BILL ANALYSIS

S.B. 348
By: Schwertner
Public Health
Committee Report (Unamended)

BACKGROUND AND PURPOSE

The STAR + PLUS Medicaid managed care program is a service delivery model that integrates acute and long-term care services. The Health and Human Services Commission (HHSC) contracts with managed care organizations to provide STAR + PLUS services to certain persons who are aging, have physical disabilities, or both. Within STAR + PLUS, qualified persons may receive additional home and community-based services and supports. As the STAR + PLUS program has expanded to additional service areas, the number of persons receiving home and community-based services and supports has increased significantly, outpacing the growth of the STAR + PLUS program as a whole. This increase has led to an increase in program costs, as the monthly premiums paid by HHSC to managed care organizations are significantly higher for clients who receive home and community-based services and supports.

Managed care organizations are responsible for assessing a person's need for services and submitting documentation used to determine if the assessed person is eligible to receive services. Recent audits of the managed care program found evidence that some managed care organizations are unnecessarily recommending home and community-based services and supports for people who do not need the 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.

S.B. 348 seeks to increase oversight and deter inappropriate client placements in the STAR + PLUS home and community-based services and supports program to ensure appropriate state spending by creating 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

S.B. 348 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.

S.B. 348 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.

S.B. 348 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.