

By: Frank

H.B. No. 5183

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

1 care, and member and provider satisfaction;

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

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

6 (d) The measures shall include:

7 (1) outcome-based performance measures described by
8 Section [533.0051](#);

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

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

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

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

19 (g) The commission shall:

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

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

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

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

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

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

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

16 (4) terminate the contract.

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

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

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

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

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

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

6 (a) Following the termination of a health plan provider's
7 contract in a region, the commission may select a health plan
8 provider to operate in that region [~~The commission shall select the~~
9 ~~health plan providers~~] under the program through a competitive
10 procurement process. A health plan provider, other than a state
11 administered primary care case management network, must hold a
12 certificate of authority or other appropriate license issued by the
13 Texas Department of Insurance that authorizes the health plan
14 provider to provide the type of child health plan offered and must
15 satisfy, except as provided by this chapter, any applicable
16 requirement of the Insurance Code or another insurance law of this
17 state.

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

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

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

24 (h) A contract the commission signs with a managed care
25 organization shall not be terminated except through the process
26 described in Sec. 540.02042(h) and (i) or upon the request of the
27 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, [±]in awarding a contract[±] to a managed care organization[±] 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. (a) The Health and Human Services Commission shall enter into contracts with the managed care organizations that had contracts in effect as of January 1, 2025 for the STAR, CHIP, and STAR Kids programs. These contracts shall be subject to Sections 540.0204, 540.02041, and 540.02042 of the Government Code and Section 62.155 of the Health and Safety Code. The commission shall cancel all procurements for the STAR, CHIP, or STAR Kids programs that were pending as of January 1, 2025.

(b) As specified in the notice of intent to award, the commission shall enter into contracts with managed care

1 organizations that are awardees designated in the notice of intent
2 to award of any pending procurements. These contracts shall be
3 subject to Sections 540.0204, 540.02041, and 540.02042 of the
4 Government Code and Section 62.155 of the Health and Safety Code.

5 (c) By January 1, 2030, the Health and Human Services
6 Commission shall have entered into contracts with the managed care
7 organizations for the Star + Plus program that had contracts in
8 effect as of January 1, 2029 for the Star + Plus program. These
9 contracts shall be subject to Sections 540.0204, 540.02041, and
10 540.02042 of the Government Code and Section 62.155 of the Health
11 and Safety Code.

12 (d) A Medicaid recipient or child health plan program
13 participant enrolled in a managed care plan with a contract
14 described by Subsection (a) shall continue enrollment in the
15 managed care plan until the recipient or participant chooses to be
16 enrolled in a different managed care plan, is no longer eligible for
17 services, or is enrolled in a plan subject to contract termination
18 in the region in which the recipient or participant resides.

19 SECTION 7. This Act takes effect September 1, 2025.