

BILL ANALYSIS

Senate Research Center
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C.S.S.B. 1927
By: Kolkhorst
Health & Human Services
4/20/2017
Committee Report (Substituted)

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).

C.S.S.B. 1927 improves the cost-effectiveness and efficiency of the Medicaid managed care system in Texas by evaluating options for increasing MCO competition. The bill establishes a new framework for MCOs and the state to share Medicaid fraud/recoupment recoveries. The bill also increases transparency and public access to data on the overall quality of the Medicaid program.

C.S.S.B. 1927 amends current law relating to requiring the Health and Human Services Commission to evaluate and implement changes to the Medicaid and child health plan programs to make the programs 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 B, Chapter 531, Government Code, by adding Section 531.02142, as follows:

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) Requires the Health and Human Services Commission (HHSC), to the extent permitted by federal law, to make available to the public on its Internet website in an easy-to-read format data relating to the quality of health care received by recipients and the health outcomes of recipients under Medicaid. Requires that data made available to the public be made available in a manner that does not identify or allow for the identification of individual recipients.

(b) Authorizes HHSC, in performing its duties under this section, to collaborate with an institution of higher education or another state agency with experience in analyzing and producing public use data.

SECTION 2. Amends Section 531.1131, Government Code, by amending Subsections (a), (b), and (c) and adding Subsections (c-1), (c-2), and (c-3), as follows:

(a) Requires a managed care organization (MCO) or an entity, rather than an MCO's special investigative unit (unit) under Section 531.113(a)(1) (relating to requiring certain MCOs to establish and maintain an investigative unit within the MCO to fulfill certain tasks), if an MCO or an entity with which the MCO contracts under Section 531.113(a)(2) (relating to requiring certain MCOs to contract with another entity for

certain investigations) discovers fraud or abuse in Medicaid or the child health plan program, to immediately submit written notice to HHSC's Office of Inspector General (OIG-HHSC) and the Office of the Attorney General (OAG), rather than immediately and contemporaneously notify OIG-HHSC and OAG, in the form and manner prescribed by OIG-HHSC and containing a detailed description of the fraud or abuse and each payment made to a provider as a result of the fraud or abuse. Makes a nonsubstantive change.

(b) Prohibits the MCO or the contracted entity described by Subsection (a), rather than the MCO's unit or contracted entity described by Subsection (a), if the amount sought to be recovered under Subsection (a)(2) (relating to requiring the MCO or entity to begin payment recovery efforts) exceeds \$100,000, from engaging in payment recovery efforts if, not later than a certain date, the MCO or entity, rather than the unit or entity, receives a certain notice from either OIG-HHSC or OAG. Makes conforming changes.

(c) Authorizes an MCO to retain one-half of any money recovered under Subsection (a)(2) by the MCO or the contracted entity described by Subsection (a). Requires the MCO to remit the remaining amount of recovered money to OIG for deposit to the credit of the general revenue fund (fund). Makes conforming changes.

(c-1) Provides that, if OIG-HHSC notifies an MCO under Subsection (b), proceeds with recovery efforts, and recovers all or part of the payments the MCO identified as required by Subsection (a)(1), the MCO is entitled to one-half of the amount recovered for each payment the MCO identified after any applicable federal share is deducted. Prohibits the MCO from receiving more than one-half of the total amount of money recovered after any applicable federal share is deducted.

(c-2) Authorizes OIG-HHSC, notwithstanding any provision of this section and if OIG-HHSC discovers fraud, waste, or abuse in Medicaid or the child health plan program in the performance of its duties, to recover payments made to a provider as a result of the fraud, waste, or abuse as otherwise provided by this subchapter (Medicaid and Other Health and Human Services Fraud, Abuse, or Overcharges). Requires that all recovered payments be deposited to the credit of the fund.

(c-3) Requires OIG-HHSC to coordinate with appropriate MCOs to ensure that OIG-HHSC and an MCO or an entity with which an MCO contracts under Section 531.113(a)(2) do not both begin payment recovery efforts for the same case of fraud, waste, or abuse.

SECTION 3. Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.023 and 533.024, as follows:

Sec. 533.023. OPTIONS FOR ESTABLISHING COMPETITIVE PROCUREMENT PROCESS. Requires HHSC, not later than December 1, 2018, to develop and analyze options, including the potential costs of and cost savings that may be achieved by the options, for establishing a range of rates within which an MCO is required to bid during a competitive procurement process to contract with HHSC to arrange for or provide a managed care plan. Provides that this section expires September 1, 2019.

Sec. 533.024. ASSESSMENT OF STATEWIDE MANAGED CARE PLANS. (a) Requires HHSC, not later than December 1, 2018, 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. Requires HHSC, in conducting the assessment, to consider certain factors.

(b) Provides that this section expires September 1, 2019.

SECTION 4. (a) Requires HHSC, using existing resources, 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 legislature, and the Legislative Budget Board (LBB). Authorizes the required report to be combined with any other report required by this Act or other law.

SECTION 5. (a) Requires HHSC to conduct a study to evaluate the 30-day limitation on reimbursement for inpatient hospital care provided to Medicaid recipients enrolled in the STAR + PLUS Medicaid managed care program under 1 T.A.C. Section 354.1072(a)(1) and other applicable law. Requires HHSC, in evaluating the limitation and to the extent data is available on the subject, to consider:

(1) the number of Medicaid recipients affected by the limitation and their clinical outcomes;

(2) the types of providers providing health care services to Medicaid recipients who have been denied Medicaid coverage because of the limitation;

(3) the impact of the limitation on the providers described in Subdivision (2);

(4) the appropriateness of hospitals using money received under the uncompensated care payment program established under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) to pay for health care services provided to Medicaid recipients who have been denied Medicaid coverage because of the limitation; and

(5) the impact of the limitation on reducing unnecessary Medicaid inpatient hospital days and any cost savings achieved by the limitation under Medicaid.

(b) Requires HHSC, not later than December 1, 2018, to submit a report containing the results of the study conducted under Subsection (a) to the governor, the legislature, and LBB. Authorizes the required report to be combined with any other report required by this Act or other law.

SECTION 6. (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 Subsection (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 legislature, and LBB. Authorizes the required report to be combined with any other report required by this Act or other law.

SECTION 7. Makes application of Section 531.1131, Government Code, as amended by this Act, prospective.

SECTION 8. 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 9. Effective date: September 1, 2017.