BILL ANALYSIS

Senate Research Center
78R7271 CLG-F

S.B. 1185
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DIGEST AND PURPOSE

Currently, the Health and Human Services Commission (HHSC) oversees contracts with several managed care plans as part of the Medicaid STAR contract. HHSC is charged with developing performance, operation, quality of care, marketing, financial standards and standards relating to children's access to quality health care services for all health plans participating in the Medicaid managed care (MMC) program. Because the MMC is under a contract to provide services specifically related to HHSC, there might be a potential conflict of interest. As proposed, S.B. 1185 centralizes the oversight of the MMC plans in the Texas Department of Insurance (TDI). This bill also directs TDI to monitor and assess the performance of MMC plans to ensure that plans fully reimburse out-of-network physicians and providers for offering care to a plans' Medicaid clients.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Article 1.61, Insurance Code, as follows:

Art. 1.61. New heading: MEDICAID MANAGED CARE ORGANIZATIONS. (a) Defines "managed care organization" and "managed care plan."

(b) Requires the Texas Department of Insurance (TDI), in consultation with the Health and Human Services Commission (HHSC), as necessary or appropriate, to establish performance, operation, quality of care, and financial standards, standards relating to access to good quality health care services, and complaint system guidelines that are specific to managed care organizations that serve Medicaid clients. Requires TDI, in establishing standards under this article, to:

(1) include measures to monitor and assess the performance of managed care organizations relating to the health status and outcome of care for Medicaid clients; and

(2) ensure that:

(A) to the extent possible, each Medicaid client can receive good quality health care services in the client's local community under a managed care plan provided through a managed care organization delivery network;

(B) managed care plans are provided through managed care organization delivery networks with adequate capacity to provide good quality health care services to Medicaid clients;

(C) managed care plans provide timely access and appropriate referrals for specialty care; and

(D) managed care plans fully reimburse all reasonable charges of out-of-network physicians and providers for health care services provided to the plans' Medicaid clients.

(c) Changes “guidelines” to “complaint system guidelines.”

SECTION 2. Amends Section 533.005, Government Code, as follows:

(2) Adds the phrase “for network physicians and providers” in relation to capitation and provider payment rates.

(10) Amends this subdivision to provide a requirement that the managed care organization comply and cooperate with HHSC and TDI in connection with all audits, investigations, and enforcement action.

(11) Adds this subdivision to require that the managed care organization fully reimburse all reasonable charges of an out-of-network physician or provider that provides health care services to a recipient.

SECTION 3. Repealer: Sections 12.017 (Managed Care Organizations: Medicaid Program) and 533.047 (Managed Care Organizations: Medicaid Program), Health and Safety Code.

SECTION 4. Makes application of this Act prospective.

SECTION 5. Effective date: September 1, 2003.