BILL ANALYSIS

Senate Research Center

H.B. 2896
By: Coleman (Moncrief)
Health Services
5/14/1999
Committee Report (Amended)

DIGEST

In 1993, Texas began the transition to managed care for certain recipients of Medicaid services, with pilot programs in Travis County and the tri-county area of Jefferson, Chambers, and Galveston counties. Since that time, Medicaid managed care has been implemented in four additional service areas: Bexar, Tarrant, Lubbock, and Harris counties. The Dallas County and El Paso County service areas are scheduled for implementation in the fall of 1999, which would bring total enrollment in Medicaid managed care to more than 800,000 individuals. The transition to Medicaid managed care has produced difficulties with client enrollment, access to services, and provider reimbursement. The Health and Human Services Commission and the Texas Department of Health jointly operate the Medicaid program and are charged with ensuring that the implementation of Medicaid managed care meets the state's goals of improving the health of needy Texans while realizing cost efficiencies in the system. H.B. 2896 places a moratorium on future implementation of Medicaid managed care until the commission demonstrates that certain issues are resolved. Additionally, this bill requires the commission to develop rules regarding the sharing of annual profit earned by Medicaid managed care.

PURPOSE

As proposed, H.B. 2896 sets forth procedures and guidelines for the administration and operation of the state Medicaid program.

RULEMAKING AUTHORITY

Rulemaking authority is granted to Health and Human Services Commission in SECTIONS 9 and 11 (Section 533.014, Government Code, and Section 2.07(c), Chapter 1153, Acts of the 75th Legislature, Regular Session, 1997) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 12B, Health and Safety Code, by adding Section 12.0123, as follows:

> Sec. 12.0123. EXTERNAL AUDITS OF CERTAIN MEDICAID CONTRACTORS. Defines "Medicaid contractor." Requires the Texas Department of Health (department) to contract with an independent audit to perform annual external financial and performance audits of any Medicaid contractor used by the department during the operation of a part of the state Medicaid program. Requires the department to ensure that the audit procedures are used consistently in audits under this section. Requires an audit required by this section to be completed before the end of the fiscal year immediately following the fiscal year for which the audit is performed.

SECTION 2. Amends Section 533.003, Government Code, to require the Health and Human Services Commission (commission) to consider the ability of organizations to process Medicaid claims electronically, in awarding contracts to managed care organizations (MCO).

SECTION 3. Amends Section 533.004, Government Code, by amending Subsection (a) and adding Subsection (e), to require the commission to contract with a, rather than at least one, MCO in a health care service region, in providing health care services through Medicaid managed care. Requires the commission to contract with a MCO that holds a certificate of authority as a health maintenance organization (HMO) under Section 5, Article 20A.05, V.T.C.S. and meets certain other criteria requirements, in providing health care services through Medicaid managed care to recipients in a health care service region, with the exception of the Harris service area for the STAR Medicaid managed program.

SECTION 4. Amends Section 533.005, Government Code, to require a contract between a MCO and the commission for the provision of health care services to contain a requirement that the commission inform the organization of the recipients' Medicaid certification, rather than recertification, date.

SECTION 5. Amends Section 533.006(a), Government Code, to require the commission to require that each MCO that contracts with the commission to seek participation in the organization's provider network from each specialized pediatric laboratory in the region. Makes conforming changes.

SECTION 6. Amends Section 533.007(e), Government Code, to require a compliance and readiness review required under this subsection to include the ability of the MCO to process claims electronically.

SECTION 7. Amends Section 533.0075, Government Code, to require the commission to develop and implement a process to increase the number of providers qualified to determine presumptive eligibility for pregnant women and newborn infants in managed care plans; ensure immediate access to prenatal services and newborn care for pregnant women and newborn infants enrolled in managed care plans; and temporarily assign Medicaid-eligible newborn infants to the traditional fee-for-service component of the state Medicaid program for a certain period.

SECTION 8. Amends Chapter 533A, Government Code, by adding Sections 533.012 - 533.015. as follows:

Sec. 533.012. MORATORIUM ON IMPLEMENTATION OF CERTAIN PILOT PROGRAMS; REVIEW; REPORT. (a) Prohibits the commission, notwithstanding any other law, from implementing Medicaid managed care pilot programs, Medicaid behavioral health pilot programs, or Medicaid Star +Plus pilot programs (Medicaid programs) in a region for which the commission has not received certain bids for health care services or entered into a contract with an MCO to provide health care services for the region.

(b) Requires the commission to review any outstanding administrative and financial issues with respect to the Medicaid programs implemented in health care service regions and review the impact of the Medicaid managed care delivery of certain factors.

(c) Requires the commission, in performing its duties and functions under Subsection (b), to seek input from the state Medicaid managed care advisory committee created by Subchapter C. Authorizes the commission to coordinate the review required under Subsection (b) with any other study or review the commission is required to complete.

(d) Authorizes the commission, notwithstanding Subsection(a), to implement Medicaid programs in a region described by that subsection if the commission makes certain findings with respect to outstanding administrative and financial issues and the benefit of the programs to recipients and providers.

(e) Requires the commission, no later than November 1, 2000, to submit a report to the governor and the legislature that includes certain information and recommendations.

(f) Prohibits this section, to the extent practicable, from being construed to affect the duty of the commission to plan the continued expansion of Medicaid programs in health care service regions described by Subsection (a) after July 1, 2001.

(g) Provides that this section expires July 1, 2001.

Sec. 533.013. PREMIUM PAYMENT RATE DETERMINATION; REVIEW AND COMMENT. Requires the commission, in determining premium rates paid to an MCO under a managed care plan, to consider certain factors with respect to a particular region. Prohibits the commission, in determining premium payment rates paid to an MCO licensed under Chapter 20A, V.T.C.S., from discounting premium payment rates in an amount that is more than necessary to meet federal budget neutrality requirements for projected fee-for-service costs except under certain conditions. Requires the premium payment rates paid to an MCO licensed under Chapter 20A, V.T.C.S., to be established by competitive bidding. Prohibits the rates from exceeding the maximum premium payment rates established by the commission under Subsection (b). Provides

that Subsection (b) applies only to an MCO with respect to Medicaid programs implemented after June 1, 1999.

Sec. 533.014. PROFIT SHARING. Requires the commission to adopt rules regarding the sharing of profits earned by an MCO through a managed health care plan providing health care services under a contract with the commission under this chapter. Requires any amount received by the state under this section to be deposited in the general revenue fund for the purpose of funding Medicaid outreach and education activities.

Sec. 533.015. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. Requires the commission to coordinate all external oversight activities to minimize duplication of oversight of managed care plans under the state Medicaid program and disruption of operations under those plans.

SECTION 9. Chapter 533, Government Code, by adding Subchapter C, as follows:

SUBCHAPTER C. STATEWIDE ADVISORY COMMITTEE

Sec. 533.041. APPOINTMENT AND COMPOSITION. Requires the commission to appoint a state Medicaid managed care advisory committee (committee). Sets forth the composition of the committee.

Sec. 533.042. MEETINGS. Requires the committee to meet at least quarterly and provides that the committee is subject to Chapter 551.

Sec. 553.043. POWERS AND DUTIES. Requires the committee to provide recommendations to the commission on the statewide implementation and operation of Medicaid managed care; assist the commission with issues relevant to Medicaid managed care to improve the policies established for and programs operating under Medicaid managed care; and disseminate to each regional advisory committee appointed under Subchapter B information on best practices with respect to Medicaid managed care that is obtained from regional advisory committee.

Sec. 533.044. OTHER LAW. Subjects the committee to Chapter 2110, except as provided this subchapter.

SECTION 10. Amends Section 2.07(c), Chapter 1153, Acts of the 75th Legislature, Regular Session, 1997, to require the commission to study the feasibility of authorizing providers to reenroll in the program online or through other electronic means. Requires the commission to develop and implement the electronic method of reenrollment for providers not later than September 1, 2000, upon a determination of its feasibility. Requires a provider to reenroll in the state Medicaid program not later than March 31, 2000, rather than September 1, 1999, unless certain conditions exist. Authorizes the commission, by rule, to extend a reenrollment deadline prescribed by this subsection if a significant number of providers,, as determined by the commission, have not met the reenrollment requirements by the applicable deadline.

SECTION 11. Requires the commission to implement the process for increasing the number of providers qualified to determine the presumptive eligibility of certain recipients in Medicaid managed care plans required by Section 533.0075(4), Government Code, by January 1, 2000. Requires the commission to report quarterly to certain committees of the legislature regarding the status of the expedited process described by Subsection (a) of this section. Requires the commission to submit quarterly reports until the commission determines the process is fully implemented and functioning successfully.

SECTION 12. Requires the commission to request a waiver or authorization from an appropriate federal agency if determined necessary for implementation of this Act, and authorizes the delay of implementation until the waiver or authorization is granted.

SECTION 13. Provides that this Act takes effect only if a specific appropriation for the implementation of this Act is provided in H.B. No. 1, Acts of the 76th Legislature, Regular Session, 1999. Provides that if no specific appropriation in H.B. 1 is provided, then this Act has no effect.

SECTION 14. Emergency clause.
Effective date: upon passage.