By:  Guillen, Raymond, Klick H.B. No. 2474

A BILL TO BE ENTITLED

AN ACT

relating to the continuation of medical assistance for certain individuals.

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

SECTION 1.  Section 32.0256, Human Resources Code, is amended to read as follows:

Sec. 32.0256.  CONTINUATION OF MEDICAL ASSISTANCE FOR CERTAIN INDIVIDUALS; ANNUAL REPORT. (a) A recipient [~~described by Section 32.025(a)~~] who experiences an event or circumstance, including a temporary increase in income of a duration of one month or less or a minor technical or clerical error committed on or with respect to the recipient's renewal application or other document required for benefits renewal, that would normally result in the recipient being determined ineligible for medical assistance continues to be eligible for that assistance if the individual:

(1)  either:

(A)  receives services through one of the following programs that serve [~~a program for~~] individuals with an intellectual or developmental disability [~~authorized~~] under Section 1915(c), Social Security Act (42 U.S.C. Section 1396n(c)):

(i)  the home and community-based services (HCS) waiver program; or

(ii)  the Texas home living (TxHmL) waiver program; or

(B)  resides in an ICF-IID facility; and

(2)  continues to meet the functional and diagnostic criteria for the receipt of services under a program described by Subdivision (1)(A) or for residency in an ICF-IID facility.

(b)  To continue to be eligible for medical assistance, a recipient described by Subsection (a) who is determined ineligible for medical assistance because of an event or circumstance caused wholly by the action or inaction of the recipient or the recipient's parent or guardian must submit an application for medical assistance in accordance with Section 32.025(b) not later than the 90th day after the date on which the recipient is determined ineligible.

(c)  The commission may not suspend or terminate the eligibility of a recipient for medical assistance benefits if the recipient's ineligibility is caused partly or wholly by a technical or clerical error committed by the commission or an agent of the commission.

(d)  The commission shall:

(1)  coordinate with and inform relevant health care providers if a recipient described by Subsection (a) is at risk of being determined ineligible for medical assistance benefits or is determined ineligible for those benefits; and

(2)  make reasonable efforts to ensure the medical assistance benefits of a recipient described by Subsection (a) are not suspended or terminated.

(e)  Not later than December 31 of each year, the commission shall prepare and submit a report to the legislature regarding the suspension or termination of medical assistance benefits of recipients described by Subsection (a) that occurred during the preceding state fiscal year. The report must include:

(1)  the number of recipients who are living in a community-based, residential setting whose eligibility for benefits was suspended or terminated during each month of the fiscal year;

(2)  if the commission reinstated the benefits of a recipient, the average, median, shortest, and longest length of time the commission took to reinstate those benefits;

(3)  the number of recipients whose benefits were not reinstated by the commission;

(4)  the specific reason for the suspension or termination of benefits of a recipient, including an analysis of the percentage of suspensions or terminations related to:

(A)  an increase in the recipient's income;

(B)  a failure by the recipient or the recipient's parent or guardian to properly submit a renewal application or other document required for benefits renewal;

(C)  a change in the recipient's condition that results in the recipient no longer meeting the functional or diagnostic criteria necessary to establish the recipient's eligibility for services under a program described by Subsection (a)(1)(A) or for residency in an ICF-IID facility;

(D)  a technical or clerical error committed by the commission or an agent of the commission; and

(E)  any other reason that occurs with enough frequency to warrant its inclusion in the analysis, as determined by the commission; and

(5)  a statement of the amount of retroactive reimbursements paid to health care providers for the provision of services to a recipient during the time the recipient's eligibility for benefits was suspended or terminated.

SECTION 2.  Section 3, Chapter 1072 (H.B. 3292), Acts of the 85th Legislature, Regular Session, 2017, is repealed.

SECTION 3.  Notwithstanding Section 32.0256(e), Human Resources Code, as added by this Act, the Health and Human Services Commission shall ensure that the initial report required under that subsection includes a description of the number of recipients described by Section 32.0256(a), Human Resources Code, as amended by this Act, who are living in a community-based, residential setting and whose eligibility for benefits was suspended or terminated during each month of the state fiscal years ending August 31, 2016, August 31, 2017, and August 31, 2018.

SECTION 4.  (a) As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall conduct a review of the commission's policies and processes relating to the renewal of Medicaid benefits for the following Medicaid recipients:

(1)  persons receiving services through one of the following Medicaid programs authorized under Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n(c)) that provide services to persons with an intellectual or developmental disability:

(A)  the home and community-based services (HCS) waiver program; or

(B)  the Texas home living (TxHmL) waiver program; and

(2)  persons residing in an ICF-IID facility.

(b)  In conducting the review under this section, the Health and Human Services Commission shall:

(1)  analyze existing data relating to:

(A)  the number of Medicaid recipients who lost eligibility for Medicaid benefits during each month of the state fiscal years ending August 31, 2016, August 31, 2017, and August 31, 2018; and

(B)  the reasons for those recipients' loss of eligibility, including because of minor technical or clerical errors made on or with respect to a renewal application or other document required to renew eligibility for the benefits;

(2)  evaluate the impact recipients' temporary loss of benefits has on the recipients and health care providers; and

(3)  identify best practices for the commission, recipients and their legally authorized representatives, and health care providers to minimize recipients' loss of eligibility for the benefits because of:

(A)  minor technical or clerical errors made on or with respect to a renewal application or other document required to renew eligibility for the benefits; or

(B)  the recipient's failure to provide information necessary to renew eligibility for the benefits.

(c)  Based on the findings of the review conducted under this section, the Health and Human Services Commission shall, in consultation with relevant stakeholders, develop a plan to implement best practices and address barriers to timely renewal of eligibility for Medicaid benefits and continuation of services for Medicaid recipients described by Subsection (a) of this section. The plan must specifically identify best practices for avoiding loss of eligibility for Medicaid benefits by those recipients because of minor technical or clerical errors made on or with respect to a renewal application or other document required to renew eligibility for the benefits.

(d)  Not later than November 1, 2020, the Health and Human Services Commission shall submit to the legislature the plan developed under Subsection (c) of this section. The plan must include:

(1)  a summary of issues identified by the commission's review of policies and processes under this section;

(2)  a timeline for the commission's implementation of the best practices identified for implementation in the review; and

(3)  recommendations for potential legislation if the commission determines that changes in statute are required to address issues identified in the review.

(e)  This section expires September 1, 2021.

SECTION 5.  If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for 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 6.  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, 2019.