

BILL ANALYSIS

Senate Research Center
85R14552 EES-D

S.B. 1927
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Health & Human Services
4/10/2017
As Filed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Medicaid is a state-federal partnership established to provide healthcare for those who meet certain income and eligibility criteria. In 2015, Medicaid provided healthcare for nearly one in seven Texans. In recent years, Texas has adopted a managed care model to manage and coordinate benefits for Medicaid recipients. Approximately 88 percent of all Medicaid recipients receive their benefits through managed care organizations (MCOs).

S.B. 1927 seeks to improve the cost-effectiveness and efficiency of the Medicaid managed care system in Texas by increasing MCO competition. The bill also seeks to study certain areas of concern in the Medicaid program including dental access for adults with disabilities and barriers to consumer directed services in Medicaid. In addition, the bill also directs the Health and Human Services Commission to evaluate current delivery models under the Medicaid program and provide a report to the legislature on its findings specifically in terms of cost-effectiveness, competition among providers, and overall health outcomes of Medicaid recipients.

As proposed, S.B. 1927 amends current law relating to requiring the Health and Human Services Commission to evaluate and implement changes to the Medicaid program to make the program more cost-effective, increase competition among providers, and improve health outcomes for recipients.

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 A, Chapter 533, Government Code, by adding Sections 533.023, 533.024, and 533.025, as follows:

Sec. 533.023. **COMPETITIVE BIDS.** Requires the Health and Human Services Commission (HHSC) to establish a range of rates within which a managed care organization (MCO) is required to bid during a competitive bidding process to contract with HHSC to arrange for or provide a managed care plan.

Sec. 533.024. **ASSESSMENT OF STATEWIDE MANAGED CARE PLANS.** Requires HHSC to assess the feasibility and cost-effectiveness of contracting with MCOs to arrange for or provide managed care plans to recipients throughout the state instead of on a regional basis.

Sec. 533.025. **SHARING OF MONEY RECOVERED.** Requires an MCO participating in Medicaid to share with HHSC any money recovered by the MCO as a result of a fraud investigation of or a recoupment of an overpayment or debt from a network provider or recipient.

SECTION 2. (a) Requires HHSC, to the extent funds are appropriated to HHSC for that purpose, to identify and evaluate barriers preventing Medicaid recipients enrolled in the STAR + PLUS Medicaid managed care program or a home and community-based services waiver program from

choosing the consumer directed services options and develop recommendations for increasing the percentage of Medicaid recipients enrolled in those programs who choose the consumer directed services option, and to study the feasibility of establishing a community attendant registry to assist Medicaid recipients enrolled in the community attendant services program in locating providers.

(b) Requires HHSC, not later than December 1, 2018, to submit a report containing HHSC's findings and recommendations under Subsection (a) to the governor, the Legislative Budget Board (LBB), and the standing committees of the senate and the house of representatives with primary jurisdiction over health and human services.

SECTION 3. (a) Requires HHSC to conduct a study of the provision of certain dental services to adults with disabilities under the Medicaid program.

(b) Sets forth requirements for HHSC in conducting the study under Subseciton (a).

(c) Requires HHSC, not later than December 1, 2018, to submit a report containing the results of the study conducted under Subsection (a) of this section and HHSC's recommendations for improving access to dental services in the community for and reducing the provision of dental services during emergency room visits to adults with disabilities receiving services under the Medicaid program to the governor, the lieutenant governor, the speaker of the house of representatives, the Senate Finance Committee, the House Appropriations Committee, the Senate Health and Human Services Committee, the House Public Health Committee, and the House Human Services Committee.

SECTION 4. (a) Requires HHSC to evaluate delivery models for the provision of services under the Medicaid program based on certain factors.

(b) Requires HHSC, not later than December 1, 2018, to submit a report to the governor, the LBB, and the appropriate standing committees of the senate and the house of representatives containing the results of the evaluation conducted under Subsection (a) of this section, including certain summaries.

SECTION 5. Requires a state agency, if before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, to request the waiver or authorization and authorizes the agency to delay implementing that provision until the waiver or authorization is granted.

SECTION 6. Effective date: September 1, 2017.