BILL ANALYSIS

Senate Research Center

S.B. 1756
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AUTHOR'S/SPONSOR'S STATEMENT OF INTENT

S.B. 1756 requires the Health and Human Services Commission (HHSC) to implement a non-capitated model of care management, called Integrated Care Management, that would control costs for the state as it maximizes federal dollars to state and local governments.

S.B. 1756 directs HHSC to manage care for the aged, blind, and disabled populations in Medicaid in urban areas through a model that will maximize. Like other forms of managed care, Integrated Managed Care would improve patient care and reduce costs by improving use of preventive and primary care services; utilizing care coordination and disease management to foster early detection and treatment of high-cost and high intensity medical services; reducing inpatient hospital and nursing home utilization through concurrent and retrospective reviews; increasing use of more cost-effective services, such as home health and community based services, to avoid nursing home care; implementing clinically based best practices to encourage uniformity and assure cost-effective outcomes; sharing with physicians and health care providers things like pharmacy utilization and cost data they need to improve that management and coordination of care; and reducing the administrative costs associated with capitated models of care.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the Health and Human Services Commission in SECTION 4 (Section 533.026, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 533.001, Government Code, by adding Subdivisions (6), (7), and (8) and subsequently renumbering existing subdivisions, to define "medical home," "case management," and "care coordination."

SECTION 2. Amends Section 533.002, Government Code, to require the Health and Human Services Commission (HHSC) to implement the Medicaid managed care program as part of the health care delivery system developed under Chapter 532 [sic] [the Government Code as currently written does not contain a Chapter 532] by contracting with managed care organizations in a manner that, to the extent possible, reduces administrative, financial, and nonfinancial barriers for physicians and providers who participate in the medical assistance program and minimizes non-direct care expenditures, except those non-direct care expenditures which assure better care outcomes.

SECTION 3. Amends Section 533.025, Government Code, as follows:

(a) Makes no changes to Subsection (a).

(b) Requires HHSC, except as otherwise provided by this section and notwithstanding any other law, to provide medical assistance for health, rather than acute, care through the most cost-effective model of Medicaid managed care as determined by HHSC. Requires HHSC, in any geographic area that may be affected by a Medicaid managed care model, to seek local input and hold a public hearing in the affected area prior to making a determination as to any Medicaid managed care model to be implemented. Makes a conforming change.

(c) Requires the executive commissioner of HHSC (commissioner), in determining whether a model or arrangement described by Subsection (b) is more cost-effective, to consider the impact, including fiscal impact, to the medical delivery infrastructure of municipalities, counties, hospital districts, or other taxing entities that provide health care or health care service for indigent or Medicaid populations and the long-term impact to the medical assistance provider network, including participation in the network by privately practicing physicians, home and community support services providers, mental health providers, and assisted living and adult daycare providers.

(d) Requires the commissioner to issue a public report providing his findings, determinations, evaluations, and weight given to each required provision of this section and requires such report to be provided to the governor, lieutenant governor, and the speaker of the house of representatives.

(e) Makes no changes to Subsection (e).

(f) Requires HHSC, notwithstanding Subsection (b)(1), to maintain and enhance any primary care case management program in existence on January 1, 2005.

(g) Requires HHSC, in any Medicaid managed care program established after January 1, 2005, to establish a primary care case management model as one option.

SECTION 4. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.026, as follows:

Sec. 533.026. ESTABLISHMENT OF AN INTEGRATED CARE MANAGEMENT MODEL. (a) Requires HHSC, by rule, to establish an integrated care management model throughout the state.

(b) Requires Integrated Care Management, for purposes of this section, to be established as "Integrated Care Management I" and "Integrated Care Management II."

(c) Sets forth the populations to be included within "Integrated Care Management I."

(d) Sets forth the populations to be included within "Integrated Care Management II."

(e) Sets forth the specific services which are included in Integrated Care Management I.

(f) Sets forth the specific services which are included in Integrated Care Management II.

(g) Requires that, in developing the long term care provisions of the integrated care management model, policy development continue to reside within the Department of Aging and Disability Services.

(h) Requires HHSC, in establishing Integrated Care Management II, to limit its implementation to nine urban service delivery areas of the state.

(i) Requires the commissioner to contract for technological support and care coordination necessary to assure proper utilization of services and cost effective outcomes. Provides that the contracted tools of care management should enhance the ability of the integrated care management provider to be effective and responsive in making treatment decisions. Authorizes the commissioner to amend contracts or enter into new contracts with existing contractors to perform the services required by this subsection. Requires the commissioner, in contracting, to take into account the effect on the physicians and health care providers who will utilize the system and make every reasonable attempt to minimize any

administrative burden on the physicians and health care providers within the program.

(j) Requires the commissioner to establish an advisory committee to assist in the development of the integrated care management model. Requires HHSC to consult with the advisory committee during the development of the model and before and during any rulemaking relating to the model. Requires the members to serve without compensation. Provides that the committee is not subject to Chapter 551 (Open Meetings), Government Code. Requires the advisory committee to establish one subcommittee to address the specific medical and community support services of children with complex or special health care needs and one subcommittee to address the medical and community support services of adults with complex or special health care needs. Authorizes the advisory committee to establish other subcommittees, as necessary, to address operational and design issues relating to Integrated Care Management implementation. Requires any subcommittee members to serve without compensation. Sets forth guidelines for members of the advisory committee.

(k) Requires the commissioner to establish a regional advisory committee to assist in the development and implementation of the model in each geographic area encompassed by the model. Requires members of the regional advisory committee to be drawn from the geographic area covered by the model and to include the same categories of representatives as specified in Subsection (f) of this section. Provides that the committee is not subject to Chapter 551, Government Code.

(l) Requires HHSC, not later than January 5, 2007, to submit to the LBB, the lieutenant governor, and the speaker of the house of representatives a preliminary report containing the findings of the implementation of the integrated care management program and HHSC's recommendations for further improvements of the model. Requires the report to include patient and provider satisfaction, patient access to primary and specialty care services, patient outcomes and health status improvement, cost savings, and cost impact to local funding entities.

SECTION 5. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.027, as follows:

Sec. 533.027. EFFECTIVENESS OF AN INTEGRATED CARE MANAGEMENT MODEL. Requires HHSC, in determining whether integrated care management achieves cost savings, to consider savings achieved through the continuation of disease management and increased utilization of home and community based services instead of more expense institutional care. Requires the comptroller of public accounts to verify the findings of HHSC in evaluating the cost savings of the integrated care management model.

SECTION 5. [sic] (a) Effective date: upon passage or September 1, 2005.

(b) Requires the commissioner to adopt the rules required to implement the integrated care management model no later than December 1, 2005.