SUBJECT: Amending administration provisions in Medicaid managed care program

COMMITTEE: Human Services — committee substitute recommended

VOTE: 8 ayes — Frank, Hinojosa, Hull, Klick, Meza, Neave, Noble, Shaheen

0 nays

1 present not voting — Rose

WITNESSES: For — James Whittenburg, Longhorn Health Solutions; Kay Ghahremani, Texas Association of Community Health Plans; Laurie Vanhoose, Texas Association of Health Plans; Chris Yule, Travis Medical; Leah Rummel, UnitedHealthcare; (*Registered, but did not testify*: Lawrence Collins, Amerigroup (Anthem); Marisa Finley, Baylor Scott & White Health; Patricia Kolodzey, Blue Cross Blue Shield of Texas; Michael Dole, Driscoll Health Plan; Jessica Boston, Molina Healthcare Inc; Eric Knustrom, Private Providers Association of Texas; Karen Cheng, Superior Heath Plan; Gregg Knaupe, Texas Association For Home Care & Hospice; Lee Johnson, Texas Council of Community Centers; Ashley Ford, The Arc of Texas)

Against — John Culberson, American Association for Home Care; Rebecca Galinsky, Protect TX Fragile Kids; Hannah Mehta, Protect TX Fragile Kids; Adrienne Trigg, Texas Medical Equipment Providers; Susan Burek; (*Registered, but did not testify*: Josh Fultz, Protect Texas Fragile Kids)

On — Gary Siller, American Association for Home Care; Linda Litzinger, Texas Parent to Parent; (*Registered, but did not testify*: Stephanie Stephens, Health and Human Services Commission)

BACKGROUND: Government Code sec. 533.055 requires a contract between a Medicaid managed care organization (MCO) and the Health and Human Services Commission to include capitation rates that ensure the cost-effective provision of quality health care.

Sec. 533.0063(b) requires, with some exceptions, an MCO to provide a paper copy of the organization's provider network directory to a recipient upon request. Sec. 533.0063(c) requires an MCO participating in the STAR + PLUS or STAR Kids Medicaid managed care program to issue a paper copy of a provider network directory unless the recipient opts out of receiving the directory in paper format.

Human Resources Code sec. 32.025(g) requires the application form for Medicaid to include:

- for an applicant who is pregnant, a question regarding whether the pregnancy is the woman's first gestational pregnancy; and
- a question regarding the applicant's preferences for being contacted.

DIGEST:

CSHB 2658 would amend Medicaid managed care provisions on capitation rates, provider network directories in paper form, and Medicaid application forms.

Capitation rates. The bill would add a provision to the capitation rates required in a contract between a Medicaid managed care organization (MCO) and the Health and Human Services Commission (HHSC). The capitation rates would have to include acuity and risk adjustment methodologies that considered the costs of providing acute care services and long-term services and supports, including private duty nursing services, provided under the plan.

To the extent permitted by the terms of the contract, HHSC would have to seek to amend a contract with an MCO entered into before the bill's effective date to comply with the required capitation rates under the bill.

Provider network directory. If a recipient requested to receive the provider network directory in paper form, the bill would require the MCO to mail the most recent paper directory by the fifth business day after the recipient's request was received.

The bill would amend Government Code sec. 533.0063(c) by requiring, at least annually, an MCO to include in the organization's outreach efforts and educational materials a written or verbal offer allowing each recipient enrolled in the managed care plan to elect to receive the organization's provider network directory, including any directory updates, in paper form.

Medicaid application form. The Medicaid application form under Human Resources Code sec. 32.025(g) would have to include an option for an applicant who could be enrolled in a Medicaid managed care plan. The option would allow an applicant to elect to receive the plan's provider network directory in paper form, including any directory updates.

As soon as practicable after the bill's effective date, HHSC would have to adopt the revised application form under Human Resources Code sec. 32.025(g).

The bill would take effect September 1, 2021, and would apply only to a contract between HHSC and an MCO that was entered into or renewed on or after the bill's effective date.

SUPPORTERS SAY:

CSHB 2658 would reduce financial uncertainty and administrative complexity in the Medicaid managed care program. The bill would improve the way in which the capitation rate, or the rate at which Medicaid managed care providers are reimbursed, is determined by requiring the rate to include a risk adjustment in Medicaid payments in order to better support the needs of patients with increased acuity, or with more intensive care needs. This change would help avoid situations where managed care organizations (MCOs) leave Medicaid because of insolvency.

The bill also would improve efficiency in Medicaid managed care by requiring MCOs to send a paper copy of provider directories only if enrollees requested it. Currently, paper directories are automatically sent to enrollees, resulting in the information quickly becoming outdated as

providers leave or enroll in Medicaid. The bill would ensure those who wish to receive paper copies could still opt in to receive them during Medicaid enrollment.

Concerns about the bill as filed were addressed in the committee substitute by removing the provision that would have required the Health and Human Services Commission to honor a contract requirement enabling a managed care organization to make the initial and subsequent primary care provider assignments and changes in accordance with state law.

CRITICS SAY:

No concerns identified.