By: Lindsay S.B. No. 1185

A BILL TO BE ENTITLED

AN ACT

relating to standards, guidelines, and contractual provisions of Medicaid managed care plans.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Article 1.61, Insurance Code, is amended to read as follows:

Art. 1.61. MEDICAID MANAGED CARE ORGANIZATIONS [~~ORGANIZATION: FISCAL SOLVENCY AND COMPLAINT SYSTEM GUIDELINES~~].

(a) In this article, "managed care organization" and "managed care plan" have the meanings assigned by Section 533.001, Government Code. A managed care organization or managed care plan that serves Medicaid clients is subject to Chapter 843 of this code and any other state law applicable to a managed care organization or managed care plan, except to the extent of a conflict with Chapter 32, Human Resources Code, or other state or federal law applicable to the state Medicaid program or the administration of Medicaid funds in this state.

(b) In consultation [~~conjunction~~] with the [~~Texas Department of~~] Health and Human Services Commission, the department, as necessary or appropriate, shall establish performance, operation, quality of care, and financial [~~fiscal solvency~~] standards, standards relating to access to good quality health care services, and complaint system guidelines that are specific to [~~for~~] managed care organizations that serve Medicaid clients. In establishing

standards under this article, the department shall:

(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) Complaint system guidelines [~~Guidelines~~] must require that information regarding a managed care organization's complaint process be made available in an appropriate communication format to each Medicaid client when the person enrolls in the program.

SECTION 2. Section 533.005, Government Code, is amended to read as follows:

Sec. 533.005. REQUIRED CONTRACT PROVISIONS. A contract between a managed care organization and the commission for the organization to provide health care services to recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation and provider payment rates for network physicians and providers that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

(5) a requirement that the managed care organization provide information and referral about the availability of educational, social, and other community services that could benefit a recipient;

(6) procedures for recipient outreach and education;

(7) a requirement that the managed care organization make payment to a physician or provider for health care services rendered to a recipient under a managed care plan not later than the 45th day after the date a claim for payment is received with documentation reasonably necessary for the managed care organization to process the claim, or within a period, not to exceed

60 days, specified by a written agreement between the physician or provider and the managed care organization;

(8) a requirement that the commission, on the date of a recipient's enrollment in a managed care plan issued by the managed care organization, inform the organization of the recipient's Medicaid certification date;

(9) a requirement that the managed care organization comply with Section 533.006 as a condition of contract retention and renewal; [~~and~~]

(10) a requirement that the managed care organization [~~provide the information required by Section 533.012 and otherwise~~] comply and cooperate with the commission and with the Texas Department of Insurance in connection with all audits, [~~commission's office of~~] investigations, and enforcement actions; and

(11) a requirement 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. Sections 12.017 and 533.047, Health and Safety Code, are repealed.

SECTION 4. The change in law made by this Act to Section 533.005, Government Code, applies only to a contract with a managed care organization entered into or renewed on or after the effective date of this Act. A contract entered into before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect

for that purpose.

SECTION 5. This Act takes effect September 1, 2003.