SUBJECT: Creating Medicaid managed care organization standards

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Berlanga, Hirschi, Coleman, Delisi, Glaze, Janek, Maxey, McDonald, Rodriguez

0 nays

0 absent

SENATE VOTE: On final passage, March 23 — 30-0

WITNESSES: (*On House companion, HB 1974*):

For — Roy Ray, AARP; Pamela Brown, Texas Legal Services Center, Houston Welfare Rights Organization; Lisa McGiffert, Consumers Union; Mary Jo Magruder, Texas Family Planning Council for Developmental Disabilities; Maria Tanez; Joyce Dawidczyk, United Cerebral Palsy; Nancy Epstein, Disability Policy Consortium; James Willmann, Texas Nurses Association; Barrett Markland, Advocacy, Inc.

Against — None

On — Karen Hale, Texas Department of Mental Health and Mental Retardation; DeAnn Friedholm, Texas Health and Human Services Commission; Lynne Hudson, Susan Steeg, Texas Department of Health; Donald Gessler, M.D., Texas HMO Association

BACKGROUND: For background on Medicaid, the state-federal health program for certain low-income persons, see analysis of SB 10 in today's *Daily Floor Report*.

DIGEST: CSSB 600 would require the Texas Department of Health (TDH) to develop standards for managed care organizations that serve Medicaid clients for health care and mental health and mental retardation services. The act would take effect September 1, 1995.

The standards would cover performance, operation, quality of care, marketing, financial and children's access. TDH would also be required to ensure that Medicaid managed health care plans provide good quality care, pediatric care and timely and appropriate specialty referrals. TDH would also be required to include measures to monitor and assess the performance of the managed care organizations on the health status of Medicaid clients.

The Texas Department of Insurance, in conjunction with TDH, would be required to establish fiscal solvency standards and complaint system guidelines for managed care organizations that serve Medicaid clients. Complaint process information would be required to be made available in an appropriate communication format to each Medicaid client upon enrollment.

SUPPORTERS SAY:

CSSB 600 would establish protections to prevent taxpayer money from being spent on low-quality or fly-by-night managed care organizations that have plagued other states that converted their Medicaid programs to managed care. The state is in a bargaining position of substantial strength — offering to managed care plans a potential source of 2.3 million enrollees and guaranteed monthly payments — and can use this position to negotiate high quality care, efficiency and effectiveness from contracting managed care organizations.

CSSB 600 would help ensure that contracted managed care plans deliver the services they promise and that taxpayer dollars are spent efficiently. Existing Insurance Code provisions do not adequately regulate and monitor managed care plans other than health maintenance organizations (HMOs). Unethical or inadequate providers and plans will be drawn into the market to compete for the high number of Medicaid enrollees and monthly payments. Since capitated (per-capita) managed care plans are paid monthly regardless of the amount of services provided, incentives exist to contract for care but not provide appropriate or needed services.

CSSB 600 would not be setting a higher standard of regulation for Medicaid managed care but would be enacting standards to meet potential foreseen and unforeseen problems that may arise in implementing managed care for a large publicly funded program.

CSSB 600 is one of the recommendations from the Senate Health and Human Services Committee interim study on Medicaid reform.

OPPONENTS SAY:

CSSB 601 would establish a higher standard of regulation and oversight in Medicaid managed care plans than over those available to most privately paid managed care enrollees and providers. This higher standard should be expanded to apply to all managed care plans, not just those contracting with the Medicaid program.

NOTES:

The committee substitute differs from the Senate-passed version in that it would require TDH to include measure to monitor and assess the performance of managed care organizations. It also expands quality-of-care requirements and requires complaint-process information to be given to Medicaid clients when they enroll in the system.

Also on today's calendar are five other bills relating to Medicaid and allied issues: SB 10, SB 601, SB 602, SB 604 and SB 605.