BILL ANALYSIS

Senate Research Center
87R27260 MM-D

C.S.H.B. 2658
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Health & Human Services
5/20/2021
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The 83rd Texas Legislature approved the expansion of Medicaid managed care and the transition from fee for service based payment to quality incentive and performance based payments. Nearly 95 percent of Medicaid recipients currently receive their benefits through managed care.

C.S.H.B. 2658 seeks to create more efficiencies in the Medicaid managed care program while improving health outcomes and lowering costs.

C.S.H.B. 2658 amends current law relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the Health and Human Services Commission in SECTION 1 (Section 531.024142, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 2 (Section 533.00251, Government Code) and SECTION 8 (Section 32.0317, Human Resources Code) of this bill.

Rulemaking authority previously granted to the executive commissioner of the Health and Human Services Commission is modified in SECTION 5 (Section 533.009, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.024142, 531.02493, 531.0501, 531.0512, and 531.0605, as follows:

Sec. 531.024142. NONHOSPITAL AMBULANCE TRANSPORT AND TREATMENT PROGRAM. (a) Requires the Health and Human Services Commission (HHSC) by rule to develop and implement a program designed to improve quality of care and lower costs in Medicaid by:

(1) reducing avoidable transports to hospital emergency departments and unnecessary hospitalizations;

(2) encouraging transports to alternative care settings for appropriate care; and

(3) providing greater flexibility to ambulance care providers to address the emergency health care needs of Medicaid recipients following a 9-1-1 emergency services call.

(b) Requires that the program be substantially similar to the Centers for Medicare and Medicaid Services' Emergency Triage, Treat, and Transport (ET3) model.

Sec. 531.02493. CERTIFIED NURSE AIDE PROGRAM. (a) Requires HHSC to study:

(1) the cost-effectiveness of providing, as a Medicaid benefit through a certified nurse aide trained in the Grand-Aide curriculum or a substantially similar training program, in-home support to a Medicaid recipient's care team after the recipient's discharge from a hospital; and

(2) the feasibility of allowing a Medicaid managed care organization to treat payments to certified nurse aides providing care as described by Subdivision (1) as quality improvement costs.

(b) Requires HHSC, not later than December 1, 2022, to prepare and submit a report to the governor and the legislature that summarizes HHSC's findings and conclusions from the study.

(c) Provides that this section expires September 1, 2023.

Sec. 531.0501. MEDICAID WAIVER PROGRAMS: INTEREST LIST MANAGEMENT. (a) Requires HHSC, in consultation with the Intellectual and Developmental Disability System Redesign Advisory Committee established under Section 534.053 (Intellectual and Developmental Disability System Redesign Advisory Committee) and the STAR Kids managed care advisory committee, to study the feasibility of creating an online portal for individuals to request to be placed and check the individual’s placement on a Medicaid waiver program interest list. Requires HHSC, as part of the study, to determine the most cost-effective automated method for determining the level of need of an individual seeking services through a Medicaid waiver program.

(b) Requires HHSC, not later than January 1, 2023, to prepare and submit a report to the governor, the lieutenant governor, the speaker of the Texas House of Representatives (house), and the standing legislative committees with primary jurisdiction over health and human services that summarizes HHSC's findings and conclusions from the study.

(c) Provides that Subsections (a) and (b) and this subsection expire September 1, 2023.

(d) Requires HHSC to develop a protocol in the office of the ombudsman to improve the capture and updating of contact information for an individual who contacts the office of the ombudsman regarding Medicaid waiver programs or services.

Sec. 531.0512. NOTIFICATION REGARDING CONSUMER DIRECTION MODEL. Requires HHSC to:

(1) develop a procedure to verify that a Medicaid recipient or the recipient's parent or legal guardian is informed regarding the consumer direction model and provided the option to choose to receive care under that model, and if the individual declines to receive care under the consumer direction model, document the declination; and

(2) ensure that each Medicaid managed care organization implements the procedure.

Sec. 531.0605. ADVANCING CARE FOR EXCEPTIONAL KIDS PILOT PROGRAM. (a) Requires HHSC to collaborate with Medicaid managed care organizations and the STAR Kids Managed Care Advisory Committee to develop and implement a pilot program that is substantially similar to the program described by Section 3, Medicaid Services Investment and Accountability Act of 2019 (Pub. L. No. 116-16), to provide coordinated care through a health home to children with complex medical conditions.

(b) Provides that HHSC is required to seek guidance from the Centers for Medicare and Medicaid Services and the United States Department of Health and Human Services regarding the design of the program and, based on the guidance, is authorized to actively seek and apply for federal funding to implement the program.

(c) Requires HHSC, not later than December 31, 2024, to prepare and submit a report to the legislature that includes:

(1) a summary of HHSC's implementation of the pilot program; and

(2) if the pilot program has been operating for a period sufficient to obtain necessary data, a summary of HHSC's evaluation of the effect of the pilot program on the coordination of care for children with complex medical conditions and a recommendation as to whether the pilot program should be continued, expanded, or terminated.

(d) Provides that the pilot program terminates and this section expires September 1, 2025.

SECTION 2. Amends Section 533.00251, Government Code, by adding Subsection (h), as follows:

(h) Requires the executive commissioner of HHSC (executive commissioner), in addition to the minimum performance standards HHSC establishes for nursing facility providers seeking to participate in the STAR+PLUS Medicaid managed care program, to adopt rules establishing minimum performance standards applicable to nursing facility providers that participate in the program. Provides that HHSC is responsible for monitoring provider performance in accordance with the standards and requiring corrective actions, as HHSC determines necessary, from providers that do not meet the standards. Requires HHSC to share data regarding the requirements of this subsection with STAR+PLUS Medicaid managed care organizations as appropriate.

SECTION 3. Amends Section 533.005(a), Government Code, as follows:

(a) Requires that a contract between a Medicaid managed care organization and HHSC for the organization to provide health care services to recipients contain:

(1) makes no changes to this subdivision;

(2) capitation rates that:

(A) 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 plan; and

(B) creates this paragraph from existing text and makes no further changes;

(3)-(26) makes no changes to these subdivisions.

SECTION 4. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00515, as follows:

Sec. 533.00515. MEDICATION THERAPY MANAGEMENT. Requires the executive commissioner to collaborate with Medicaid managed care organizations to implement medication therapy management services to lower costs and improve quality outcomes for recipients by reducing adverse drug events.

SECTION 5. Amends Section 533.009(c), Government Code, as follows:

(c) Requires that the managed care organization, at a minimum, be required, if a disease management program provided by the organization has low active participation rates, to identify the reason for the low rates and develop an approach to increase active participation in disease management programs for high-risk recipients. Makes nonsubstantive changes.

SECTION 6. Amends Section 32.028, Human Resources Code, by adding Subsection (p), to require the executive commissioner to establish a reimbursement rate for medication therapy management services.

SECTION 7. Amends Section 32.054, Human Resources Code, by adding Subsection (f), as follows:

(f) Requires HHSC, to prevent serious medical conditions and reduce emergency room visits necessitated by complications resulting from a lack of access to dental care, to provide medical assistance reimbursement for preventive dental services, including reimbursement for at least one preventive dental care visit per year, for an adult recipient with a disability who is enrolled in the STAR+PLUS Medicaid managed care program. Provides that this subsection does not apply to an adult recipient who is enrolled in the STAR+PLUS home and community-based services (HCBS) waiver program. Prohibits this subsection from being construed to reduce dental services available to persons with disabilities that are otherwise reimbursable under the medical assistance program.

SECTION 8. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Sections 32.0317 and 32.0611, as follows:

Sec. 32.0317. REIMBURSEMENT FOR SERVICES PROVIDED UNDER SCHOOL HEALTH AND RELATED SERVICES PROGRAM. Requires the executive commissioner to adopt rules requiring parental consent for services provided under the school health and related services program in order for a school district to receive reimbursement for the services. Requires that the rules allow a school district to seek a waiver to receive reimbursement for services provided to a student who does not have a parent or legal guardian who can provide consent.

Sec. 36.0611. COMMUNITY ATTENDANT SERVICES: QUALITY INITIATIVES AND EDUCATION INCENTIVES. (a) Requires HHSC to develop specific quality initiatives for attendants providing community attendant services to improve quality outcomes for recipients.

(b) Requires HHSC to coordinate with the Texas Higher Education Coordinating Board and the Texas Workforce Commission to develop a program to facilitate the award of academic or workforce education credit for programs of study or courses of instruction leading to a degree, certificate, or credential in a health-related field based on an attendant's work experience providing community attendant services.

SECTION 9. (a) Defines "commission," "executive commissioner," and "Medicaid."

(b) Requires HHSC, using existing resources, to:

(1) review HHSC's staff rate enhancement programs to identify and evaluate methods for improving administration of those programs to reduce administrative barriers that prevent an increase in direct care staffing and direct care wages and benefits in nursing homes and develop recommendations for increasing participation in the programs;

(2) revise HHSC's policies regarding the quality incentive payment program (QIPP) to require improvements to staff-to-patient ratios in nursing facilities participating in the program by January 1, 2023;

(3) examine, in collaboration with the Department of Family and Protective Services, implementation in other states of the Centers for Medicare and Medicaid Services' Integrated Care for Kids (InCK) Model to determine whether implementing the model could benefit children in this state, including children enrolled in the STAR Health Medicaid managed care program; and

(4) identify factors influencing active participation by Medicaid recipients in disease management programs by examining variations in eligibility criteria for the programs and participation rates by health plan, disease management program, and year.

(c) Authorizes the executive commissioner to approve a capitation payment system that provides for reimbursement for physicians under a primary care capitation model or total care capitation model.

SECTION 10. (a) Defines "commission" and "Medicaid."

(b) Requires HHSC, as soon as practicable after the effective date of this Act, to conduct a study to determine the cost-effectiveness and feasibility of providing to Medicaid recipients who have been diagnosed with diabetes, including Type 1 diabetes, Type 2 diabetes, and gestational diabetes:

(1) diabetes self-management education and support services that follow the National Standards for Diabetes Self-Management Education and Support and that are authorized to be delivered by a certified diabetes educator; and

(2) medical nutrition therapy services.

(c) Requires HHSC, if HHSC determines that providing one or both of the types of services described by Subsection (b) of this section would improve health outcomes for Medicaid recipients and lower Medicaid costs, notwithstanding Section 32.057 (Contracts for Disease Management Programs), Human Resources Code, or Section 533.009 (Special Disease Management), Government Code, and to the extent allowed by federal law to develop a program to provide the benefits and seek prior approval from the Legislative Budget Board before implementing the program.

SECTION 11. (a) Defines "commission" and "Medicaid."

(b) Requires HHSC, as soon as practicable after the effective date of this Act, to conduct a study to:

(1) identify benefits and services, other than long-term services and supports, provided under Medicaid that are not provided in this state under the Medicaid managed care model; and

(2) evaluate the feasibility, cost-effectiveness, and impact on Medicaid recipients of providing the benefits and services identified under Subdivision (1) of this subsection through the Medicaid managed care model.

(c) Requires HHSC, not later than December 1, 2022, to prepare and submit a report to the legislature that includes:

(1) a summary of HHSC's evaluation under Subsection (b)(2) of this section; and

(2) a recommendation as to whether HHSC should implement providing benefits and services identified under Subsection (b)(1) of this section through the Medicaid managed care model.

SECTION 12. (a) (1) Defines "commission," "Medicaid," and "Medicaid managed care organization."

(2) Defines "dually eligible individual."

(b) Requires HHSC to conduct a study regarding dually eligible individuals who are enrolled in the Medicaid managed care program. Requires that the study include an evaluation of:

(1) Medicare cost-sharing requirements for those individuals;

(2) the cost-effectiveness for a Medicaid managed care organization to provide all Medicaid-eligible services not covered under Medicare and require cost-sharing for those services; and

(3) the impact on dually eligible individuals and Medicaid providers that would result from the implementation of Subdivision (2) of this subsection.

(c) Requires HHSC, not later than September 1, 2022, to prepare and submit a report to the legislature that includes:

(1) a summary of HHSC's findings from the study conducted under Subsection (b) of this section; and

(2) a recommendation as to whether HHSC should implement Subsection (b)(2) of this section.

SECTION 13. (a) Requires HHSC, using existing resources, to conduct a study to assess the impact of revising the capitation rate setting strategy used to cover long-term care services and supports provide to recipients under the STAR+PLUS Medicaid managed care program from a strategy based on the setting in which services are provide to a strategy based on a blended rate. Requires that the study:

(1) assess the potential impact using a blended capitation rate would have on recipients' choice of setting;

(2) include an actuarial analysis of the impact using a blended capitation rate would have on program spending; and

(3) consider the experience of other states that use a blended capitation rate to reimburse managed care organizations for the provision of long-term care services and supports under Medicaid.

(b) Requires HHSC, not later than September 1, 2022, to prepare and submit a report that summarizes the findings of the study conducted under Subsection (a) of this section to the governor, the lieutenant governor, the speaker of the house, the House Human Services Committee, and the Senate Health and Human Services Committee.

SECTION 14. Provides that notwithstanding Section 2, Chapter 1117 (H.B. 3523), Acts of the 84th Legislature, Regular Session, 2015, Section 533.00251(c), Government Code, as amended by Section 2 of that Act, takes effect September 1, 2023.

SECTION 15. (a) Provides that Section 533.005(a), Government Code, as amended by this Act, applies only to a contract between HHSC and a Medicaid managed care organization that is entered into or renewed on or after the effective date of this Act.

(b) Requires HHSC, to the extent permitted by the terms of the contract, to seek to amend a contract entered into before the effective date of this Act with a Medicaid managed care organization to comply with Section 533.005(a), Government Code, as amended by this Act.

SECTION 16. Requires HHSC, as soon as practicable after the effective date of this Act, to conduct the study and make the determination required by Section 531.0501(a), Government Code, as added by this Act.

SECTION 17. 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 18. Provides that HHSC is required to implement this Act only if the legislature appropriates money specifically for that purpose. Provides that if the legislature does not appropriate money specifically for that purpose, HHSC is authorized, but is not required, to implement this Act using other appropriations available for the purpose.

SECTION 19. Effective date: September 1, 2021.