

## **BILL ANALYSIS**

Senate Research Center

H.B. 2658  
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Health & Human Services  
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Engrossed

### **AUTHOR'S / SPONSOR'S STATEMENT OF INTENT**

Stakeholders have suggested that the state's Medicaid system, which relies on managed care organizations for the coordination and delivery of certain services, suffers from certain deficiencies, resulting in administrative complexity and financial uncertainty for some Medicaid providers and recipients. H.B. 2658 seeks to remedy these deficiencies by implementing changes to requirements regarding capitation rates in Medicaid contracts and ensuring managed care recipients have the option to receive a physical, paper copy of their managed care organization's network provider directory.

H.B. 2658 amends current law relating to the operation and administration of the Medicaid managed care program, including requirements for and reimbursement of managed care organizations.

### **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 533.005(a), Government Code, as follows:

(a) Requires that a contract between a Medicaid managed care organization and the Health and Human Services Commission (HHSC) for the organization to provide health care services to recipients contain:

(1) makes no changes to this subdivision;

(2) capitation rates that:

(A) include acuity and risk adjustment methodologies that consider the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the plan; and

(B) creates this paragraph from existing text and makes no further changes;

(3)-(26) makes no changes to these subdivisions.

SECTION 2. Amends Sections 533.0063(b) and (c), Government Code, as follows:

(b) Requires the Medicaid managed care organization, if a recipient requests to receive the directory in paper form, to mail to the recipient the most recent paper form of the directory not later than the fifth business day after the date the organization receives the recipient's request. Deletes existing text creating an exception under Subsection (c). Makes a nonsubstantive change.

(c) Requires a Medicaid managed care organization, at least annually, to include in the organization's outreach efforts directed at and educational materials sent to recipients enrolled in a managed care plan offered by the organization a written or verbal offer allowing each recipient to elect to receive the organization's provider network directory for the program, including any updates to the directory, in paper form.

Deletes existing text requiring a managed care organization participating in the STAR + PLUS Medicaid managed care program or STAR Kids Medicaid managed care program established under Section 533.00253 (STAR Kids Medicaid Managed Care Program), for a recipient in that program, to issue a provider network directory for the program in paper form unless the recipient opts out of receiving the directory in paper form.

SECTION 3. Amends Section 32.025(g), Human Resources Code, as follows:

(g) Requires that the application form adopted under Section 32.025 (Application for Medical Assistance) include:

(1) makes a nonsubstantive change to this subdivision;

(2) for an applicant who may be enrolled in a Medicaid managed care plan under Chapter 533 (Medicaid Managed Care Program), Government Code, an option for an applicant to elect to receive the provider network directory, including any updates to the directory, associated with the plan in which the applicant is enrolled in paper form; and

(3) creates this subdivision from existing text and makes no further changes.

SECTION 4. (a) Provides that Section 533.005(a), Government Code, as amended by this Act, applies only to a contract between HHSC and a Medicaid managed care organization that is entered into or renewed on or after the effective date of this Act.

(b) Requires HHSC, to the extent permitted by the terms of the contract, to seek to amend a contract entered into before the effective date of this Act with a Medicaid managed care organization to comply with Section 533.005(a), Government Code, as amended by this Act.

SECTION 5. Requires HHSC, as soon as practicable after the effective date of this Act, to adopt a revised application form for medical assistance benefits that conforms to the requirements of Section 32.025(g), Human Resources Code, as amended by this Act.

SECTION 6. Requires HHSC, using existing resources, to conduct a study to assess the impact of revising Star+Plus capitation for managed long term care from payment based on site of care to a blended rate. Provides that the study will assess how revising the method of calculating the capitation impacts consumers' choice of setting as well as conduct an actuarial analysis of the impact on program spending. Requires that the study take into consideration the experience of other states utilizing a blended rate for Medicaid managed long term care. Requires HHSC to provide a report with their findings to the speaker of the Texas House of Representatives, lieutenant governor, House Human Services Committee and Senate Health and Human Services Committee.

SECTION 7. 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 a delay of implementation until such a waiver or authorization is granted.

SECTION 8. Effective date: September 1, 2021.