BILL ANALYSIS

C.S.H.B. 1159
By: Kolkhorst
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The STAR + PLUS Medicaid managed care program is a service delivery model that integrates acute and long-term services and supports. The Health and Human Services Commission (HHSC) contracts with managed care organizations across several service areas to provide STAR + PLUS services to certain persons who are aging, have physical disabilities, or both. Within STAR + PLUS, qualified persons may receive home and community-based services and supports. It has been reported that the monthly premiums paid by HHSC to managed care organizations for persons receiving STAR + PLUS home and community-based services and supports are significantly higher than the monthly premiums for other clients in the STAR + PLUS program.

The managed care organizations are responsible for assessing a person's need for services and submitting documentation used to determine if the assessed person is functionally eligible to receive services. Interested parties contend that, given the managed care organizations' financial incentive to recommend enrollment of persons in the STAR + PLUS home and community-based services and supports program, and a lack of sufficient controls in this process, the state is at risk of paying a higher level of premiums than is necessary. These parties note that expansion of the STAR + PLUS program magnifies this risk.

C.S.H.B. 1159 seeks to provide state oversight and deter inappropriate client placements in the STAR + PLUS home and community-based services and supports program by implementing a utilization review process at HHSC's office of contract management.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 1159 amends the Government Code to require the Health and Human Services Commission's (HHSC) office of contract management to establish an annual utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program. The bill requires HHSC to determine the topics to be examined in the review process and requires the review process to include a thorough investigation of each managed care organization's procedures for determining whether a recipient should be enrolled in the STAR + PLUS home and community-based services and supports program, including the conduct of functional assessments for that purpose and records relating to those assessments.

C.S.H.B. 1159 requires the office to use the utilization review process to review each fiscal year every managed care organization participating in the STAR + PLUS Medicaid managed care program or only the managed care organizations that, using a risk-based assessment process, the office determines have a higher likelihood of inappropriate client placement in the STAR +

PLUS home and community-based services and supports program. The bill adds a temporary provision, set to expire September 1, 2016, requiring the office, during the state fiscal biennium ending August 31, 2015, to use the utilization review process to review every managed care organization participating in the STAR + PLUS Medicaid managed care program.

C.S.H.B. 1159 requires HHSC, in conjunction with the office, to provide a report to the standing committees of the senate and house of representatives with jurisdiction over the Medicaid program not later than December 1 of each year. The bill requires the report to summarize the results of the utilization reviews conducted during the preceding fiscal year, provide analysis of errors committed by each reviewed managed care organization, and extrapolate those findings and make recommendations for improving the efficiency of the program. The bill prohibits a service provider who contracts with a managed care organization, if a utilization review results in a determination to recoup money from the managed care organization, from being held liable for the good faith provision of services based on an authorization from the managed care organization. The bill requires HHSC to provide the first report not later than December 1, 2014.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 1159 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00281 to read as follows: Sec. 533.00281. UTILIZATION REVIEW FOR STAR + PLUS MEDICAID MANAGED CARE ORGANIZATIONS. (a) The commission's office of inspector general shall establish an annual utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program. The office shall determine the topics to be examined in the review process, except that the review process must include a thorough investigation of each managed care organization's procedures for determining whether a recipient should be enrolled in the STAR + PLUS home and community-based services and supports (HCBS) program, including the conduct of functional assessments for that purpose and records relating to those assessments. (b) The office of inspector general shall use the utilization review process to review each fiscal year: (1) every managed care organization participating in the STAR + PLUS Medicaid	SECTION 1. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00281 to read as follows: Sec. 533.00281. UTILIZATION REVIEW FOR STAR + PLUS MEDICAID MANAGED CARE ORGANIZATIONS. (a) The commission's office of contract management shall establish an annual utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program. The commission shall determine the topics to be examined in the review process, except that the review process must include a thorough investigation of each managed care organization's procedures for determining whether a recipient should be enrolled in the STAR + PLUS home and community-based services and supports (HCBS) program, including the conduct of functional assessments for that purpose and records relating to those assessments. (b) The office of contract management shall use the utilization review process to review each fiscal year: (1) every managed care organization participating in the STAR + PLUS Medicaid

managed care program; or (2) only the managed care organizations that, using a risk-based assessment process, the office determines have a higher likelihood of inappropriate client placement in the STAR + PLUS home and community-based services and supports (HCBS) program. (c) Notwithstanding Subsection (b), during the state fiscal biennium ending August 31, 2015, the office of inspector general shall use the utilization review process to review every managed care organization participating in the STAR + PLUS Medicaid managed care program. This subsection expires September 1, 2016. (d) In conjunction with the commission's office of inspector general, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over the Medicaid program not later than December 1 of each year. The report must: (1) summarize the results of the utilization reviews conducted under this section during the preceding fiscal year; (2) provide analysis of errors committed by each reviewed managed care organization; and (3) extrapolate those findings and make recommendations for improving the efficiency of the program.	managed care program; or (2) only the managed care organizations that, using a risk-based assessment process, the office determines have a higher likelihood of inappropriate client placement in the STAR + PLUS home and community-based services and supports (HCBS) program. (c) Notwithstanding Subsection (b), during the state fiscal biennium ending August 31, 2015, the office of contract management shall use the utilization review process to review every managed care organization participating in the STAR + PLUS Medicaid managed care program. This subsection expires September 1, 2016. (d) In conjunction with the commission's office of contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over the Medicaid program not later than December 1 of each year. The report must: (1) summarize the results of the utilization reviews conducted under this section during the preceding fiscal year; (2) provide analysis of errors committed by each reviewed managed care organization; and (3) extrapolate those findings and make recommendations for improving the efficiency of the program. (e) If a utilization review conducted under this section results in a determination to recoup money from a managed care organization, a service provider who contracts with the managed care organization may not be held liable for the good faith provision of services based on an authorization from the managed care organization.
SECTION 2. The Health and Human Services Commission shall provide the first report required by Section 533.00281(d), Government Code, as added by this Act, not later than December 1, 2014.	SECTION 2. Same as introduced version.
SECTION 3. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for	SECTION 3. Same as introduced version.

implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.	
SECTION 4. 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, 2013.	SECTION 4. Same as introduced version.