BILL ANALYSIS

Senate Research Center
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C.S.H.B. 4
By: Price et al. (Buckingham)
Health & Human Services
5/18/2021
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

In 2019, the Texas Legislature passed S.B. 670, which made several needed changes to the regulation and payment of telemedicine and telehealth services provided through the Texas Medicaid program. As a result, the opportunity to use telemedicine and telehealth in the Medicaid program was expanded significantly prior to the onset of COVID-19.

Since March of 2020, the Health and Human Services Commission has allowed additional flexibilities in the use of telemedicine and telehealth to provide services to Medicaid and CHIP recipients. These flexibilities, in addition to the framework put in place by S.B. 670, have been remarkably successful in supporting social distancing and allowing patients to continue to receive services via telemedicine and telehealth during the pandemic.

H.B. 4 proposes to make permanent most of the Medicaid/CHIP waivers that were put in place as part of the state's COVID-19 response while still upholding the standard of care. It also addresses gaps related to the use of technology in delivering services and information to clients that were identified by stakeholders during the COVID-19 pandemic.

(Original Author's / Sponsor's Statement of Intent)

C.S.H.B. 4 amends current law relating to the provision and delivery of certain health care services in this state, including under Medicaid and other public benefits programs, using telecommunications or information technology and to reimbursement for some of those services.

RULEMAKING AUTHORITY

Rulemaking authority previously granted to the executive commissioner of the Health and Human Services Commission is modified in SECTION 1 (Section 531.0216, Government Code) and SECTION 9 (Section 462.025, Health and Safety Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 2 (Section 531.02161, Government Code), SECTION 6 (Section 533.039, Government Code), and SECTION 8 (Section 462.015, Health and Safety Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.0216(i), Government Code, to require the executive commissioner of the Health and Human Services Commission (executive commissioner) by rule to ensure that certain health centers, including a rural health clinic as defined by 42 U.S.C. Section 1396d(l)(1), may be reimbursed for the originating site facility fee or the distant site practitioner fee or both, as appropriate, for a covered telemedicine medical service or telehealth service delivered by a health care provider to a Medicaid recipient.

SECTION 2. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02161, as follows:

> Sec. 531.02161. PROVISION OF SERVICES THROUGH TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY UNDER MEDICAID AND OTHER PUBLIC

BENEFITS PROGRAMS. (a) Defines "behavioral health services" and provides that "case management services" includes service coordination, service management, and care coordination, for purposes of this section.

(b) Requires the Health and Human Services Commission (HHSC), to the extent permitted by federal law and to the extent it is cost-effective and clinically effective, as determined by HHSC, to ensure that Medicaid recipients, child health plan program enrollees, and other individuals receiving benefits under a public benefits program administered by HHSC or a health and human services agency, regardless of whether receiving benefits through a managed care delivery model or another delivery model, have the option to receive services as telemedicine medical services, telehealth services, or otherwise using telecommunications or information technology, including the following services:

(1) preventative health and wellness services;

(2) case management services, including targeted case management services;

(3) subject to Subsection (c), behavioral health services;

(4) occupational, physical, and speech therapy services;

(5) nutritional counseling services; and

(6) assessment services, including nursing assessments under the following Section 1915(c) waiver programs:

(A) the community living assistance and support services (CLASS) waiver program;

(B) the deaf-blind with multiple disabilities (DBMD) waiver program;

(C) the home and community-based services (HCS) waiver program; and

(D) the Texas home living (TxHmL) waiver program.

(c) Requires the executive commissioner, to the extent permitted by state and federal law and to the extent it is cost-effective and clinically effective, as determined by HHSC, by rule to develop and implement a system to ensure behavioral health services are authorized to be provided using an audio-only platform consistent with Section 111.008 (Mental Health Services Excluded), Occupations Code, to a Medicaid recipient, a child health plan program enrollee, or another individual receiving those services under another public benefits program administered by HHSC or a health and human services agency.

(d) Authorizes the executive commissioner by rule, if the executive commissioner determines that providing services other than behavioral health services is appropriate using an audio-only platform under a public benefits program administered by HHSC or a health and human services agency, in accordance with applicable federal and state law, to authorize the provision of those services under the applicable program using the audio-only platform. Requires the executive commissioner, in determining whether the use of an audio-only platform in a program is appropriate under this subsection, to consider whether using the platform would be cost-effective and clinically effective.

SECTION 3. Amends Section 531.02164, Government Code, by adding Subsection (f), as follows:

(f) Authorizes a Medicaid managed care organization, to comply with state and federal requirements to provide access to medically necessary services under the Medicaid managed care program, to reimburse providers for home telemonitoring services provided to persons who have conditions and exhibit risk factors other than those expressly authorized by Section 531.02164 (Medicaid Services Provided Through Home Telemonitoring Services). Requires the organization, in determining whether the managed care organization should provide reimbursement for services under this subsection, to consider whether reimbursement for the service is cost-effective and providing the service is clinically effective.

SECTION 4. Amends Section 533.0061(b), Government Code, to require that the provider access standards established under Section 533.0061 (Provider Access Standards; Report), to the extent it is feasible, meet certain criteria, including, subject to Section 531.0216(c) (relating to HHSC encouraging health care providers to provide telemedicine medical services) and consistent with Section 111.007, Occupations Code, consider and include the availability of telehealth services and telemedicine medical services within the provider network of a Medicaid managed care organization. Makes nonsubstantive changes.

SECTION 5. Amends Section 533.008, Government Code, by adding Subsection (c), as follows:

(c) Requires the executive commissioner to adopt and publish guidelines for Medicaid managed care organizations regarding how organizations are authorized to communicate by text message or e-mail with recipients enrolled in the organization's managed care plan using the contact information provided in a recipient's application for Medicaid benefits under Section 32.025(g)(2), Human Resources Code.

SECTION 6. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.039, as follows:

Sec. 533.039. DELIVERY OF BENEFITS USING TELECOMMUNICATIONS AND INFORMATION TECHNOLOGY. (a) Requires HHSC to establish policies and procedures to improve access to care under the Medicaid managed care program by encouraging the use of telehealth services, telemedicine medical services, home telemonitoring services, and other telecommunications or information technology under the program.

(b) Requires the executive commissioner by rule, to the extent permitted by federal law, to establish policies and procedures that allow a Medicaid managed care organization to conduct assessments of and provide care coordination services using another telecommunications or information technology if. Requires the executive commissioner, in establishing the policies and procedures, to consider:

(1) the extent to which a managed care organization determines using the telecommunications or information technology is appropriate;

(2) whether the recipient requests that the assessment or service be provided using telecommunications or information technology;

(3) whether the recipient consents to receiving the assessment or service using telecommunications or information technology;

(4) whether conducting the assessment, including an assessment for an initial waiver eligibility determination, or providing the service in person is not feasible because of the existence of an emergency or state of disaster, including a public health emergency or natural disaster; and

(5) whether HHSC determines using the telecommunications or information technology is appropriate under the circumstances.

(c) Requires a Medicaid managed care organization, if the managed care organization conducts an assessment of or provides care coordination services to a

recipient using telecommunications or information technology, to monitor the health care services provided to the recipient for evidence of fraud, waste, and abuse and to determine whether additional social services or supports are needed.

(d) Requires HHSC, to the extent permitted by federal law, to allow a recipient who is assessed or provided with care coordination services by a Medicaid managed care organization using telecommunications or information technology to provide consent or other authorizations to receive services verbally instead of in writing.

(e) Requires HHSC to determine categories of recipients of home and community-based services who are required to receive in-person visits. Requires a Medicaid managed care organization, except during circumstances described by Subsection (b)(4), for a recipient of home and community-based services for which HHSC requires in-person visits, to conduct at least one in-person visit with the recipient to make an initial waiver eligibility determination and conduct additional in-person visits with the recipient if necessary, as determined by the managed care organization.

(f) Authorizes HHSC, notwithstanding the provisions of this section, on a case-by-case basis, to require a Medicaid managed care organization to discontinue the use of telecommunications or information technology for assessment or service coordination services if HHSC determines that the discontinuation is in the best interest of the recipient.

SECTION 7. Amends Section 62.1571, Health and Safety Code, as follows:

Sec. 62.1571. New heading: TELEMEDICINE MEDICAL SERVICES AND TELEHEALTH SERVICES. (a) - (d) Makes conforming and nonsubstantive changes to these subsections.

SECTION 8. Amends Subchapter A, Chapter 462, Health and Safety Code, by adding Section 462.015, as follows:

Sec. 462.015. OUTPATIENT TREATMENT SERVICES PROVIDED USING TELECOMMUNICATIONS OR INFORMATION TECHNOLOGY. (a) Authorizes an outpatient chemical dependency treatment program provided by a treatment facility licensed under Chapter 464 (Facilities Treating Persons with a Chemical Dependency) to provide services under the program to adult and adolescent clients, consistent with HHSC rule, using telecommunications or information technology.

(b) Requires the executive commissioner to adopt rules to implement this section.

SECTION 9. Amends Section 462.025, Health and Safety Code, by adding Subsection (d-1), to require that the rules governing the intake, screening, and assessment procedures establish minimum standards for providing intake, screening, and assessment using telecommunications or information technology.

SECTION 10. 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 certain information, including for all applications, a question regarding the applicant's preferences for being contacted by a managed care organization or health care provider, in a certain form set forth in this subsection.

SECTION 11. Requires HHSC, not later than January 1, 2022, to:

(1) implement Section 531.02161, Government Code, as added by this Act; and

(2) publish the guidelines required by Section 533.008(c), Government Code, as added by this Act.

SECTION 12. 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 13. Effective date: upon passage or September 1, 2021.