By: Kolkhorst S.B. No. 1927

(In the Senate - Filed March 10, 2017; March 27, 2017, read first time and referred to Committee on Health & Human Services; April 24, 2017, reported adversely, with favorable Committee Substitute by the following vote: Yeas 9, Nays 0; April 24, 2017, sent to printer.)

COMMITTEE VOTE

| | Yea | Nay | Absent | PNV |
|---|---|---|---|---|
| Schwertner | X | | | |
| Uresti | X | | | |
| Buckingham | X | | | |
| Burton | X | | | |
| Kolkhorst | X | | | |
| Miles | X | | | |
| Perry | X | | | |
| Taylor of Collin | X | | | |
| Watson | X | | | |

COMMITTEE SUBSTITUTE FOR S.B. No. 1927 By: Kolkhorst

A BILL TO BE ENTITLED
AN ACT

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.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.02142 to read as follows:

Sec. 531.02142. PUBLIC ACCESS TO CERTAIN MEDICAID DATA. (a) To the extent permitted by federal law, the commission shall 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. Data made available to the public under this section must be made available in a manner that does not identify or allow for the identification of individual recipients.

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

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

(a) If a managed care organization [~~organization's special investigative unit under Section 531.113(a)(1)~~] or an [~~the~~] entity with which the managed care organization contracts under Section 531.113(a)(2) discovers fraud or abuse in Medicaid or the child health plan program, the organization [~~unit~~] or entity shall:

(1) immediately submit written notice to [~~and contemporaneously notify~~] the commission's office of inspector general and the office of the attorney general in the form and manner prescribed by the office of inspector general 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;

(2) subject to Subsection (b), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with applicable rules adopted by the executive commissioner.

(b) If the amount sought to be recovered under Subsection

2-1 (a)(2) exceeds $100,000, the managed care organization
2-2 [~~organization's special investigative unit~~] or the contracted
2-3 entity described by Subsection (a) may not engage in payment
2-4 recovery efforts if, not later than the 10th business day after the
2-5 date the organization [~~unit~~] or entity notified the commission's
2-6 office of inspector general and the office of the attorney general
2-7 under Subsection (a)(1), the organization [~~unit~~] or entity receives
2-8 a notice from either office indicating that the organization [~~unit~~]
2-9 or entity is not authorized to proceed with recovery efforts.
2-10 (c) A managed care organization may retain one-half of any
2-11 money recovered under Subsection (a)(2) by the organization
2-12 [~~organization's special investigative unit~~] or the contracted
2-13 entity described by Subsection (a). The managed care organization
2-14 shall remit the remaining amount of money recovered under
2-15 Subsection (a)(2) to the commission's office of inspector general
2-16 for deposit to the credit of the general revenue fund.
2-17 (c-1) If the commission's office of inspector general
2-18 notifies a managed care organization under Subsection (b), proceeds
2-19 with recovery efforts, and recovers all or part of the payments the
2-20 organization identified as required by Subsection (a)(1), the
2-21 organization is entitled to one-half of the amount recovered for
2-22 each payment the organization identified after any applicable
2-23 federal share is deducted. The organization may not receive more
2-24 than one-half of the total amount of money recovered after any
2-25 applicable federal share is deducted.
2-26 (c-2) Notwithstanding any provision of this section, if the
2-27 commission's office of inspector general discovers fraud, waste, or
2-28 abuse in Medicaid or the child health plan program in the
2-29 performance of its duties, the office may recover payments made to a
2-30 provider as a result of the fraud, waste, or abuse as otherwise
2-31 provided by this subchapter. All payments recovered by the office
2-32 under this subsection shall be deposited to the credit of the
2-33 general revenue fund.
2-34 (c-3) The commission's office of inspector general shall
2-35 coordinate with appropriate managed care organizations to ensure
2-36 that the office and an organization or an entity with which an
2-37 organization contracts under Section 531.113(a)(2) do not both
2-38 begin payment recovery efforts under this section for the same case
2-39 of fraud, waste, or abuse.
2-40 SECTION 3. Subchapter A, Chapter 533, Government Code, is
2-41 amended by adding Sections 533.023 and 533.024 to read as follows:
2-42 Sec. 533.023. OPTIONS FOR ESTABLISHING COMPETITIVE
2-43 PROCUREMENT PROCESS. Not later than December 1, 2018, the
2-44 commission shall develop and analyze options, including the
2-45 potential costs of and cost savings that may be achieved by the
2-46 options, for establishing a range of rates within which a managed
2-47 care organization must bid during a competitive procurement process
2-48 to contract with the commission to arrange for or provide a managed
2-49 care plan. This section expires September 1, 2019.
2-50 Sec. 533.024. ASSESSMENT OF STATEWIDE MANAGED CARE PLANS.
2-51 (a) Not later than December 1, 2018, the commission shall assess
2-52 the feasibility and cost-effectiveness of contracting with managed
2-53 care organizations to arrange for or provide managed care plans to
2-54 recipients throughout the state instead of on a regional basis. In
2-55 conducting the assessment, the commission shall consider:
2-56 (1) regional variations in the cost of and access to
2-57 health care services;
2-58 (2) recipient access to and choice of providers;
2-59 (3) the potential impact on providers, including
2-60 safety net providers; and
2-61 (4) public input.
2-62 (b) This section expires September 1, 2019.
2-63 SECTION 4. (a) Using existing resources, the Health and
2-64 Human Services Commission shall:
2-65 (1) identify and evaluate barriers preventing
2-66 Medicaid recipients enrolled in the STAR + PLUS Medicaid managed
2-67 care program or a home and community-based services waiver program
2-68 from choosing the consumer directed services option and develop
2-69 recommendations for increasing the percentage of Medicaid

3-1 recipients enrolled in those programs who choose the consumer
3-2 directed services option; and
3-3 (2) study the feasibility of establishing a community
3-4 attendant registry to assist Medicaid recipients enrolled in the
3-5 community attendant services program in locating providers.
3-6 (b) Not later than December 1, 2018, the Health and Human
3-7 Services Commission shall submit a report containing the
3-8 commission's findings and recommendations under Subsection (a) of
3-9 this section to the governor, the legislature, and the Legislative
3-10 Budget Board. The report required by this subsection may be
3-11 combined with any other report required by this Act or other law.
3-12 SECTION 5. (a) The Health and Human Services Commission
3-13 shall conduct a study to evaluate the 30-day limitation on
3-14 reimbursement for inpatient hospital care provided to Medicaid
3-15 recipients enrolled in the STAR + PLUS Medicaid managed care
3-16 program under 1 T.A.C. Section 354.1072(a)(1) and other applicable
3-17 law. In evaluating the limitation and to the extent data is
3-18 available on the subject, the commission shall consider:
3-19 (1) the number of Medicaid recipients affected by the
3-20 limitation and their clinical outcomes;
3-21 (2) the types of providers providing health care
3-22 services to Medicaid recipients who have been denied Medicaid
3-23 coverage because of the limitation;
3-24 (3) the impact of the limitation on the providers
3-25 described in Subdivision (2) of this subsection;
3-26 (4) the appropriateness of hospitals using money
3-27 received under the uncompensated care payment program established
3-28 under the Texas Health Care Transformation and Quality Improvement
3-29 Program waiver issued under Section 1115 of the federal Social
3-30 Security Act (42 U.S.C. Section 1315) to pay for health care
3-31 services provided to Medicaid recipients who have been denied
3-32 Medicaid coverage because of the limitation; and
3-33 (5) the impact of the limitation on reducing
3-34 unnecessary Medicaid inpatient hospital days and any cost savings
3-35 achieved by the limitation under Medicaid.
3-36 (b) Not later than December 1, 2018, the Health and Human
3-37 Services Commission shall submit a report containing the results of
3-38 the study conducted under Subsection (a) of this section to the
3-39 governor, the legislature, and the Legislative Budget Board. The
3-40 report required under this subsection may be combined with any
3-41 other report required by this Act or other law.
3-42 SECTION 6. (a) The Health and Human Services Commission
3-43 shall conduct a study of the provision of dental services to adults
3-44 with disabilities under the Medicaid program, including:
3-45 (1) the types of dental services provided, including
3-46 preventive dental care, emergency dental services, and
3-47 periodontal, restorative, and prosthodontic services;
3-48 (2) limits or caps on the types and costs of dental
3-49 services provided;
3-50 (3) unique considerations in providing dental care to
3-51 adults with disabilities, including additional services necessary
3-52 for adults with particular disabilities; and
3-53 (4) the availability and accessibility of dentists who
3-54 provide dental care to adults with disabilities, including the
3-55 availability of dentists who provide additional services necessary
3-56 for adults with particular disabilities.
3-57 (b) In conducting the study under Subsection (a) of this
3-58 section, the Health and Human Services Commission shall:
3-59 (1) identify the number of adults with disabilities
3-60 whose Medicaid benefits include limited or no dental services and
3-61 who, as a result, have sought medically necessary dental services
3-62 during an emergency room visit;
3-63 (2) if feasible, estimate the number of adults with
3-64 disabilities who are receiving services under the Medicaid program
3-65 and who have access to alternative sources of dental care,
3-66 including pro bono dental services, faith-based dental services
3-67 providers, and other public health care providers; and
3-68 (3) collect data on the receipt of dental services
3-69 during emergency room visits by adults with disabilities who are

4-1 receiving services under the Medicaid program, including the
4-2 reasons for seeking dental services during an emergency room visit
4-3 and the costs of providing the dental services during an emergency
4-4 room visit, as compared to the cost of providing the dental services
4-5 in the community.
4-6 (c) Not later than December 1, 2018, the Health and Human
4-7 Services Commission shall submit a report containing the results of
4-8 the study conducted under Subsection (a) of this section and the
4-9 commission's recommendations for improving access to dental
4-10 services in the community for and reducing the provision of dental
4-11 services during emergency room visits to adults with disabilities
4-12 receiving services under the Medicaid program to the governor, the
4-13 legislature, and the Legislative Budget Board. The report required
4-14 by this subsection may be combined with any other report required by
4-15 this Act or other law.
4-16 SECTION 7. Section 531.1131, Government Code, as amended by
4-17 this Act, applies only to an amount of money recovered on or after
4-18 the effective date of this Act. An amount of money recovered before
4-19 the effective date of this Act is governed by the law in effect
4-20 immediately before that date, and that law is continued in effect
4-21 for that purpose.
4-22 SECTION 8. If before implementing any provision of this Act
4-23 a state agency determines that a waiver or authorization from a
4-24 federal agency is necessary for implementation of that provision,
4-25 the agency affected by the provision shall request the waiver or
4-26 authorization and may delay implementing that provision until the
4-27 waiver or authorization is granted.
4-28 SECTION 9. This Act takes effect September 1, 2017.

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