SUBJECT: Implementation of Medicaid managed care

COMMITTEE: Public Health — committee substitute recommended

VOTE: 6 ayes — Berlanga, Hirschi, Coleman, Davila, Glaze, Maxey

0 nays

2 absent —Delisi, Janek

WITNESSES: For — Jim Allison, County Judges and Commissioners Association of Texas; Joe A. DaSilva, Texas Hospital Association; Alfred Gilchrist, Texas Medical Association; Troy Alexander, Texas Academy of Family Physicians; Tim Graves, Texas Health Care Association

Against — None

On — Lisa McGiffert, Consumers Union; Donald Lee, Conference of Urban Counties; Eric Baumgarner, Texas Department of Health

BACKGROUND: The 72nd Legislature authorized the development of Medicaid managed care pilot projects in Travis County and in the tri-county region of Jefferson, Chambers and Galveston counties. The 74th Legislature authorized the Health and Human Services Commission to expand managed care projects, which have been implemented in Bexar, Tarrant and Lubbock counties. The commission has plans to implement managed care in Harris County by the end of 1998 and Dallas and El Paso counties by the end of 1999, and to cover the entire state by the year 2001.

"Managed care" encompasses health care financing and delivery in health benefit plans that govern both the use and cost of health care services. The best known type is the health maintenance organization, or HMO.

DIGEST: CSHB 3258 would direct the Health and Human Services Commission to follow specified goals and guidelines in awarding and monitoring Medicaid contracts to managed care organizations (MCOs), including the establishment of regional advisory committees.

The commission would have to report to the governor, the lieutenant governor and the speaker by December 1, 1998, on the impact of Medicaid managed care on the public health sector and to report within a year of implementation the implementation of managed care in each region, and as soon as possible for all regions with managed care plans in existence before September 1, 1996.

The bill would also require the commission and the departments of health and human services to submit a plan by September 1, 1997, to realize costs savings by simplifying eligibility criteria and streamlining eligibility determination processes for recipients of Medicaid, welfare and other public assistance benefits.

The bill would take effect immediately if finally approved by a two-thirds record vote of the membership in each house. Contract compliance requirements would take effect September 1, 1997, and would apply only to contracts entered into or renewed on or after that date.

Contract awards and compliance. In awarding contracts the commission would have to give extra consideration to organizations that agree to assure continuity of care for Medicaid recipients for at least three months beyond the period of their Medicaid eligibility, and to consider the need to use different managed care plans to meet the needs of different populations.

Contracts would have to contain specified accountability procedures; cost-effective capitation and provider rates; requirements for a one-stop approach to client information and referral; requirements to seek participation from disproportionate share hospitals and providers who traditionally have provided care to Medicaid and charity care patients, and special provisions for rural providers and regions. Contract MCOs would have to include for at least three years on their network providers who have provided significant levels of indigent and Medicaid care.

The commission would have to ensure that MCOs, to the extent possible, develop special disease management programs to address chronic health conditions in Medicaid recipients.

MCOs would have to submit an implementation plan to the commission 90

days before Medicaid recipients started enrolling, and the commission would begin its review of the organization 60 days before Medicaid enrollment, which would include on-site inspections and tests of claims processing and complaint systems.

Enrollment. The commission would have to ensure that Medicaid recipients choose appropriate managed care plans by providing initial and follow-up information, allowing plans to provide information directly to recipients, and by employing specified considerations when assigning patients to plans who fail to choose a plan and provider on their own. The considerations would include existing physician-patient relationships, geographic convenience, and services offered in addition to required benefits that add value to the plan's benefits.

Regional advisory committees. The commission would have to appoint a regional advisory committee not later than the 180th day before Medicaid managed care is implemented in a health care service region. The commissioner would serve as the presiding officer. The committee would have to meet at least quarterly during the first year and at least annually each following year, to review and comment on contracted MCOs and the implementation of managed care in the region.

The committee would have to consist of regional representatives of a hospital district, nonprofit hospital, for-profit hospital, MCO and a children's hospital; regional representatives from the Texas Department of Health, the Texas Department of Human Services and the Texas Department of Mental Health and Mental Retardation; three representatives of the Medicaid recipient community; a regional physician; a rural health care provider if appropriate; and other representatives considered necessary by the commission. Committee members who were not state agency representatives could receive compensation for travel expenses.

SUPPORTERS SAY:

CSHB 3258 would ensure that state and federal dollars are spent wisely, that patients and providers are satisfied with health care service delivery, that quality care is being rendered, and that charity care providers and local entities with a stake in the system have a formal role or voice in managed care. CSHB 3258 would help create a managed care system that is competitive while also preserving the state's "safety net" of charity care

providers and also would address problems uncovered during the implementation of managed care programs in recent years.

Such protections are needed because the budget for Medicaid acute health care services is about $5 billion, and by the end of fiscal 1999 almost 800,000 Medicaid recipients are expected to be enrolled in managed care plans. Without sufficient oversight and contractual provisions, some HMOs could be delivering inadequate or insufficient care but receiving, on a constant monthly basis, publicly funded premiums for each enrollee regardless of health care services delivered.

The bill also would recognize the long-term commitment and investments made by public and nonprofit providers of charity care, and their associated medical staffs and communities, by requiring contracted MCOs to include in their provider networks providers who have previously provided significant levels of charity care and Medicaid services. This step is important because these entities are the "safety net" providers for individuals who are completely uninsured, and who have traditionally relied on Medicaid funding to help finance their charity care programs. These providers also are familiar sources of care to many Medicaid recipients and have established relationships with many families on Medicaid. Although participation would be guaranteed for most public providers, they would still have to comply with the application process and the evaluation by the commission and the advisory committee to ensure the plan is ready for enrollment (known as readiness review).

Traditional charity care providers would also be protected in provisions that require the commission, when choosing "default" assignments for recipients who fail to choose a particular plan or primary care provider, to consider "value added" services of a managed care network, such as whether it would provide transportation, child care services, or continuity of care beyond a recipient's Medicaid eligibility. This provision is important because many Medicaid recipients are unfamiliar with managed care concepts and seek care from providers only when very sick. However, provider reimbursement under managed care requires patients to be enrolled under a particular plan and primary care provider regardless of medical condition, so that payments for healthy patients balance expenditures for sick patients.

CSHB 3258 would first make sure that patients have enough information to make good plan and provider choices so that the need for default assignments would be reduced. It would also funnel assignments of patients who fail to choose a plan on their own toward traditional charity care and other providers who tend to provide a variety of services in addition to acute patient care. By doing so it also would provide incentives for all managed care providers to develop plans that would meet the wide-ranging health-related needs of Medicaid recipients, which often differs from the needs of middle and upper income families.

A regional advisory committee would give local providers, consumers and other stakeholders a formal voice in the development of managed care projects in their region. CSHB 3258 would make sure that adequate representation of all public and private interests was incorporated into every regional committee.

OPPONENTS SAY:

CSHB 3258 should be modified to better address marketing and medical teaching program concerns and to improve representation on regional advisory committees. The bill also unduly favors public providers, and "value added" and other provisions should be amended to make competition fair between public and private managed care providers.

"Value added" considerations when assigning "default" enrollees should be changed to allow fair competition between commercial HMOs and traditional charity care providers who are supported by tax dollars or benefit from tax exemptions and therefore are able to provide more than just required health benefits.

Marketing guidelines for managed care entities should be more firmly established in law to specifically prevent abuses experienced in other states, such as managed care entities inducing or even intimidating Medicaid recipients into enrolling into their plans by making false or misleading statements, offering free turkeys and other inappropriate marketing pitches.

Medical teaching programs should also be included in the list of required providers on a Medicaid managed care entity's network because the state has long depended upon these programs to help foot the bill for indigent care, and Medicaid patients, who are primarily women and children, are a stable

source of patients for medical schools training primary care physicians such as pediatricians, obstetric/gynecologists and family practice physicians.

Regional advisory committee provisions should also include county representatives, and could be more loosely written so as to allow regions to bring together representatives that fit their particular communities and health care resources.

NOTES:

The original version of the bill would have amended existing law relating to commission duties under the Medicaid program to include contracting parameters design responsibilities, to require instead of ensure that the commission seek participation from traditional charity care providers, and to maximize cooperation with existing public health entities. It also would have created a special legislative oversight committee to monitor Medicaid managed care program implementation.

Rep. Coleman plans to offer a floor substitute that would even the competition between commercial HMOs and nonprofit providers; separate enrollment processes from marketing practices and establish strict marketing guidelines that focus on patient information; make regional advisory committee provisions more flexible to assure local needs for representation; and require medical teaching programs to be included in provider networks.