

BILL ANALYSIS

Senate Research Center

S.B. 1648
By: Perry
Health & Human Services
6/10/2021
Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Medically Dependent Children's Program (MDCP) is a program within STAR Kids. The program offers enhanced, community-based services for individuals who need the level of care provided in a nursing facility but who would like to remain in the community. The program currently serves more than 5,000.

Last session, S.B. 1207 offered numerous reforms to the MDCP program. One of the sections dealt with how a managed care organization coordinates benefits for an enrollee. There were a few subsections addressing enrollees who are covered under Medicaid as well as primary third-party coverage. One section, addressing continuity of care, was drafted to be and intended to be for all enrollees regardless of primary third-party coverage. However, because all of the subsections addressing coordination of care appeared in the same section, it was interpreted that the provision, which was intended to apply to all, would only be contingent upon primary third-party coverage.

S.B. 1648 clarifies that continuity of care applies whether the enrollee is also covered under third-party primary coverage or not. In cases where the enrollee does not have third-party primary coverage and would like to have continuity of care with that specialty provider, the managed care organization and provider would have to negotiate a single-case agreement. Until that agreement is reached, reimbursement would be specified by current rule in the Texas Administrative Code.

A single-case agreement entered into under this section is not considered an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements.

(Original Author's/Sponsor's Statement of Intent)

S.B. 1648 amends current law relating to the provision of benefits under the Medicaid program, including to recipients with complex medical needs.

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 B, Chapter 531, Government Code, by adding Section 531.024165, as follows:

Sec. 531.024165. MEDICAL REVIEW OF MEDICAID SERVICE DENIALS FOR FOSTER CARE YOUTH. (a) Requires the Health and Human Services Commission (HHSC), using existing resources, to coordinate with the Department of Family and Protective Services (DFPS) to develop and implement a process to review a denial of services under the Medicaid managed care program on the basis of medical necessity for foster care youth.

(b) Requires HHSC and DFPS, not later than December 31, 2022, to submit a report to the legislature that includes a summary of the process developed and implemented under Subsection (a).

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

SECTION 2. Amends Section 531.024172(d), Government Code, to provide that, in implementing the electronic visit verification system HHSC is required to ensure that a health care provider is allowed to enter a variable schedule into the electronic visit verification system.

SECTION 3. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.0501, 531.0512, and 531.0605, as follows:

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 or 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 appropriate and 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, 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:

(A) 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

(B) 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 the STAR Kids Managed Care Advisory Committee, Medicaid recipients, family members of children with complex medical conditions, children's health care advocates, Medicaid managed care organizations, and other stakeholders 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) Requires HHSC 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, authorizes HHSC 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 4. Amends the heading to Section 533.038, Government Code, to read as follows:

Sec. 533.038. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS.

SECTION 5. Amends Section 533.038, Government Code, by amending Subsection (g) and adding Subsections (h) and (i), as follows:

(g) Requires HHSC to develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship with a specialty provider to continue receiving care from that provider, regardless of whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage.

(h) Requires the managed care organization, if a recipient who has complex medical needs wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the managed care plan in which the recipient is enrolled, to develop a simple, timely, and efficient process to and to make a good faith effort to, negotiate a single-case agreement with the specialty provider. Requires that the specialty provider, until the Medicaid managed care organization and the specialty provider enter into the single-case agreement, be reimbursed in accordance with the applicable reimbursement methodology specified in HHSC rule, including 1 T.A.C. Section 353.4.

(i) Provides that a single-case agreement entered into under Section 533.038 is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements.

SECTION 6. Amends Section 32.054, Human Resources Code, by adding Subsection (f), to require 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 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 7. Repealer: Section 531.0601(f) (relating to providing that Section 531.0601 (Long-Term Care Services Waiver Program Interest Lists) expires December 1, 2021), Government Code.

SECTION 8. Provides that HHSC is required to implement a provision of this Act only if the legislature appropriates money to HHSC 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 a provision of this Act using other appropriations that are available for that purpose.

SECTION 9. 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 delay of implementation until such a waiver or authorization is granted.

SECTION 10. Effective date: September 1, 2021.