BILL ANALYSIS

Senate Research Center
86R14212 LED-D

S.B. 2040
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As Filed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Over the last two decades, in an effort to improve quality and contain costs, the State of Texas has transitioned the delivery and administration of Medicaid from a fee-for-service model to a managed care model. Today, Medicaid managed care organizations (MCOs) deliver and manage health care services for more than 90 percent of Medicaid clients, approximately four million Texans.

During the interim, a number of concerns were raised by Medicaid clients and providers regarding the MCO model and whether it is the most effective model to provide needed care, especially with regard to children with disabilities.

S.B. 2040 would direct the Health and Human Services Commission to prepare a written report regarding Medicaid provider reimbursement rates and access to care. Among other provisions, the report would include the factors used in reimbursement rate methodology, provider participation, regional differences in provider participation, and the effect of Medicaid provider incentive payment programs. The report would be due to the legislature no later than December 2020.

As proposed, S.B. 2040 amends current law relating to a report regarding Medicaid reimbursement rates and access to care.

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. (a) Defines "commission" as the Health and Human Services Commission (HHSC).

(b) Requires HHSC to prepare a written report regarding provider reimbursement rates and access to care in the Medicaid program. Requires the report to:

(1) outline each factor of the reimbursement rate methodology used by Medicaid managed care organizations and that factor's weight in the methodology;

(2) explicitly illustrate the manner in which the following affect current methodologies:

(A) previously adopted reimbursement rates;

(B) the cost of uncompensated care provided to uninsured persons; and

(C) use of private insurance benefits;

(3) propose alternative reimbursement methodologies that do not consider the items described by Subdivision (2) of this subsection;

(4) evaluate how Medicaid provider reimbursement rates affect access to care for Medicaid recipients, measured by the number of providers each year who have stopped participating in Medicaid since HHSC began offering Medicaid services through a managed care delivery model;

(5) compare provider participation in Medicaid by region, particularly increases or decreases in the number of participating providers since HHSC began offering Medicaid services through a managed care delivery model, categorized by provider specialty and subspecialty;

(6) list, for each year since HHSC began offering Medicaid services through a managed care delivery model, counties in which provider access standards have not been met;

(7) examine Medicaid provider incentive payment programs and their effect on incentivizing providers to participate or continue participating in Medicaid;

(8) determine the feasibility and cost of establishing:

(A) a minimum fee schedule for Medicaid providers in counties where provider access standards are not being met; and

(B) a different reimbursement rate for classes of providers who provide care in a county:

(i) located on an international border; or

(ii) with a Medicaid population at least 10 percent higher than the statewide average Medicaid population.

(c) Requires HHSC, not later than December 1, 2020, to prepare and submit to the legislature the report described by Subsection (b) of this section. Provides that, notwithstanding that subsection, HHSC is not required to include in the report any information HHSC determines is proprietary.

SECTION 2. Effective date: September 1, 2019.