BILL ANALYSIS

Senate Research Center

C.S.H.B. 2913
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Health & Human Services
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Committee Report (Substituted)

DIGEST

Texas began the transition to managed care for recipients of Medicaid services in 1993 with pilot programs in various counties. Fully implemented, those pilot programs moved 60,000 individuals into managed care through contracts with a health maintenance organization (HMO) and a pre-paid health plan, and through a state-administered primary care case management system (PCCM). Since that time, managed care has expanded to five additional sites, covering a total of 280,000 individuals through contracts with seven HMOs and through three PCCM systems. By the fall of 1999, five more sites are scheduled for conversion to managed care, bringing the number of Texans in Medicaid managed care to roughly 829,000. In addition, the state will begin piloting a managed care program for the long-term population. Implementing changes of this magnitude are always accompanied by problems. Improving employee coordination and accountability among the state agencies for the administration of Medicaid managed care would yield several benefits to the state, to recipients, and to Medicaid providers. Communication among the heads of the state agencies is critical because the next phase of managed care expansion will create new demand not only on contract monitoring, but also on oversight, utilization review, audit, hotline, and provider and member service functions.

C.S.H.B. 2913 facilitates the administration and operation of Medicaid managed care by consolidating responsibility to the Health and Human Services Commission (HHSC) and establishing an interagency advisory committee. In addition, this bill requires HHSC, in consultation with health and human services agencies, to appoint Medicaid managed care advisory committees in all regions in which HHSC plans to provide health care services.

PURPOSE

As proposed, C.S.H.B. 2913 provides for the authority of the Health and Human Services Commission to administer and operate the Medicaid managed care program.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the Health and Human Services Commission in SECTION 1 (Section 531.021(b), Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.021, Government Code, to provide that the Health and Human Services Commission (HHSC), is responsible for adopting reasonable rules and standards governing the determination of fees, charges, and rates for medical assistance payments under Chapter 32, Human Resources Code. Requires HHSC, in discharging its duties relating to the Medicaid managed care program, to consult with and consider input from the advisory committee created under Section 531.047 and from each health and human services agency that operates part of the Medicaid program.

SECTION 2. Amends Chapter 531B, Government Code, by adding Section 531.047, as follows:

> Sec. 531.047. MEDICAID MANAGED CARE INTERAGENCY ADVISORY COMMITTEE. Provides that an interagency advisory committee (committee) is created to provide assistance and recommendations to HHSC relating to the Medicaid managed care program. Sets forth provisions regarding composition of the committee, election of officers, meetings, members' expenses, and at will employment. Provides that the committee is not

subject to Article 6252-33, V.T.C.S.

SECTION 3. (a) Amends Title 4I, Government Code, by adding Chapter 533, as follows:

CHAPTER 533. IMPLEMENTATION OF MEDICAID MANAGED CARE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 533.001. DEFINITIONS. Defines "commission," "commissioner," "health and human services agencies," "managed care organization," "managed care plan," and "recipient."

Sec. 533.002. PURPOSE. Requires the Health and Human Services Commission or an agency operating part of the state Medicaid managed care program, as appropriate (commission), to implement the Medicaid managed care program as part of the health care delivery system developed under Chapter 532 by contracting with managed care organizations in a manner that achieves certain goals.

Sec. 533.003. CONSIDERATIONS IN AWARDING CONTRACTS. Requires the commission, in awarding contracts to managed care organizations, to give extra consideration to organizations that agree to assure continuity of care for a certain period; and to consider the need to use different managed care plans to meet the needs of different populations.

Sec. 533.004. MANDATORY CONTRACTS. Sets forth the terms by which the commission is required, in providing health care services through Medicaid managed care to recipients in a health care service region, to contract with certain managed care organizations in that region. Prohibits the commission from contracting with a managed care organization described by Subsection (a)(1) if a political subdivision described in Subsection (a)(1)(A) has entered into an agreement with the state to provide funds for the expansion of Medicaid for children, unless the political subdivision fulfills its obligation under the agreement to provide those funds. Requires the commission to make the provision of those funds a condition of the continuation of the contract with the managed care organization. Requires the commission to comply with this section in awarding and renewing contracts to provide health care services through Medicaid managed care to recipients in a region. Sets forth the conditions under which Subsection (c) does not apply.

Sec. 533.005. REQUIRED CONTRACT PROVISIONS. Sets forth requirements for contracts between managed care organizations and the commission for the organization to provide health care services.

Sec. 533.006. PROVIDER NETWORKS. Requires the commission to require that each managed care organization that contracts with the commission to provide health care services to recipients in a region to seek participation in the organization's provider network from certain hospitals; and include certain entities in its provider network for not less than three years. Requires a contract between a managed care organization and the commission to provide health care services to recipients in a health care service region that includes a rural area to require that the organization include in its provider network certain rural hospitals, physicians, home and community support services agencies, and other rural health care providers.

Sec. 533.007. CONTRACT COMPLIANCE. Requires the commission to review each managed care organization that contracts with the commission to determine whether the organization is prepared to meet its contractual obligations. Sets forth the terms by which each managed care organization that contracts with the commission is required to submit an implementation plan and status reports on the plan by a certain date. Sets forth the terms by which the commission is required to conduct a compliance and readiness review of each managed care organization by a certain date. Establishes the conditions under

which the commission is authorized to delay enrollment of recipients in a managed care plan if the review reveals that the managed care organization is not prepared to meet its contractual obligations.

Sec. 533.008. MARKETING GUIDELINES. Requires the commission to establish marketing guidelines for managed care organizations that contract with the commission.

Sec. 533.009. SPECIAL DISEASE MANAGEMENT. Requires the commission to ensure that managed care organizations develop special disease management programs to address chronic health conditions. Authorizes the commission, in conjunction with an academic center, to study the application of disease management principles in the delivery of Medicaid managed care.

Sec. 533.010. SPECIAL PROTOCOLS. Authorizes the commission, in conjunction with an academic center, to study the treatment of indigent populations to develop special protocols.

SUBCHAPTER B. REGIONAL ADVISORY COMMITTEES

Sec. 533.021. APPOINTMENT. Sets forth the terms by which the commission, in consultation with health and human services agencies, is required to appoint a Medicaid managed care advisory committee (advisory committee) for that region.

Sec. 533.022. COMPOSITION. Sets forth the composition of the advisory committee.

Sec. 533.023. PRESIDING OFFICER; SUBCOMMITTEES. Sets forth provisions regarding the presiding officer and subcommittees of the advisory committee.

Sec. 533.024. MEETINGS. Sets forth provisions regarding advisory committee meetings.

Sec. 533.025. POWERS AND DUTIES. Requires the advisory committee to comment on the implementation of Medicaid managed care in the region; provide recommendations to the commission on the improvement of Medicaid managed care in the region by a certain date; and seek input from the public.

Sec. 533.026. INFORMATION FROM COMMISSION. Requires the commission, on request, to provide certain information to an advisory committee.

Sec. 533.027. COMPENSATION; REIMBURSEMENT. Sets forth provisions regarding compensation and reimbursement of members of the advisory committee.

Sec. 533.028. OTHER LAW. Establishes that except as provided by this chapter, a committee is subject to Article 6252-33, V.T.C.S.

Sec. 533.029. FUNDING. Requires the commission to fund activities under this section with money otherwise appropriated for that purpose.

(b) Requires the commission to submit a report to certain persons on the impact of Medicaid managed care on the public health sector by December 1, 1998.

(c) Sets forth the terms by which the commission is required, in cooperation with the advisory committee for a region, to submit a report to certain persons on the implementation of Medicaid managed care in that region by a certain date.

(d) Makes application of this Act prospective, regarding Section 533.007, Government Code, as added by this Act.

(e) Provides that Section 533.004, Government Code, as added by this Act, does not affect

the expansion of medical assistance for children described in H.C.R. No. 189, 75th Legislature, Regular Session, 1997.

(f) Requires the commission, if Medicaid recipients in a health care service region began to receive health care services before the effective date of this Act, to appoint an advisory committee for that region in accordance with Chapter 533B, Government Code, as added by this Act, as soon as possible after the effective date of this Act.

(g) Effective date: upon passage.

SECTION 4. Effective date: September 1, 1997, except that SECTION 3 of this Act takes effect immediately.

SECTION 5. Emergency clause.

SUMMARY OF COMMITTEE CHANGES

SECTION 1.

Amends Section 531.021, Government Code, to delete existing text making HHSC responsible for the policy, administration, evaluation, and operation of the Medicaid managed care program; and requiring the commissioner to supervise employees of health and human services agencies in the performance of Medicaid managed care duties.

SECTION 3.

Amends Section 533.004, Government Code, to change the terms under which the commission is required to contract with certain managed care organizations in a health care service region. Amends the terms under which the commission is prohibited from contracting with a managed care organization described by Subsection (a)(1) unless the political subdivision fulfills its obligation under the agreement to provide funds for the expansion of Medicaid for children; and provides exceptions.

Amends Section 533.006, Government Code, to delete proposed text requiring the commission to require that each managed care organization seek participation in the organization's provider network from certain health care providers in the region.

Amends Section 533.007, Government Code, to change the date by which the commission is required to respond to an implementation plan.

Amends Section 533.008, Government Code, to delete proposed text requiring the commission to establish guidelines that prohibit marketing at public assistance offices.

Adds Section 533.029, Government Code, to require the commission to fund activities with money otherwise appropriated for that purpose.

Deletes former SECTION 3(b), which required the commission to direct certain agencies to submit a plan to realize cost savings for the state by simplifying eligibility criteria and streamlining eligibility determination processes for recipients of financial, medical, and other public assistance.