BILL ANALYSIS

C.S.H.B. 2472
By: Delisi
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The emergence of disease management as a strategy to improve health outcomes and reduce costs is a recent innovation for the State of Texas. The state now requires managed care providers serving the Medicaid population to offer a disease management program. The state now also provides disease management services through a contracted vendor for Medicaid recipients not covered under managed care. CSHB 2472 addresses issues relating to the comparability of care between these various disease management programs, coordination of care between programs, transitions between programs by recipients, and other similar topics.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 and 2 of this bill.

ANALYSIS

This bill provides that a provider of health care services must be required to use disease management programs that are based on standards of care in the medical community, have comparable performance measures for particular diseases, and show evidence of managing complex diseases in Medicaid populations. A managed care health plan that develops a disease management program and a provider of disease management programs are required to coordinate care for patients who move from one program to the other. The executive commissioner is authorized to utilize the services of a provider of disease management programs where it is determined to be more cost effective to the Medicaid program. A recipient currently in a disease management program that is subject to a Medicaid managed care expansion has the option to remain enrolled in their current program if this is cost effective. If a state agency determines that a waiver is needed from a federal agency, the agency may delay implantation until the waiver is granted.

EFFECTIVE DATE

September 1, 2005.

COMPARISON OF ORIGINAL TO SUBSTITUTE

The substitute modifies the original by removing SECTION 1 and SECTION 2, and renumbering the substitute accordingly. It eliminates the reference to Medicare and clarifies that disease management providers must coordinate for patients who move in and out of both types of program. The substitute changes "shall" to "may" in allowing the executive commissioner to utilize services. The substitute adds a provision on cost-effectiveness.