By: Hinojosa of Hidalgo, et al. S.B. No. 2388

A BILL TO BE ENTITLED

AN ACT

relating to managed care contracts, including the procurement of managed care contracts, under Medicaid and the child health plan program.

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

SECTION 1. Subtitle I, Title 4, Government Code, is amended by adding Chapter 527 to read as follows:

CHAPTER 527. MANAGED CARE CLIENT CHOICE PROGRAM

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 527.0001. DEFINITIONS. In this chapter:

(1) "Client" means a recipient or an enrollee, as appropriate.

(2) Notwithstanding Section 521.0001(2), "commission" means the Health and Human Services Commission or an agency operating part of the Medicaid managed care program or the child health plan program, as appropriate.

(3) "Contracted managed care organization" means a managed care organization that contracts with the commission to provide health care services to clients under Medicaid or the child health care program, as appropriate.

(4) "Enrollee" means a child enrolled in the child health plan program.

(5) "Health care service region" or "region" means a managed care service area under Medicaid or the child health plan

program, as delineated by the commission.

(6) "Managed care contract" means a contract entered into by the commission and a managed care organization under which the organization agrees to provide comprehensive health care services to clients under a managed care program.

(7) "Managed care organization" means a person that is authorized or otherwise permitted by law to arrange for or provide a managed care plan.

(8) "Managed care plan" means a plan under which a person undertakes to provide, arrange for, pay for, or reimburse any part of the cost of any health care service. A part of the plan must consist of arranging for or providing health care services as distinguished from indemnification against the cost of those services on a prepaid basis through insurance or otherwise. The term includes a primary care case management provider network. The term does not include a plan that indemnifies a person for the cost of health care services through insurance.

(9) "Managed care program" means a managed care program under Medicaid or the child health plan program, including the:

(A) STAR Medicaid managed care program;

(B) STAR+PLUS Medicaid managed care program;

(C) STAR Kids managed care program established under Subchapter R, Chapter 540; and

(D) STAR Health program.

(10) "Recipient" means a Medicaid recipient.

Sec. 527.0002. APPLICABILITY OF CHAPTER. This chapter

applies only to a managed care contract, including the procurement of a managed care contract, under Medicaid and the child health plan program.

Sec. 527.0003. APPLICABILITY OF OTHER LAW; CONFLICT. (a) The requirements of this chapter are in addition to the applicable requirements of Chapter 540, including Subchapter F of that chapter, Chapters 540A and 2155 of this code, Chapter 62, Health and Safety Code, Chapter 32, Human Resources Code, and other law relating to managed care contracts and the procurement of those contracts under Medicaid and the child health plan program.

(b) If a requirement of this chapter conflicts with a requirement of other law relating to managed care contracts under Medicaid or the child health plan program, as applicable, the stricter requirement prevails.

Sec. 527.0004. MANAGED CARE CLIENT CHOICE PROGRAM. (a) In accordance with the requirements of this chapter, the commission shall implement a managed care client choice program under which the commission shall contract with managed care organizations to provide health care services to clients under Medicaid or the child health plan program, as applicable, in a manner that emphasizes strong client choice among multiple managed care plans in all health care service regions of this state.

(b) In implementing this chapter, the commission shall ensure that each client, including a client residing in a rural region, has a sufficient number of contracted managed care organizations providing services in the region from which to choose.

SUBCHAPTER B. CONTRACT PROCUREMENT

Sec. 527.0051. ANNUAL REQUEST FOR APPLICATIONS. The commission shall annually issue a request for applications for each health care service region to solicit multiple managed care organizations to contract with the commission to provide health care services to clients under a managed care program in the region.

Sec. 527.0052. CONTRACT ELIGIBILITY REQUIREMENTS. A managed care organization is eligible to be awarded a managed care contract only if the commission has:

(1) certified the organization is reasonably able to fill the contract terms under Section 527.0053; and

(2) made a written determination that the organization:

(A) is financially solvent based on the commission's review of and satisfactory assurances made by the organization; and

(B) meets the performance and quality standards established under Section 527.0054.

Sec. 527.0053. CERTIFICATION BY COMMISSION. (a) Before the commission may award a managed care contract to a managed care organization, the commission shall evaluate and certify that the organization is reasonably able to fulfill the contract terms, including all applicable federal and state law requirements.

(b) Notwithstanding any other law, the commission may not award a managed care contract to an organization that does not receive the certification required under this section.

(c) A managed care organization may appeal the commission's

denial of certification by the commission under this section.

(d) After a managed care organization is certified by the commission to provide health care services in a health care service region, the organization is not required to obtain a separate certification to be awarded another contract to provide health care services in the same region.

Sec. 527.0054. PERFORMANCE AND QUALITY STANDARDS. (a) The commission shall:

(1) subject to Subsection (b), adopt performance and quality standards each managed care organization must meet to be awarded a managed care contract; and

(2) evaluate each managed care organization that submits an application in response to a request for applications under Section 527.0051 to verify that the organization meets the standards adopted under Subdivision (1).

(b) Performance and quality standards adopted by the commission under this section must be designed to evaluate and assess:

(1) if applicable, a managed care organization's past performance under Medicaid and the child health plan program, based on reviews conducted under Section 527.0103, and the organization's experience in a given Medicaid or child health plan program market or health care service region;

(2) the quality-of-care provided by the organization;

(3) the organization's cost-efficiency;

(4) the results of customer satisfaction surveys completed by clients who have received health care services under a

managed care plan offered by the organization; and

(5) the results of satisfaction surveys completed by providers participating in the provider network under the organization's managed care plan.

Sec. 527.0055. REQUIRED CONTRACT AWARDS. If a managed care organization submits a complete application in response to a request for applications under Section 527.0051 and the organization meets the requirements of Section 527.0052, the commission shall award a contract to the organization to provide health care services to clients under the managed care program in the health care service region for which the application was submitted, provided the contract substantially complies with the terms contained in the written solicitation for the contract and applicable state and federal law.

Sec. 527.0056. CONTRACT AWARDS NOT LIMITED. The commission may not limit the number of managed care organizations awarded a managed care contract in a health care service region of this state.

SUBCHAPTER C. CONTRACT ADMINISTRATION

Sec. 527.0101. INITIAL CONTRACT READINESS REVIEW. (a) The commission shall review each managed care organization awarded a managed care contract to determine whether the organization is prepared to meet the organization's contractual obligations.

(b) A managed care organization may not begin providing health care services under a managed care contract and the commission may not issue a payment to the organization under the contract until the commission conducts the review required under this section and other applicable state or federal law.

Sec. 527.0102. MINIMUM CRITERIA FOR EVALUATING MANAGED CARE CONTRACT PERFORMANCE. (a) The executive commissioner by rule shall adopt criteria for measuring the performance of a contracted managed care organization. The criteria must include:

(1) the same performance measures developed by the commission under Section 540.0504(3);

(2) the same quality-of-care and cost-efficiency benchmarks developed under Section 543A.0052(b);

(3) if applicable, the results of the organization's performance under the most recent quality care and consumer satisfaction measures included in the Consumer Assessment of Healthcare Providers and Systems survey required under federal law; and

(4) not more than six additional criteria for measuring a managed care organization's performance, as determined by the commission.

(b) A managed care organization shall provide to the commission all data and information necessary for the commission to measure the organization's performance under this section.

Sec. 527.0103. CONTRACT PERFORMANCE EVALUATION: ANNUAL REVIEW. (a) Using the minimum criteria developed under Section 527.0102, the commission shall annually conduct a review to evaluate each managed care organization's performance in the health care service region in which the organization provides health care services to clients.

(b) The commission shall post on the commission's Internet website the results of each managed care organization's annual

evaluation conducted under this section in a format that is easily accessible to and understandable by the public.

Sec. 527.0104. DURATION OF CONTRACT. An initial managed care contract entered into in accordance with this chapter between the commission and a managed care organization in a health care service region may have an initial term of six years with an option to annually extend the contract based on the organization's performance under the preceding annual performance review conducted under Section 527.0103.

Sec. 527.0105. EFFECT OF NONCOMPLIANCE. If the executive commissioner determines a contracted managed care organization has failed to comply with this chapter or other applicable law or a material requirement of the organization's contract with the commission, the commission may:

(1) pursue any remedy available under the contract, including recovery of actual or liquidated damages;

(2) require the organization to submit to the commission and comply with a corrective action plan approved by the commission;

(3) suspend the organization's enrollment of clients in one or more regions where the organization provides health care services under a managed care program; or

(4) under the terms of the contract, terminate the organization's contract.

Sec. 527.0106. RULES. The executive commissioner shall adopt rules necessary to implement this chapter.

SECTION 2. The heading to Section 540.0206, Government

Code, as effective April 1, 2025, is amended to read as follows:

Sec. 540.0206. MANAGED CARE ORGANIZATIONS: CERTIFICATE OF AUTHORITY REQUIRED [~~MANDATORY CONTRACTS~~].

SECTION 3. Section 540.0206(a), Government Code, as effective April 1, 2025, is amended to read as follows:

[~~(a)~~] The [~~Subject to the certification required under Section 540.0203 and the considerations required under Section 540.0204, in providing health care services through Medicaid managed care to recipients in a health care service region, the~~] commission shall contract with [~~a~~] managed care organizations in accordance with Chapter 527. A managed care organization, other than a state administered primary care case management network, in a health care service [~~that~~] region must hold [~~that holds~~] a certificate of authority issued under Chapter 843, Insurance Code, to provide health care in that region [~~and that is:~~

[~~(1) wholly owned and operated by a hospital district in that region;~~

[~~(2) created by a nonprofit corporation that:~~

[~~(A) has a contract, agreement, or other arrangement with a hospital district in that region or with a municipality in that region that owns a hospital licensed under Chapter 241, Health and Safety Code, and has an obligation to provide health care to indigent patients; and~~

[~~(B) under the contract, agreement, or other arrangement, assumes the obligation to provide health care to indigent patients and leases, manages, or operates a hospital facility the hospital district or municipality owns; or~~

[~~(3) created by a nonprofit corporation that has a contract, agreement, or other arrangement with a hospital district in that region under which the nonprofit corporation acts as an agent of the district and assumes the district's obligation to arrange for services under the Medicaid expansion for children as authorized by Chapter 444 (S.B. 10), Acts of the 74th Legislature, Regular Session, 1995~~].

SECTION 4. Section 540.0502, Government Code, as effective April 1, 2025, is amended to read as follows:

Sec. 540.0502. AUTOMATIC ENROLLMENT IN MEDICAID MANAGED CARE PLAN. (a) The [~~If the~~] commission shall [~~determines that it is feasible and notwithstanding any other law, the commission may~~] implement an automatic enrollment process under which an applicant determined eligible for Medicaid is automatically enrolled in a Medicaid managed care plan the applicant chooses.

(b) The commission shall ensure recipients are allowed to change the managed care plan in which the recipient enrolls as frequently as is permitted under federal law. A Medicaid managed care organization may not prohibit, limit, or interfere with a recipient's selection of a managed care plan [~~may elect to implement the automatic enrollment process for certain recipient populations~~].

SECTION 5. Section 540A.0101(b), Government Code, as effective April 1, 2025, is amended to read as follows:

(b) The commission may temporarily waive the applicability of Subsection (a) to a Medicaid managed care organization as necessary based on the results of a review conducted under Sections

527.0103 [~~540.0207~~] and 540.0209 and until enrollment of recipients in a Medicaid managed care plan offered by the organization is permitted under that section.

SECTION 6. Section 540A.0151(d), Government Code, as effective April 1, 2025, is amended to read as follows:

(d) The commission may waive the applicability of Subsection (a) to a Medicaid managed care organization for not more than three months as necessary based on the results of a review conducted under Sections 527.0103 [~~540.0207~~] and 540.0209 and until enrollment of recipients in a Medicaid managed care plan offered by the organization is permitted under that section.

SECTION 7. Section 543A.0052(d), Government Code, as effective April 1, 2025, is amended to read as follows:

(d) In awarding contracts to managed care organizations under the child health plan program and Medicaid, the commission shall, in addition to considerations under Chapter 527 [~~Section 540.0204~~] of this code and Section 62.155, Health and Safety Code, give preference to an organization that offers a managed care plan that:

(1) successfully implements quality initiatives under Subsection (a) as the commission determines based on data or other evidence the organization provides; or

(2) meets quality-of-care and cost-efficiency benchmarks under Subsection (b).

SECTION 8. Section 62.055(f), Health and Safety Code, is amended to read as follows:

(f) The commission shall:

(1) procure all contracts with a third party administrator through a competitive procurement process in compliance with all applicable federal and state laws or regulations; and

(2) ensure that all contracts with child health plan providers under Section 62.155 are procured through a [~~competitive~~] procurement process in accordance with this chapter, Chapter 527, Government Code, and other [~~compliance with all~~] applicable federal and state laws or regulations.

SECTION 9. Subchapter C, Chapter 62, Health and Safety Code, is amended by adding Section 62.1041 to read as follows:

Sec. 62.1041. AUTOMATIC ENROLLMENT WITH HEALTH PLAN PROVIDER. (a) The commission shall implement an automatic enrollment process under which an applicant determined eligible for the child health plan is automatically enrolled with a child health plan provider the applicant chooses.

(b) The commission shall ensure enrollees under the child health plan are allowed to change the managed care plan in which enrolled as frequently as is permitted under federal law. A health plan provider may not prohibit, limit, or interfere with an enrollee's choice of health plan providers.

SECTION 10. Section 62.155(a), Health and Safety Code, is amended to read as follows:

(a) The commission shall contract with [~~select the~~] health plan providers under the program in accordance with Chapter 527, Government Code [~~through a competitive procurement process~~]. A health plan provider, other than a state administered primary care

case management network, must hold a certificate of authority or other appropriate license issued by the Texas Department of Insurance that authorizes the health plan provider to provide the type of child health plan offered and must satisfy, except as provided by this chapter, any applicable requirement of the Insurance Code or another insurance law of this state.

SECTION 11. The following provisions are repealed:

(1) Sections 540.0203, 540.0204, and 540.0207, Government Code, as effective April 1, 2025;

(2) Sections 540.0206(b), (c), (d), and (e), Government Code, as effective April 1, 2025;

(3) Sections 62.155(c) and (d), Health and Safety Code; and

(4) Section 32.049(a), Human Resources Code.

SECTION 12. The Health and Human Services Commission shall conduct public hearings for purposes of determining the six additional criteria required under Section 527.0102(a)(4), Government Code, as added by this Act, for measuring the performance of managed care organizations described by that section.

SECTION 13. (a) In this section:

(1) "Child health plan program" and "Medicaid" have the meanings assigned by Section 521.0001, Government Code.

(2) "Client," "health care service region," "managed care contract," "managed care organization," and "managed care program" have the meanings assigned by Section 527.0001, Government Code, as added by this Act.

(b) Subject to this section, the changes in law made by this Act apply only to a managed care contract entered into 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.

(c) The procurement of a managed care contract that was initiated before the effective date of this Act and that is pending on the effective date of this Act is terminated on that date.

(d) As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall seek to extend the effective date of termination of a managed care contract in effect on the effective date of this Act until the date a managed care organization is authorized to provide health care services to clients under the managed care program in the health care service region under a contract entered into in accordance with Subsection (e) of this section.

(e) The Health and Human Services Commission shall issue a request for applications to enter into a managed care contract with the commission procured in accordance with Chapter 527, Government Code, as added by this Act, and other applicable law as follows:

(1) subject to Subsection (f) of this section, a contract to provide health care services to clients under the STAR Medicaid managed care program, the STAR Kids Medicaid managed care program established under Subchapter R, Chapter 540, Government Code, and the child health plan program, must have an anticipated operational start date on or after September 1, 2027; or

(2) a contract to provide health care services to clients under the STAR Health program or the STAR+PLUS Medicaid managed care program must have an anticipated operational start date on or after September 1, 2030.

(f) The commission shall issue a request for applications under Subsection (e)(1) of this section as soon as practicable after the effective date of this Act, but not later than September 1, 2026.

SECTION 14. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, the agency affected by the provision shall request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 15. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2025.