BILL ANALYSIS

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C.S.S.B. 348
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Health & Human Services
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

C.S.S.B. 348 seeks to increase oversight of managed care organizations in the STAR+PLUS program to ensure appropriate state spending on premium and administrative payments. STAR+PLUS is a capitated Medicaid program, operated by the Health and Human Services Commission (HHSC), that integrates acute and long-term care services for certain persons who are aging and/or have physical disabilities.

Within STAR+PLUS, some clients receive additional home and community-based services and supports. Managed care organizations are responsible for assessing a consumer's need for services and submitting documentation used by the Medicaid claims administrator to determine if the assessed consumer is eligible.

As STAR+PLUS has expanded to additional service areas, the rate of increase in the number of persons receiving home and community-based services and supports has outpaced growth in the program as a whole. Overall program enrollment growth from 2008 to 2011 was 42.4 percent; growth in persons receiving home and community-based services and supports was 134.2 percent. This increase has contributed to increasing program costs over time; the monthly premiums paid by HHSC to managed care organizations are significantly higher for clients who receive home and community-based services and supports.

Texas is at a risk of paying higher premium and administrative payments to managed care organizations than is necessary. A financial incentive exists for managed cared organizations to recommend that individuals, who may not need home and community-based services and supports, receive these services due to the premium differential and the managed care organizations' administrative payment, which is based on gross receipts. The office of inspector general (OIG) at HHSC found evidence of this practice occurring in a recent audit of one managed care organization participating in STAR+PLUS.

Existing process controls may not act as a strong deterrent against this practice.

C.S.S.B. 348 creates a utilization review process at the office of contract management at HHSC (office of contract management) for managed care organizations in the STAR+PLUS program. The purpose of this review is to deter inappropriate requests for placement of persons in the STAR+PLUS home and community-based services and supports program and provide the state with an oversight mechanism.

The bill requires the office of contract management to establish an annual process and provides HHSC with discretion in determining the areas for review. Minimally, the review would involve examination of the assessment process used in determining whether a consumer should be enrolled in the STAR+PLUS home and community-based services and supports program.

The bill requires that every managed care organization undergo review by August 31, 2015. After the initial review, the office of contract management could develop a risk-based assessment process to use in determining which entities to review in the future.

The bill requires HHSC, in conjunction with the office of contract management, to provide an annual report to the committees in the senate and house of representatives with jurisdiction over Medicaid. The report is to summarize the results of the utilization reviews conducted in the

previous year, analyze errors committed by the managed care organizations, extrapolate findings to quantify cost savings, and make recommendations to improve program efficiency.

C.S.S.B. 348 amends current law relating to a utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00281, as follows:

Sec. 533.00281. UTILIZATION REVIEW FOR STAR + PLUS MEDICAID MANAGED CARE ORGANIZATIONS. (a) Requires the Health and Human Services Commission's office of contract management (office of contract management) to establish an annual utilization review process for managed care organizations participating in the STAR + PLUS Medicaid managed care program. Requires the Health and Human Services Commission (HHSC) to determine the topics to be examined in the review process, except that the review process is required 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 (HCBS) program, including the conduct of functional assessments for that purpose and records relating to those assessments.

(b) Requires the office of contract management to 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 of contract management determines have a higher likelihood of inappropriate client placement in the STAR + PLUS home and community-based services and supports (HCBS) program.

(c) Requires the office of contract management, notwithstanding Subsection (b), 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. Provides that this subsection expires September 1, 2016.

(d) Requires HHSC, in conjunction with the office of contract management, 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. Requires that the report summarize the results of the utilization reviews conducted under this section 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.

(e) Prohibits a service provider who contracts with the managed care organization from being held liable for the good faith provision of services based on an authorization from the managed care organization if a utilization review conducted under this section results in a determination to recoup money from a managed care organization.

SECTION 2. Requires HHSC to provide the first report required by Section 533.00281(d), Government Code, as added by this Act, not later than December 1, 2014.

SECTION 3. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 4. Effective date: upon passage or September 1, 2013.