of this Act conflicts with a statute enacted by the 79th Legislature, Regular Session, 2005, the provision of this Act controls.

SECTION 5. Effective date: upon passage or September 1, 2005.