BILL ANALYSIS

Senate Research Center
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C.S.S.B. 1105
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Health & Human Services
4/23/2019
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

STAR Kids is a Texas Medicaid managed care program that provides Medicaid benefits to children and adults 20 and younger who have disabilities. The Medically Dependent Children's Program (MDCP) is a 1915(c) waiver program within STAR Kids that provides respite, minor home modifications, and adaptive aids as an alternative to nursing facility care.

The 2018 Texas Medicaid Managed Care STAR Kids Program Focus Study Report found that problems in the STAR Kids program implementation included resistance to the program on the part of families and providers, changes or reductions in services, medical necessity denials, and issues with scheduling and completing the STAR Kids Screening and Assessment Instrument (SK-SAI).

S.B. 1105 seeks to address these concerns and provide needed reforms and modernization to the STAR Kids program by ensuring efficiencies in provider enrollment, public access to Medicaid data and health outcomes, a standardized process for complaints, improvement of the SK-SAI assessment process, managed care accountability, new options for delivery of care in STAR Kids, and other additional reforms to the current program. (Original Author's/Sponsor's Statement of Intent)

C.S.S.B. 1105 amends current law relating to administration and operation of Medicaid, including Medicaid managed care.

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 Section 531.001, Government Code, by adding Subdivision (4-c) to define "Medicaid managed care organization."

SECTION 2. Amends Subchapter B, Chapter 531, Government Code, by adding Sections 531.021182, 531.02131, 531.02142, 531.024162, and 531.0511, as follows:

> Sec. 531.021182. USE OF NATIONAL PROVIDER IDENTIFIER NUMBER. (a) Defines "national provider identifier number" for purposes of this section.
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> (b) Requires the Health and Human Services Commission (HHSC) to transition from using a state-issued provider identifier number to using only a national provider identifier number in accordance with this section.
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> (c) Requires HHSC to implement a Medicaid provider management and enrollment system and, following that implementation, use only a national provider identifier number to enroll a provider in Medicaid.

(d) Requires HHSC to implement a modernized claims processing system and, following that implementation, use only a national provider identifier number to process claims for and authorize Medicaid services.

Sec. 531.02131. GRIEVANCES RELATED TO MEDICAID. (a) Requires HHSC to adopt a definition of "grievance" related to Medicaid and ensure the definition is consistent among divisions within HHSC to ensure all grievances are managed consistently.

(b) Requires HHSC to standardize Medicaid grievance data reporting and tracking among divisions within HHSC.

(c) Requires HHSC to implement a no-wrong-door system for Medicaid grievances reported to HHSC.

(d) Requires HHSC to establish a procedure for expedited resolution of a grievance related to Medicaid that allows HHSC to identify a grievance related to a Medicaid access to care issue that is urgent and requires an expedited resolution and to resolve the grievance within a specified period.

(e) Requires HHSC to verify grievance data reported by a managed care organization.

(f) Requires HHSC to aggregate Medicaid recipient and provider grievance data to provide a comprehensive data set of grievances and make the aggregated data available to the legislature and the public in a manner that does not allow for the identification of a particular recipient or provider.

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) Requires HHSC, in consultation and collaboration with the appropriate advisory committees related to Medicaid, to the extent permitted by federal law, to make available to the public on HHSC's Internet website in an easy-to-read format data relating to the quality of health care received by Medicaid recipients and the health outcomes of those recipients. Requires data made available to the public under this section to 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.

Sec. 531.024162. NOTICE REQUIREMENTS REGARDING DENIAL OF COVERAGE OR PRIOR AUTHORIZATION. (a) Requires HHSC to ensure that notice sent by HHSC or a Medicaid managed care organization to a Medicaid recipient or provider regarding the denial of coverage or prior authorization for a service includes:

(1) information required by federal law;

(2) a clear and easy-to-understand explanation of the reason for the denial for the recipient; and

(3) a clinical explanation of the reason for the denial for the provider.

(b) Authorizes HHSC, to ensure cost-effectiveness, to implement the notice requirements described by Subsection (a) at the same time as other required or scheduled notice changes.

Sec. 531.0511. MEDICALLY DEPENDENT CHILDREN WAIVER PROGRAM: CONSUMER DIRECTION OF SERVICES. Requires a consumer direction model implemented under Section 531.051 (Definitions), including the consumer-directed

service option, for the delivery of services under the medically dependent children (MDCP) waiver program, notwithstanding Sections 531.051(c)(1) (relating to the executive commissioner of HHSC determining certain services appropriate for delivery through consumer direction) and (d) (relating to authorizing consumer direction models to be implemented), to allow for the delivery of all services and supports available under that program through consumer direction.

SECTION 3. Amends Section 533.00253(a)(1), to redefine "advisory committee" to mean the STAR Kids Managed Care Advisory Committee described by, rather than established under, Section 533.00254.

SECTION 4. Amends Section 533.00253, Government Code, by amending Subsection (c) and adding Subsections (c-1), (c-2), (f), (g), and (h), as follows:

(c) Authorizes HHSC to require that care management services made available as provided by Subsection (b)(7) (relating to requiring the managed care program to reduce the incidence of unnecessary institutionalizations and events) provide a care needs assessment for a recipient, rather than provide a care needs assessment for a recipient that is comprehensive, holistic, consumer-directed, evidence-based, and takes into consideration social and medical issues, for purposes of prioritizing the recipient's needs that threaten independent living.

(c-1) Requires HHSC in consultation and collaboration with the STAR Kids Managed Care Advisory Committee (advisory committee), to improve the care needs assessment tool used for purposes of a care needs assessment provided as a component of care management services and to improve the initial assessment and reassessment processes, to consider changes that will:

(1) reduce the amount of time needed to complete the care needs assessment initially and at reassessment; and

(2) improve training and consistency in the completion of the care needs assessment using the tool and in the initial assessment and reassessment processes across different Medicaid managed care organizations and different service coordinators within the same Medicaid managed care organization.

(c-2) Requires HHSC, to the extent feasible and allowed by federal law, to streamline the STAR Kids managed care program annual care needs reassessment process for a child who has not had a significant change in function that may affect medical necessity.

(f) Requires the executive commissioner in consultation and collaboration with the advisory committee, using existing resources, to determine the feasibility of providing Medicaid benefits to children enrolled in the STAR Kids managed care program under:

(1) an accountable care organization model in accordance with guidelines established by the Centers for Medicare and Medicaid Services; or

(2) an alternative model developed by or in collaboration with the Centers for Medicaid and Medicaid Services Innovation Center.

(g) Requires HHSC, not later than December 1, 2022, to prepare and submit a written report to the legislature of the executive commissioner's determination under Subsection (f).

(h) Provides that Subsections (f) and (g) and this subsection expire September 1, 2023.

SECTION 5. Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.00254 and 533.0031, as follows:

Sec. 533.00254. STAR KIDS MANAGED CARE ADVISORY COMMITTEE. (a) Requires the advisory committee established by the executive commissioner under Section 531.012 to advise HHSC on the operation of the STAR Kids managed care program under Section 533.00253 and make recommendations for improvements to that program.

(b) Provides that on December 31, 2023, the advisory committee is abolished and this section expires.

Sec. 533.0031. MEDICAID MANAGED CARE PLAN ACCREDITATION. (a) Requires a managed care plan offered by a Medicaid managed care organization to be accredited by a nationally recognized accreditation organization. Authorizes HHSC to choose whether to require all managed care plans offered by Medicaid managed care organizations to be accredited by the same organization or to allow for accreditation by different organizations.

(b) Authorizes HHSC to use the data, scoring, and other information provided to or received from an accreditation organization in HHSC's contract oversight processes.

SECTION 6. Requires HHSC to issue a request for information to seek information and comments regarding contracting with a managed care organization to arrange for or provide a managed care plan under the STAR Kids managed care program established under Section 533.00253, Government Code, as amended by this Act, throughout the state instead of on a regional basis.

SECTION 7. (a) Requires HHSC, using available resources, 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 the number of Medicaid recipients affected by the limitation and their clinical outcomes and 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, 2020, to submit a report containing the results of the study conducted under Subsection (a) of this section to the governor, the legislature, and the Legislative Budget Board. Authorizes the report required under this subsection to be combined with any other report required by this Act or other law.

SECTION 8. Requires HHSC to implement the Medicaid provider management and enrollment system required by Section 531.021182(c), Government Code, as added by this Act, no later than September 1, 2020 and the modernized claims processing system required by Section 531.021182(d), Government Code, as added by this Act, not later than September 1, 2023.

SECTION 9. Requires HHSC, not later than March 1, 2020, to develop a plan to improve the care needs assessment tool and the initial assessment and reassessment processes as required by Sections 533.00253(c-1) and (c-2), Government Code, as added by this Act, and post the plan on HHSC's Internet website.

SECTION 10. Requires HHSC to require that a managed care plan offered by a managed care organization with which HHSC enters into or renews a contract under Chapter 533, Government Code, on or after the effective date of this Act, comply with Section 533.0031, Government Code, as added by this Act, not later than September 1, 2022.

SECTION 11. Requires a state agency affected by a provision of this Act to request a waiver or authorization from a federal agency if the state agency determines that such waiver or authorization is necessary for implementation of the provision, and authorizes the agency to delay implementation until the waiver or authorization is granted.

SECTION 12. Provides that HHSC is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. Authorizes, but does not require, HHSC, if the legislature does not appropriate money for specifically for that purpose, to implement a provision of this Act using other appropriations available for that purpose.

SECTION 13. Effective date: September 1, 2019.