BILL ANALYSIS

Senate Research Center
88R7329 RDS-F

S.B. 1220
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

According to a 2022 report by the Meadows Mental Health Institute, approximately 3,000 adolescents and young adults experience first-episode psychosis (FEP) yearly in Texas, which may involve symptoms like hallucinations, delusions, and confused thoughts and speech. Conventional treatment of psychosis, however, faces challenges due to limited service availability, prioritization of medicinal interventions at the expense of patient choice, and emphasis on clinician choice in medicine. On the other hand, programs that prioritize patient choice and timely access, such as Coordinated Specialty Care (CSC), have improved treatment outcomes.

Despite the benefits of CSC, obstacles in obtaining compensation for recovery-oriented interventions with proven benefits may limit its availability. Due to inadequate access to CSC and similar services, these obstacles cause patients to resort to emergency or crisis services, criminal justice involvement, and taxpayer spending.

S.B. 1220 would require a group health benefit plan to provide coverage, based on medical necessity, of treatment, including coordinated specialty care, to a person who is 26 or younger and diagnosed with first-episode psychosis. This change would increase access to treatment for Texans who experience first episode psychosis and improve treatment outcomes.

As proposed, S.B. 1220 amends current law relating to group health benefit plan coverage for early treatment of first episode psychosis.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the Texas Department of Insurance in SECTION 4 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 1355.001, Insurance Code, by adding Subdivision (5) to define "first episode psychosis."

SECTION 2. Amends Section 1355.002, Insurance Code, by adding Subsection (c), as follows:

> (c) Provides that Section 1355.016, notwithstanding any other law, applies to the state Medicaid program, including the Medicaid managed care program operated under Chapter 533 (Medicaid Managed Care Program), Government Code.

SECTION 3. Amends Subchapter A, Chapter 1355, Insurance Code, by adding Section 1355.016, as follows:

> Sec. 1355.016. REQUIRED COVERAGE FOR EARLY TREATMENT OF FIRST EPISODE PSYCHOSIS. (a) Requires a group health benefit plan to provide coverage, based on medical necessity, as provided by this section to an individual who is younger than 26 years of age and who is diagnosed with first episode psychosis.

(b) Requires that the group health benefit plan provide coverage under this section to the enrollee for all generally recognized services prescribed in relation to first episode psychosis.

(c) Provides that "generally recognized services," for the purposes of Subsection (b), include:

(1) coordinated specialty care for first episode psychosis treatment, covering each element of the treatment model included in the Recovery After an Initial Schizophrenia Episode (RAISE) early treatment program study conducted by the National Institute of Mental Health regarding treatment for psychosis, as completed July 2017, including:

(A) psychotherapy;

(B) medication management;

(C) case management;

(D) family education and support; and

(E) education and employment support;

(2) assertive community treatment as described by the Texas Health and Human Services Commission's (HHSC) Texas Resilience and Recovery Utilization Management Guidelines: Adult Mental Health Services, as updated in April 2017, or a more recently updated version adopted by the commissioner of insurance; and

(3) peer support services, including:

(A) recovery and wellness support;

(B) mentoring; and

(C) advocacy.

(d) Provides that only coordinated specialty care or assertive community treatment provided by a provider that adheres to the fidelity of the applicable treatment model and that has contracted with HHSC to provide coordinated specialty care or assertive community treatment for first episode psychosis is required to be covered under this section.

(e) Provides that if a group health benefit plan issuer credentials a psychiatrist or licensed clinical leader of a treatment team to provide generally recognized services for the treatment of first episode psychosis, all members of the treatment team serving under the credentialed psychiatrist or licensed clinical leader are considered to be credentialed by the health benefit plan issuer.

(f) Requires a group health benefit plan issuer to reimburse a provider of coordinated specialty care or assertive community treatment for first episode psychosis based on a bundled payment model instead of providing reimbursement for each service provided to the enrollee by the member of a treatment team.

(g) Requires the Texas Department of Insurance (TDI), if requested by a group health benefit plan issuer on or after March 1, 2029, to contract with an independent third party with expertise in analyzing health benefit plan premiums and costs to perform an independent analysis of the impact of requiring coverage of the team-based treatment models described by Subsection (c) on health benefit plan premiums. Provides that a group health benefit plan, if the analysis finds that

premiums increased annually by more than one percent solely due to requiring coverage of a specific treatment model, is not required to provide coverage under this section for that treatment model, notwithstanding Subsection (c).

SECTION 4. (a) Requires TDI to convene and lead a work group that includes HHSC, providers of generally recognized services described by Section 1355.016(c), Insurance Code, as added by this Act, and group health benefit plan issuers as soon as practicable after the effective date of this Act. Requires the work group to:

(1) develop the criteria to be used to determine medical necessity for purposes of coverage under Section 1355.016, Insurance Code, as added by this Act; and

(2) determine a coding solution that allows for coordinated specialty care and assertive community treatment to be coded and reimbursed as a bundle of services as required under Section 1355.016(f), Insurance Code, as added by this Act.

(b) Requires the work group to make recommendations to TDI based on its findings not later than January 1, 2024.

(c) Requires TDI, not later than March 30, 2024, to adopt rules:

(1) establishing the criteria to be used to determine medical necessity under Section 1355.016(a), Insurance Code, as added by this Act;

(2) creating a coding solution that allows for reimbursement based on a bundled payment model for coordinated specialty care and assertive community treatment as required by Section 1355.016(f), Insurance Code, as added by this Act; and

(3) otherwise necessary to implement Section 1355.016, Insurance Code, as added by this Act.

SECTION 5. 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 6. Makes application of Section 1355.016, Insurance Code, as added by this Act, prospective to March 30, 2024.

SECTION 7. Effective date: September 1, 2023.