SUBJECT: Continuity of care for Medicaid recipients with complex medical needs

COMMITTEE: Insurance — favorable, without amendment

VOTE: 8 ayes — Oliverson, J. González, Hull, Israel, Middleton, Paul, Romero, Sanford

0 nays

1 absent — Vo

SENATE VOTE: On final passage, May 12 — 30-0

WITNESSES: For — Terri Carriker, PTFK; (*Registered, but did not testify*: Dennis Borel, Coalition of Texans with Disabilities; Elisa Tamayo, Emergence Health Network; Hannah Mehta, PTFK; Lee Johnson, Texas Council of Community Centers; Adrienne Trigg, Texas Medical Equipment Providers Association)

Against — None

On — Laurie Vanhoose, Texas Association of Health Plans; (*Registered, but did not testify*: Stephanie Stephens, Texas Health and Human Services Commission)

BACKGROUND: Government Code ch. 533 governs Medicaid managed care programs and requires the Health and Human Services Commission (HHSC) to contract with Medicaid managed care organizations.

Under sec. 533.038(g), HHSC must develop a clear and easy process, to be implemented through a contract, that allows a Medicaid recipient with complex medical needs who has an established relationship with a specialty provider to continue receiving care from that provider.

Concerns have been raised that certain provisions of previous legislation on continuity of care have not been applied as intended to all enrollees,

regardless of whether the enrollees have third-party primary health plan coverage in addition to Medicaid coverage. Some have suggested clarifying current law to ensure continuity of care when the enrollee does not have third-party primary health plan coverage.

DIGEST:

SB 1648 would require the Health and Human Services Commission (HHSC) to develop a clear and easy process, to be implemented through a contract, that allowed a Medicaid recipient with complex medical needs who had an established relationship with a specialty provider to continue receiving care from that provider, regardless of whether the recipient had primary health benefit plan coverage in addition to Medicaid coverage.

If a Medicaid recipient who had complex medical needs and did not have primary health plan coverage wanted to continue receiving care from an out-of-network Medicaid specialty provider, the Medicaid managed care organization (MCO) would be required to negotiate a single-case agreement with the specialty provider. Until the Medicaid MCO and the specialty provider entered into the single-case agreement, the specialty provider would have to be reimbursed as specified in commission rule, including 1 TAC sec. 353.4.

HHSC would be required to implement provisions of the bill only if the Legislature appropriated money specifically for that purpose. If money was not specifically appropriated for the bill, HHSC could, but would not be required to, implement provisions of the bill using other appropriations that were available for that purpose.

The bill would repeal the expiration date regarding the interest list for the medically dependent children program.

The bill would take effect September 1, 2021.

NOTES:

According to the Legislative Budget Board, the fiscal implications of the bill cannot be determined at this time because it is unknown how many Medicaid recipients with complex medical needs who do not have primary health benefit plan coverage would receive services from an out-of-

network specialty provider.