By: Frank H.B. No. 5185

A BILL TO BE ENTITLED

AN ACT

relating to contracts with managed care organizations, 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. Subchapter E, Chapter 540, Government Code, is amended by adding Sections 540.02041, 540.02042, and 540.02043533.0038 to read as follows:

Sec. 540.02041. DURATION OF CONTRACTS. (a) Contracts the commission signs with managed care organizations do not have a set term length.

(b) A contract the commission signs with a managed care organization shall not be terminated except through the process described in Sec. 540.02042(h) and (i) or upon the request of the managed care organization.

Sec. 540.02042. PERFORMANCE MEASURES. (a) The programs to which this section applies include STAR, STAR Kids, STAR + Plus, and the child health plan program.

(b) The commission shall adopt and publish clear and comprehensive measures by which the quality and performance of managed care organizations will be measured.

(c) In adopting the measures under Subsection (a), the commission shall consider:

(1) cost efficiency, quality of care, experience of

care, and member and provider satisfaction;

(2) the size and quality of a managed care organization's provider network; and

(3) past experience of the managed care organization in providing similar services in this or other states.

(d) The measures shall include:

(1) outcome-based performance measures described by Section 533.0051;

(2) the most recent results from the Agency for Healthcare Research and Quality's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey; and

(3) Healthcare Effectiveness Data and Information Set (HEDIS) measurement results.

(e) The commission may adopt measures only after a public hearing and comment process that considers proposed measures.

(f) A managed care organization is responsible for providing the commission with data necessary for the commission to determine whether the applicant has met the qualifying criteria.

(g) The commission shall:

(1) monthly evaluate a managed care organization performance and quality by region; and

(2) post on its Internet website the results of the monthly evaluations conducted under this section in a format that is readily accessible to and understandable by a member of the public.

(h) If a managed care organization that has contracted with the commission under this section fails to comply with the terms

of its contract and the commission determines the managed care organization has not made substantial efforts to mitigate or remedy the noncompliance, or if its results on the measurements described in subsection (b) are in the bottom quartile of all plans operating in the state in the same program, or if their results on the measurements described in subsection (b) are the lowest in the region, the commissioner shall pursue the following remedies in addition to any remedies available to the commission under the contract, in this order:

(1) require submission of and compliance with a corrective action plan;

(2) seek recovery of actual damages or liquidated damages specified in the contract;

(3) suspend default enrollment of recipients to the managed care organization in one or more regions; and

(4) terminate the contract.

(i) If the commission has taken remedies described in (h)(1), (h)(2), and (h)(3), and the plan has not shown significant improvement over 18 months, then the commission shall take the action described by (h)(4).

Sec. 540.02043. LIMITS ON MANAGED CARE ORGANIZATIONS. (a) The commission shall limit the number of managed care organizations operating in each Medicaid program in each region.

(b) In each Medicaid program, the commission may limit the number of regions in which a managed care organization may operate.

SECTION 3. Section 62.002, Health and Safety Code, is amended by adding Subsection (5) to read as follows:

(5) "Region" means a service area delineated by the commission.

SECTION 4. Section 62.155, Health and Safety Code, is amended by amending Subsection (a) and adding Subsections (e) and (f) to read as follows:

(a) Following the termination of a health plan provider's contract in a region, the commission may select a health plan provider to operate in that region [~~The commission shall select the health plan providers~~] under the program 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.

(e) The commission shall limit the number of health plan providers operating under the program in each region of the state.

(f) The commission may limit the number of regions in which a health plan provider may operate under the program.

(g) Contracts the commission signs with health plan providers do not have a set term length.

(h) A contract the commission signs with a managed care organization shall not be terminated except through the process described in Sec. 540.02042(h) and (i) or upon the request of the health plan provider.

SECTION 5. Section 540.0204, Government Code, is amended to read as follows:

Sec. 540.0204. CONTRACT CONSIDERATIONS RELATING TO MANAGED CARE ORGANIZATIONS. Following the termination of a managed care organization's contract, [~~If~~]in awarding a contract[~~s~~] to a managed care organization[~~s~~] in that region, the commission shall:

(1) give preference to an organization that has significant participation in the organization's provider network from each health care provider in the region who has traditionally provided care to Medicaid and charity care patients;

(2) give extra consideration to an organization that agrees to assure continuity of care for at least three months beyond a recipient's Medicaid eligibility period;

(3) consider the need to use different managed care plans to meet the needs of different populations; and

(4) consider the ability of an organization to process Medicaid claims electronically.

SECTION 6. This Act takes effect September 1, 2025.