By: Kolkhorst H.B. No. 13

A BILL TO BE ENTITLED

AN ACT

relating to the Medicaid program and alternate methods of providing health services to low-income persons in this state.

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

SECTION 1. Subtitle I, Title 4, Government Code, is amended by adding Chapter 536 to read as follows:

CHAPTER 536. GLOBAL MEDICAID DEMONSTRATION PROJECT WAIVER

Sec. 536.001. DEFINITIONS. In this chapter:

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

(2) "Demonstration project" means the global demonstration project described by Section 536.003.

(3) "Executive commissioner" means the executive commissioner of the Health and Human Services Commission.

(4) "High deductible health plan" has the meaning assigned by Section 223, Internal Revenue Code of 1986.

Sec. 536.002. CONSTRUCTION OF CHAPTER. This chapter shall be liberally construed and applied in relation to applicable federal laws so that adequate and high quality health care may be made available to all children and adults who need the care and are not financially able to pay for it.

Sec. 536.003. FEDERAL AUTHORIZATION; DEVELOPMENT OF DEMONSTRATION PROJECT. (a) The executive commissioner may seek a waiver under Section 1115 of the federal Social Security Act (42

U.S.C. Section 1315) to the state Medicaid plan to operate a global demonstration project that will allow the commission to more efficiently and effectively use federal money paid to this state under the Medicaid program to assist low-income residents of this state with obtaining health benefits coverage by using that federal money and appropriated state money to the extent necessary for purposes consistent with this chapter.

(b) The commission may develop and administer the demonstration project according to the provisions of this chapter, except that any provision that would not achieve the goal stated in Subsection (a) or a goal specified by Section 536.004 need not be addressed in the project.

(c) The executive commissioner may adopt rules necessary for the proper and efficient operation of the demonstration project.

Sec. 536.004. DEMONSTRATION PROJECT GOALS. (a) The demonstration project must employ strategies designed to achieve the following goals:

(1) maintaining health benefits through the Medicaid managed care program under Chapter 533 for a person whose net family income is at or below 100 percent of the federal poverty level and for a Medicaid recipient who is aged, blind, or disabled;

(2) providing a subsidy in accordance with Section 536.005 to a person whose net family income exceeds 100 percent of the federal poverty level but does not exceed 175 percent of the federal poverty level to cover a portion of the cost of a private health benefits plan as an alternative to providing traditional

Medicaid services for the person;

(3) making a Lone Star Health electronic benefits card available in accordance with Section 536.006 to any person eligible to receive Medicaid benefits that is linked to an account containing funds to assist the cardholder with paying for a high deductible health plan; and

(4) accounting for changes in federal law resulting from the Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), that will take effect during the period the demonstration project will operate.

(b) In developing the demonstration project, the commission shall seek to achieve the goal of maximizing flexibility under the project by negotiating with the Centers for Medicare and Medicaid Services to obtain a waiver from the mandatory benchmark benefits package and the mandatory duration and amount of Medicaid benefits required by federal law as a condition for obtaining federal matching funds for support of the Medicaid program.

Sec. 536.005. SUBSIDY TO ASSIST WITH MONTHLY PREMIUM; MANAGED CARE ALTERNATIVE. (a) As part of the demonstration project under this chapter, the commission may develop a subsidy program under which a person whose net family income exceeds 100 percent of the federal poverty level but does not exceed 175 percent of the federal poverty level is eligible for a subsidy to assist with the payment of a monthly premium for a private health benefits plan.

(b) Rules adopted by the executive commissioner must require that:

(1) the amount of the subsidy described by Subsection (a) be determined on a sliding scale based on a person's net family income, where a person with the lowest net family income on the scale receives a 100 percent subsidy and a person with the highest net family income on the scale receives a 25 percent subsidy; and

(2) if the commission determines adequate funds exist, the subsidy program may be expanded to include a person whose net family income exceeds 175 percent of the federal poverty level but does not exceed 200 percent of the federal poverty level.

(c) A recipient shall use a subsidy provided under this section to pay all or a portion of a monthly premium charged for a private health benefits plan.

(d) Notwithstanding Subsection (a), a person whose net family income is at or below 100 percent of the federal poverty level may choose to receive a subsidy under this section in lieu of participating in the Medicaid managed care program.

(e) Notwithstanding Subsection (a), a person whose net family income exceeds 100 percent of the federal poverty level but does not exceed 175 percent of the federal poverty level is eligible to receive benefits through the Medicaid managed care program if the person is unable to obtain benefits through a private health benefits plan and the person's Medicaid caseworker provides written proof that the person was unable to obtain those benefits.

Sec. 536.006. LONE STAR HEALTH CARD. (a) As part of the demonstration project under this chapter, the commission may develop an electronic benefits card, to be known as a Lone Star Health card. The card must be:

(1) available to any person eligible to receive benefits through the demonstration project; and

(2) linked to an account containing funds determined by the commission on a sliding scale based on the cardholder's net family income to assist the cardholder with paying for a high deductible health plan.

(b) The cardholder's account must be funded annually in an amount determined in accordance with a sliding scale adopted by the executive commissioner by rule. Any balance remaining in the account at the end of each year carries over into subsequent years and may be used by the cardholder for purposes described by this section.

(c) If the cardholder loses eligibility for benefits under this chapter, the card remains active, and the cardholder may continue to use any funds remaining in the account to pay for health-related services.

Sec. 536.007. CONSUMER ASSISTANCE; INTERNET PORTAL. The commission and the Texas Department of Insurance shall establish a consumer assistance program to be used by a person eligible for a subsidy under Section 536.005 or the electronic benefits card under Section 536.006. As part of that program, the commission and the department shall establish and maintain an insurance purchasing portal on the department's Internet website to assist a person eligible for benefits through the demonstration project with finding and obtaining health benefits coverage through a private health benefits plan.

Sec. 536.008. REINSURANCE; WRAP AROUND BENEFITS. The

executive commissioner may adopt rules providing for:

(1) a program developed in conjunction with the Texas Department of Insurance for the provision of reinsurance to health benefits plan providers that participate in the demonstration project; and

(2) wraparound benefits and supplemental benefits to ensure adequate coverage for persons receiving benefits through the demonstration project.

Sec. 536.009. OFFICE OF INDIVIDUAL EMPOWERMENT AND EMPLOYMENT OPPORTUNITIES. (a) If the commission establishes the demonstration project, the commission shall establish the Office of Individual Empowerment and Employment Opportunities to increase the employment rate of Medicaid recipients and those recipients' access to private health benefits coverage by providing job training and education opportunities to:

(1) female Medicaid recipients; and

(2) other Medicaid recipients who are at least 18 years of age but younger than 22 years of age.

(b) The commission may use not more than five percent of federal money paid to this state under the Medicaid program for job training and education programs described by Subsection (a) and shall ensure that program services are particularly focused on areas of this state with high unemployment.

(c) The office may coordinate with the Texas Workforce Commission to administer this section.

(d) The commission shall annually prepare and publish on the commission's Internet website a report summarizing the number of

persons assisted through the office, the funds spent, and recommendations for modifications to the program.

Sec. 536.010. DEMONSTRATION PROJECT MODIFICATIONS. (a) The commission may modify any process or methodology specified in this chapter to the extent necessary to comply with federal law or the terms of the waiver authorizing the demonstration project. The commission may modify a process or methodology for any other reason only if the commission determines that the modification is consistent with federal law and the terms of the waiver.

(b) Except as otherwise provided by this section and subject to the terms of the waiver authorized by this section, the commission has broad discretion to develop the demonstration project.

SECTION 2. Section 533.005(a), Government Code, is amended to read as follows:

(a) A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(2-a) average efficiency standards adopted by the executive commissioner by rule that encourage quality of care while containing costs;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan not later than the 45th day after the date a claim for payment is received with documentation reasonably necessary for the managed care organization to process the claim, or within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization;

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization

comply with Section 533.006 as a condition of contract retention and renewal;

(10) a requirement that the managed care organization provide the information required by Section 533.012 and otherwise comply and cooperate with the commission's office of inspector general;

(11) a requirement that the managed care organization's usages of out-of-network providers or groups of out-of-network providers may not exceed limits for those usages relating to total inpatient admissions, total outpatient services, and emergency room admissions determined by the commission;

(12) if the commission finds that a managed care organization has violated Subdivision (11), a requirement that the managed care organization reimburse an out-of-network provider for health care services at a rate that is equal to the allowable rate for those services, as determined under Sections 32.028 and 32.0281, Human Resources Code;

(13) a requirement that the organization use advanced practice nurses in addition to physicians as primary care providers to increase the availability of primary care providers in the organization's provider network;

(14) a requirement that the managed care organization reimburse a federally qualified health center or rural health clinic for health care services provided to a recipient outside of regular business hours, including on a weekend day or holiday, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the

recipient does not have a referral from the recipient's primary care physician; and

(15) a requirement that the managed care organization develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

(A) a tracking mechanism to document the status and final disposition of each provider's claims payment appeal;

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal; and

(C) the determination of the physician resolving the dispute to be binding on the managed care organization and provider.

SECTION 3. Sections 32.0248(a), (g), and (i), Human Resources Code, are amended to read as follows:

(a) The department shall operate [~~establish~~] a [~~five-year~~] demonstration project through the medical assistance program to expand access to preventive health and family planning services for women. A woman eligible under Subsection (b) to participate in the demonstration project may receive appropriate preventive health and family planning services, including:

(1) medical history recording and evaluation;

(2) physical examinations;

(3) health screenings, including screening for:

(A) diabetes;

(B) cervical cancer;

(C) breast cancer;

(D) sexually transmitted diseases;

(E) hypertension;

(F) cholesterol; and

(G) tuberculosis;

(4) counseling and education on contraceptive methods emphasizing the health benefits of abstinence from sexual activity to recipients who are not married, except for counseling and education regarding emergency contraception;

(5) provision of contraceptives, except for the provision of emergency contraception;

(6) risk assessment; and

(7) referral of medical problems to appropriate providers that are entities or organizations that do not perform or promote elective abortions or contract or affiliate with entities that perform or promote elective abortions.

(g) Not later than December 1 of each even-numbered year, the department shall submit a report to the legislature regarding the department's progress in [~~establishing and~~] operating the demonstration project.

(i) This section expires September 1, 2019 [~~2011~~].

SECTION 4. (a) The Health and Human Services Commission may create and establish an indigent care program for eligible residents of this state whose net family incomes are at or below 300 percent of the federal poverty level and who do not have private

health benefits coverage or receive benefits through the medical assistance program under Chapter 32, Human Resources Code.

(b) The Health and Human Services Commission shall develop the program described by Subsection (a) of this section to achieve the following goals:

(1) providing financial assistance to an eligible person for health care services, including access to a primary care physician who serves as a medical home, through a monthly payment plan based on total household income and family size;

(2) promoting patient responsibility and program viability;

(3) paying providers on a fee-for-service basis; and

(4) developing community partnerships.

(c) The Health and Human Services Commission shall develop the program under this section as soon as practicable after the effective date of this Act.

SECTION 5. (a) In this section:

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

(2) "FMAP" means the federal medical assistance percentage by which state expenditures under the Medicaid program are matched with federal funds.

(3) "Medicaid program" means the medical assistance program under Chapter 32, Human Resources Code.

(b) The commission shall actively pursue a modification to the formula prescribed by federal law for determining this state's FMAP to achieve a formula that would produce an FMAP that accounts

for and is periodically adjusted to reflect changes in the following factors in this state:

(1) the total population;

(2) the population growth rate; and

(3) the percentage of the population with household incomes below the federal poverty level.

(c) The commission shall pursue the modification as required by Subsection (b) of this section by providing to the Texas delegation to the United States Congress and the federal Centers for Medicare and Medicaid Services and other appropriate federal agencies data regarding the factors listed in that subsection and information indicating the effects of those factors on the Medicaid program that are unique to this state.

(d) In addition to the modification to the FMAP described by Subsection (b) of this section, the commission shall make efforts to obtain additional federal Medicaid funding for Medicaid services required to be provided to persons in this state who are not legally present in the United States. As part of that effort, the commission shall provide to the Texas delegation to the United States Congress and the federal Centers for Medicare and Medicaid Services and other appropriate federal agencies data regarding the costs to this state of providing those services.

(e) This section expires September 1, 2013.

SECTION 6. (a) The executive commissioner of the Health and Human Services Commission shall adopt the average efficiency standards for purposes of Section 533.005(a)(2-a), Government Code, as added by this Act, not later than January 1, 2012.

(b) The Health and Human Services Commission, in a contract between the commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after January 1, 2012, shall include the average efficiency standards required by Section 533.005(a)(2-a), Government Code, as added by this Act.

(c) The Health and Human Services Commission shall seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before January 1, 2012, to include the average efficiency standards required by Section 533.005(a)(2-a), Government Code, as added by this Act.

SECTION 7. (a) The Health and Human Services Commission shall actively develop a proposal for a waiver or other authorization from the appropriate federal agency that is necessary to implement Chapter 536, Government Code, as added by this Act.

(b) As soon as possible after the effective date of this Act, the Health and Human Services Commission shall request and actively pursue approval from the appropriate federal agency of the waiver or other authorization developed under Chapter 536, Government Code, as added by this Act.

SECTION 8. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2011.