BILL ANALYSIS

C.S.H.B. 2658
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Stakeholders have suggested that the state's Medicaid system, which relies on managed care organizations for the coordination and delivery of certain services, suffers from certain deficiencies, resulting in administrative complexity and financial uncertainty for some Medicaid providers and recipients. C.S.H.B. 2658 seeks to remedy these deficiencies by implementing changes to requirements regarding capitation rates in Medicaid contracts and ensuring managed care recipients have the option to receive a physical, paper copy of their managed care organization's network provider directory.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

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. 2658 amends the Government Code to require the capitation rates in a Medicaid managed care contract to include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the managed care plan. The bill requires the Health and Human Services Commission (HHSC) to seek to amend a contract entered into before the bill's effective date to comply with this requirement.

C.S.H.B. 2658 removes a requirement for a managed care organization (MCO) participating in the STAR + PLUS Medicaid managed care program or STAR Kids Medicaid managed care program to issue a provider network directory for the program in paper form to recipients in the program on an opt-out basis. The bill requires instead that any Medicaid MCO mail a recipient the most recent paper form of its provider network directory on an opt-in basis not later than the fifth business day after the date the MCO receives the recipient's request.

C.S.H.B. 2658 requires an MCO at least annually to include in its outreach efforts directed at and education materials sent to recipients enrolled in a managed care plan offered by the MCO a written or verbal offer allowing each recipient to elect to receive its provider network directory for the managed care program, including any updates to the directory, in paper form.

C.S.H.B. 2658 amends the Human Resources Code to require an application for Medicaid benefits to include an option for an applicant who may be enrolled in a Medicaid managed care plan to elect to receive the provider network directory, including any updates to the directory,

associated with the plan in which the applicant is enrolled in paper form. The bill requires HHSC, as soon as practicable after the bill's effective date, to adopt a revised application form that conforms to this requirement.

EFFECTIVE DATE

September 1, 2021.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2658 may differ from the original in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute does not repeal, as the original does, the exception to the requirement that an MCO, for a program recipient, issue a provider network directory in paper form unless the recipient opts out of receiving the directory in paper form. Instead, the substitute includes the following provisions regarding an MCO's provider network directory:

- a requirement for a Medicaid MCO to mail its directory in paper form to a recipient enrolled in a plan the MCO offers, on request, not later than the fifth business day after the date the request was received;
- a requirement for an MCO, at least annually, to include in its outreach efforts directed at and educational materials sent to its enrolled recipients a written or verbal offer allowing each recipient to elect to receive the directory in paper form, including any directory updates;
- a requirement for an application for Medicaid benefits to include an option for an applicable applicant to elect to receive an MCO's directory in paper form; and
- a procedural provision requiring HHSC to adopt a revised application form that conforms to the above requirement.

The substitute includes a procedural provision, which is not included in the original, requiring HHSC to seek to amend a Medicaid managed care contract entered into before the bill's effective date to comply with the bill's requirements regarding the capitation rates included in those contracts.

The substitute does not include the following provisions that are included in the original:

- a requirement for HHSC to honor a contract requirement to enable a Medicaid MCO to make the initial and subsequent primary care provider (PCP) assignments and changes as required by law;
- an authorization for an MCO to assign Medicaid members to a PCP based on published criteria that seeks to preserve existing provider-member relationships and considers a member's proximity to PCPs and other criteria as established by the MCO; and
- a provision revising limitations on a Medicaid recipient's authority to disenroll from a managed care plan and switch to a new plan.