BILL ANALYSIS

Senate Research Center

S.B. 1467
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DIGEST AND PURPOSE

Under current federal law, an individual who is eligible for Supplemental Security Income (SSI) is automatically eligible for health care services through the state's Medicaid program. Federal and state law prohibit children who qualify for Medicaid from being enrolled in the Children's Health Insurance Program (CHIP). Similarly, under the state's Medicaid plan, and pursuant to federal and state laws and regulations, an SSI recipient who lives outside of Harris County is not required to participate in Medicaid managed care. An SSI recipient who lives in Harris County is required to participate in a certain form of Medicaid managed care. As proposed, S.B. 1467 establishes procedures for the Health and Human Services Commission (HHSC) to follow when disenrolling SSI recipients from Medicaid managed care or the CHIP program. This bill also requires HHSC to reimburse a health care plan that provides services to an SSI-eligible individual retroactively to the date the individual became eligible for SSI. Additionally, there are provisions which provide for the disenrollment of an individual from Medicaid managed care and prospectively enrolling them in the SSI managed care program available only in Harris County.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to an agency affected by any provision of the Act in SECTION 4 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 62C, Health and Safety Code, by adding Section 62.106, as follows:

> Sec. 62.106. RECIPIENTS OF SUPPLEMENTAL SECURITY INCOME. (a) Requires the Health and Human Services Commission (HHSC), within 21 days of receiving notice from the Social Security Administration that a child enrolled in the state child health plan is eligible for Supplemental Security Income (SSI), to take certain actions.
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> (b) Requires a health plan provider, to be eligible for reimbursement under Subsection (c), to refund to HHS any capitation payments received to provide health benefits coverage for the child for a period on or after the date the child became eligible for SSI.

SECTION 2. Amends Section 533.0076, Government Code, by adding Subsection (d), to provide that this section does not prohibit HHSC from disenrolling a recipient under Section 533.0077.

SECTION 3. Amends Chapter 533A, Government Code, by adding Section 533.0077, as follows:

> Sec. 533.0077. RECIPIENTS OF SUPPLEMENTAL SECURITY INCOME. (a) Requires HHSC, within 21 days of receiving notice from the Social Security Administration that a recipient enrolled in a managed care plan is eligible for SSI, to take certain actions, except as provided for under Subsection (b) and (c).

(b) Provides that Subsection (a) does not apply to a medical assistance managed care program designed primarily to provide behavioral health services separate and apart from other medical services and implemented with one or more federal waivers.

(c) Provides that this subsection applies to any area of the state in which one or more federal waivers require a recipient who is receiving SSI to enroll in a managed care plan for comprehensive medical services and long-term care services. Requires HHSC, within 21 days of receiving notice from the Social Security Administration that a recipient enrolled in a managed care plan has become eligible for SSI, to take certain actions.

(d) Requires a managed care organization, to be eligible for reimbursement under Subsection (a)(3) or (c)(3), to refund to HHSC any capitation payments received to provide health benefits coverage for the recipient for a period on or after the date the recipient became eligible for SSI, as determined by the Social Security Administration.

SECTION 4. Provides that it is the understanding of the legislature that the current waivers in place with federal government already provide for the provisions of this Act; therefore, it is the legislature's understanding that no waivers or authorizations from the federal government should be necessary to implement this Act, that no appropriations are necessary to implement this Act, and that no changes in capitation rates paid to any managed care organization are necessary to implement this Act. Requires an agency affected by any provision of the Act, within 30 days of the effective date of this Act, to determine whether a waiver or authorization from a federal agency is necessary for implementation of any provision of this Act or whether capitation payment rates paid to any affected organizations must be amended to implement this Act. Requires the affected agency, if such a determination is made, to promulgate rules within 180 days of the effective date of this Act regarding any such waiver, authorization, or change to capitation payment rates prior to seeking such a waiver, authorization or making any such change to capitation payment rates. Requires the state agency, following the final adoption of any such rules, to seek such a waiver or authorization from a federal agency. Authorizes implementation of this Act to be delayed pending receipt of a waiver or authorization from a federal agency.

SECTION 5. Effective date: upon passage or September 1, 2001. [Bill as drafted reflects an effective date of 2001.]