HOUSE BILL 1269

43RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1997

INTRODUCED BY

JOHN A. HEATON

AN ACT

RELATING TO HEALTH CARE; ENACTING THE MEDICAID MANAGED CARE ACT; PROVIDING FOR A REASONABLE TRANSITION TO A FAIR AND EFFECTIVE MEDICAID MANAGED HEALTH CARE SYSTEM.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. SHORT TITLE.--This act may be cited as the "Medicaid Managed Care Act".

Section 2. PURPOSE OF ACT.--

A. The purpose of the Medicaid Managed Care Act is to provide for a reasonable transition to a fair and effective managed health care system for the medicaid program in New Mexico. The state should convert medicaid to a managed health care system only in a careful, studied and deliberate manner. The system should be implemented initially on a pilot basis in two selected urban sites and one selected rural site and revised

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as necessary before it is extended to other areas in the state.

B. The Medicaid Managed Care Act is designed to protect medicaid recipients, especially those at risk for needed behavioral health services; doctors, hospitals, clinics and others that provide services to the medicaid population in New Mexico, especially those in rural areas that are publicly financed and serve disproportionately large populations of poor persons; and the state, which administers and enforces the medicaid program and seeks to ensure that a fair and equitable health care delivery system is available throughout New Mexico.

Section 3. DEFINITIONS.--As used in the Medicaid Managed Care Act:

A. "enrollee" or "patient" means an individual who is entitled to receive health care benefits from a managed health care plan;

B. "essential community provider" means a person that provides a significant proportion of its health or health-related services to medically needy indigent patients, including uninsured, underserved or special needs populations;

C. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a skilled nursing center, a residential treatment center, a home health agency, a diagnostic, laboratory or imaging center and a rehabilitation or other therapeutic health

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setting;

D. "health care insurer" means a person that has a valid certificate of authority in good standing under the New Mexico Insurance Code to act as an insurer, a health maintenance organization, a nonprofit health care organization or a prepaid dental plan;

E. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health services consistent with state law;

F. "health care provider" or "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals, health care facilities and essential community providers;

G. "managed health care plan" or "plan" means a health benefit plan of a health care insurer or a provider service network that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the health care insurer. "Managed health care plan" includes a plan that provides comprehensive health care services to enrollees on a prepaid, capitated basis and includes the health care services offered by a health maintenance organization, a preferred provider organization, an individual practice organization, a competitive medical plan, an exclusive

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provider organization, an integrated delivery system, an independent physician-provider organization, a physician hospital-provider organization and a managed care services organization. "Managed health care plan" or "plan" does not include a traditional fee-for-service indemnity plan or a plan that covers only short-term travel, accident-only, limited benefit or specified disease policies;

H. "person" means an individual or other entity;

I. "primary health care clinic" means a nonprofit community-based entity established to provide the first level of basic or general health care needs, including diagnostic and treatment services, for residents of a health care underserved area as that area is defined in regulation adopted by the department of health; and

J. "provider service network" means two or more health care providers affiliated for the purpose of providing health care services to enrollees on a capitated or similar prepaid flat-rate basis.

Section 4. MEDICAID MANAGED HEALTH CARE SYSTEM--TRANSITION AND PILOT PROJECT IMPLEMENTATION.--

A. The medicaid program in New Mexico shall be converted to a managed health care system only in a careful, studied and deliberate manner. The system shall be implemented initially with managed health care plans only on a pilot project test basis in two selected urban sites and one selected rural

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site, which shall be chosen by the human services department only after appropriate public notices have been issued, hearings held and written comments received.

B. The managed health care system for medicaid shall be revised as necessary, based on the experiences of the pilot projects, before it is extended, to other areas in the state. Before the program is so extended, the human services department shall submit a written, public report to the legislature that assesses the pilot projects' effectiveness and describes the program revisions that will be made based on the experiences of the pilot projects.

Section 5. MEDICAID MANAGED HEALTH CARE PLAN OPERATIONS--ENROLLMENT RESTRICTIONS--EDUCATING MEDICAID ENROLLEES ABOUT MANAGED HEALTH CARE PLANS AND OPERATIONS.--

A. The human services department shall monitor each managed health care plan offered through the medicaid program and take all reasonable steps necessary to ensure that each plan operates fairly and efficiently, protects patient interests and fulfills the plan's primary obligation to deliver good quality health care services.

B. No managed health care plan offered through the medicaid program may directly recruit new members for enrollment into the medicaid program. All recruiting and enrollment of eligible persons into the medicaid program shall be arranged directly by the human services department. The department may

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provide for enrollment directly at hospitals or other health care or government facilities.

C. The human services department shall educate eligible medicaid recipients in clear, conspicuous and understandable ways about:

(1) the issues they should consider so they may decide rationally and fairly into which available managed health care plan they should choose to enroll; and

(2) how to operate in and use effectively a managed health care plan.

Section 6. SPECIALIZED HEALTH CARE PROGRAMS--MANAGED CARE DELAY--PILOT PROJECTS--STUDY AND REPORT.--

A. Until at least July 1, 1998, no managed health care plan offered through the medicaid program shall offer specialized behavioral or developmental disability health services except for two pilot project tests, one in an urban and one in a rural setting. The provisions of this section apply to the specialized health care services needed for a person treated for a developmental disability, a developmental delay, a seriously disabling mental illness, a serious emotional disturbance, physical or sexual abuse or neglect, substance abuse or other behavioral health problem as defined in regulations adopted by the department of health.

B. The specialized behavioral or developmental disability health services covered under the provisions of this

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section shall be provided until at least July 1, 1998 only by specialized providers in accordance with regulations adopted by the department of health. The human services department shall, after consulting with the department of health and the children, youth and families department, adopt regulations to designate essential community providers and other providers that may offer specialized behavioral or developmental disability health services during this period.

C. The human services department shall study the two pilot project tests required under the provisions of this section and assess the operations and impacts of the test projects before authorizing a managed health care plan to offer specialized behavioral or developmental disability health services in other settings. The department shall submit a written, public report analyzing the effectiveness of the pilot project tests and describing the program revisions based on those tests that will be implemented. The report shall be submitted to the legislature or an appropriate interim legislative committee before specialized behavioral or developmental disability health services are extended to any other settings.

Section 7. PUBLIC NONPROFIT HOSPITALS.--

A. A managed health care plan offered through the medicaid program shall be required to use under reasonable terms and conditions any public nonprofit hospital that elects to

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participate in the plan, if the hospital meets all reasonable quality of care and service payment requirements imposed by the plan. The terms shall be no less favorable than those offered any other provider, and they shall provide payments that are reasonable and adequate to meet costs incurred by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

B. The human services department shall assure continuity of general support from a managed health care plan offered through the medicaid program to a public nonprofit hospital that provides for medical education and that serves a disproportionately large indigent population.

C. A managed health care plan offered through the medicaid program may not limit the number or location of public nonprofit hospitals that elect to participate in the plan.

Section 8. PRIMARY HEALTH CARE CLINICS PARTICIPATION.--

A. A managed health care plan offered through the medicaid program shall be required to use under reasonable terms and conditions any primary health care clinic that elects to participate in the plan, if the primary health care clinic meets all reasonable quality of care and service payment requirements imposed by the plan. The terms shall be no less favorable than those offered by any other provider, and they shall provide payments that are reasonable and adequate to meet costs incurred

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by efficiently and economically operated facilities, taking into account the disproportionately greater severity of illness and injury experienced by the patient population served.

B. A managed health care plan offered through the medicaid program may not limit the number or location of primary health care clinics that elect to participate in the plan.

Section 9. PLAN ARRANGEMENTS WITH HEALTH CARE PROVIDERS.--A managed health care plan offered through the medicaid program may not adopt a gag rule or practice that prohibits a health care provider from discussing a more expensive or different treatment option with an enrollee, even if the plan does not approve of the option. A plan shall be required to fully inform all enrollees of any arrangements with providers that create a financial incentive for a provider to limit or deny health care services.

Section 10. ENROLLEE GRIEVANCES AND APPEALS.--A managed health care plan offered through the medicaid program shall adopt and implement a prompt and fair grievance procedure for resolving enrollee complaints and addressing enrollee questions and concerns regarding any aspect of the plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the plan's provider network. The grievance procedure shall notify enrollees of their statutory appeal rights. The provisions of the Public Assistance Appeals Act apply to appeals by enrollees under the

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Medicaid Managed Care Act.

Section 11. REGULATIONS.--The human services department may adopt regulations it deems necessary or appropriate to administer the provisions of the Medicaid Managed Care Act.

Section 12. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 1997.

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State of New Mexico
House of Representatives

FORTY-THIRD LEGISLATURE

FIRST SESSION, 1997

March 6, 1997

Mr. Speaker:

Your CONSUMER AND PUBLIC AFFAIRS COMMITTEE, to whom has been referred

HOUSE BILL 1269

has had it under consideration and reports same with recommendation that it DO PASS, amended as follows:

1. On page 3, line 20, after the period strike the remainder of the line and strike lines 21 through 25.

2. On page 4, strike lines 1 through 3 and on line 4, strike "organization.".

3. On page 4, between lines 7 and 8 insert the following new subsection:

"H. "managed health care system" means a delivery system of comprehensive coverage providing basic health care and health-

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related services that utilize principles of management, coordination and medical review to achieve financial and quality-of-care efficiencies in the medicaid program; and that may include the development of a primary care network, utilization review activities, continuous quality improvement efforts, methods of prospective reimbursement, regional purchasing contracts, use of provider service networks and incentives to encourage health promotion, prevention and financial accountability and prudence;".

4. Reletter the succeeding subsections accordingly.

5. On page 4, line 23, after the period insert:

"The managed health care system for the medicaid program shall be operated by the human services department or through managed health care plans contracting with the human services department.".

6. On page 4, line 23, strike "shall" and insert in lieu thereof "may".

7. On page 5, line 4, after "B." strike lines 4 through 6.

8. On page 5, line 7, strike "program is so extended" and insert in lieu thereof "managed health care plan pilot projects are extended to other areas of the state".

9. On page 5, between lines 11 and 12, insert the following

new subsection:

"C. The human services department may implement the managed health care system by instituting any of the principles of a managed health care system on a pilot project test basis. The managed health care system for the medicaid program shall be revised as necessary, based on the experiences of the pilot projects.".,

and thence referred to the BUSINESS AND INDUSTRY COMMITTEE.

Respectfully submitted,

_____

Gary King, Chairman

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Adopted _____ Not Adopted _____

(Chief Clerk)

(Chief Clerk)

Date _____

The roll call vote was 5 For 3 Against

Yes: 5

No: Dana, Johnson, Vaughn

Excused: Crook, Rios

Absent: None

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State of New Mexico
House of Representatives

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

March 13, 1997

Mr. Speaker:

Your APPROPRIATIONS AND FINANCE COMMITTEE, to whom has been referred

HOUSE BILL 1269, as amended

has had it under consideration and reports same with recommendation that it DO NOT PASS, but that

HOUSE APPROPRIATIONS AND FINANCE COMMITTEE
SUBSTITUTE FOR HOUSE BILL 1269

DO PASS.

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Respectfully submitted,

_____

Max Coll, Chairman

Adopted _____ Not Adopted _____

(Chief Clerk)

(Chief Clerk)

Date _____

The roll call vote was 13 For 4 Against

Yes: 13

No: Bird, Buffett, Knowles, Marquardt

Excused: None

Absent: None

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HOUSE APPROPRIATIONS AND FINANCE COMMITTEE SUBSTITUTE FOR HOUSE BILL 1269

43RD LEGISLATURE - STATE OF NEW MEXICO - FIRST SESSION, 1997

AN ACT

RELATING TO HEALTH CARE; ENACTING THE MEDICAID MANAGED CARE ACT; PROVIDING REQUIREMENTS FOR THE MEDICAID MANAGED HEALTH CARE SYSTEM AND MEDICAID MANAGED HEALTH CARE PLANS; IMPOSING A CIVIL PENALTY.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF NEW MEXICO:

Section 1. SHORT TITLE.--This act may be cited as the "Medicaid Managed Care Act".

Section 2. PURPOSE OF ACT.--

A. The purpose of the Medicaid Managed Care Act is to protect medicaid recipients, especially those populations with special needs; health care providers serving the medicaid population in New Mexico, especially those in rural and underserved areas and serving a disproportionately large population of poor persons; and the state, which administers and helps finance the medicaid program and seeks to ensure that an equitable health care delivery system is available throughout

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New Mexico.

B. The Medicaid Managed Care Act seeks to provide for a reasonable transition to a fair and effective managed health care system for the medicaid program in New Mexico.

Section 3. DEFINITIONS.--As used in the Medicaid Managed Care Act:

A. "commission" means the New Mexico health policy commission;

B. "department" means the human services department;

C. "designated legislative interim committee" means the New Mexico legislative council or an interim legislative committee that is delegated authority by the New Mexico legislative council to exercise powers granted to an interim legislative committee in the Medicaid Managed Care Act;

D. "enrollee", "patient" or "consumer" means an individual who is enrolled in medicaid and is entitled to receive health care benefits from a managed health care plan;

E. "essential community provider" means a person that provides the major portion of its health and health-related services to medically needy indigent patients, including uninsured, underserved or special needs populations;

F. "excluded metropolitan statistical area" means a federally recognized metropolitan statistical area of at least three hundred thousand persons;

G. "health care facility" means an institution providing health care services, including a hospital or other licensed inpatient center, an ambulatory surgical or treatment center, a home health agency, a diagnostic, laboratory or imaging center and a rehabilitation or other therapeutic health setting;

H. "health care insurer" means a person that has a valid certificate of authority in good standing under the New Mexico Insurance Code to act as an insurer, a health maintenance organization, a nonprofit health care plan or a prepaid dental plan;

I. "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified or otherwise authorized by the state to provide health services consistent with state law;

J. "health care provider" or "provider" means a person that is licensed or otherwise authorized by the state to furnish health care services and includes health care professionals, health care facilities and essential community providers;

K. "health care services" means a service or product furnished to an individual for the purpose of preventing, diagnosing, alleviating, curing or healing a physical or mental illness or injury and includes services incidental to furnishing the described services or products, community-based mental health services and services for developmental delay;

L. "managed health care plan" or "plan" means a medicaid

managed health care plan that is a health benefit plan of a health care insurer or a provider service network offered through the medicaid program that either requires an enrollee to use, or creates incentives, including financial incentives, for an enrollee to use health care providers managed, owned, under contract with or employed by the health care insurer. "Managed health care plan" means a medicaid managed health care plan that includes a plan that provides comprehensive health care services to enrollees on a prepaid, capitated basis and includes the health care services offered by a health maintenance organization, a preferred provider organization, an individual practice organization, a competitive medical plan, an exclusive provider organization, an integrated delivery system, an independent physician-provider organization, a physician hospital-provider organization and a managed care services organization;

M. "person" means an individual or other legal entity;

N. "primary health care clinic" means a nonprofit community-based entity established to provide the first level of basic or general health care needs, including diagnostic and treatment services, for residents of a health care underserved area as that area is defined in regulations adopted by the department of health;

O. "provider service network" means two or more health care providers affiliated for the purpose of providing health care services to enrollees on a capitated or similar prepaid, flat-rate

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basis; and

P. "secretary" means the secretary of human services.

Section 4. MEDICAID MANAGED CARE SYSTEM--TRANSITION--REGIONAL IMPLEMENTATION--LEGISLATIVE APPROVAL REQUIRED.--

A. The medicaid program in New Mexico shall be converted to a managed health care system only in a careful, studied and deliberate manner. The department shall implement the system in phases by regions, as appropriate, over a period not to exceed two years. There shall be no fewer than four regions, starting first with the greater Albuquerque area. Areas of the state that are chosen as regions for implementation of the medicaid managed health care system shall be selected based on the health care delivery system capacity to meet the needs of the enrollees, with those areas that have the greatest such capacity being chosen as regions first.

B. The department shall study each regional phase-in of the medicaid managed care system and assess the operations and impact of each phase-in on the region and the state as a whole prior to extending the system to another region. At the same time, the commission shall establish a technical workgroup to gather information, review and conduct a separate, independent assessment of each regional phase-in of the medicaid managed care system. The department shall make available to the commission and its technical workgroup all requested data, information, analysis and reviews.

C. Before each time that the medicaid managed care system is extended to another region, the department and the commission technical workgroup shall submit their reports to the designated legislative interim committee on the system's effectiveness and its impact on health care services infrastructure and access to care for indigent individuals.

D. If the department implements a medicaid managed care system pursuant to a waiver from the federal government under Section 1915(b) of the federal Social Security Act, legislative approval shall be obtained each time before the medicaid managed care system is extended to another region in the state beyond the greater Albuquerque area. Legislative approval shall also be obtained before the system is revised pursuant to any waiver that may be sought from the federal government under Section 1115 of the federal Social Security Act.

E. A contract with a managed health care plan shall not exceed a two-year term without legislative approval.

F. The legislative approvals required in this section may be obtained either by the full legislature, by a resolution adopted by both houses, or preliminarily by the designated legislative interim committee, subject to final approval by the full legislature. If the legislature does not act on the approval in the next regular session following the action taken by the designated legislative interim committee, the action taken by the committee shall be deemed to be approved by the full legislature.

Section 5. PATIENT PROTECTION--DISCLOSURES--RIGHTS TO HEALTH CARE SERVICES--GRIEVANCE PROCEDURE--UTILIZATION REVIEW PROGRAM--CONTINUOUS QUALITY PROGRAM--DEPARTMENT OF INSURANCE REGULATIONS.--

A. Each covered person enrolled in a managed health care plan offered through the medicaid program has the right to be treated fairly. A managed health care plan offered through the medicaid program shall deliver high quality and appropriate health care services to enrollees. The department shall ensure that each covered person enrolled in a managed health care plan is treated fairly and is accorded the rights necessary to protect patient interests.

B. The department shall ensure at a minimum that:

(1) a managed health care plan shall provide oral and written summaries, policies and procedures that explain, prior to or at the time of enrollment and at subsequent periodic times as appropriate, in a clear, conspicuous and readily understandable form, full and fair disclosure of the plan's benefits, terms, conditions, prior authorization requirements, enrollee financial responsibility for copayments, grievance procedures, appeal rights and the patient rights generally available to all covered persons;

(2) a managed health care plan shall provide each covered person with appropriate basic and comprehensive health care services, in accordance with the medicaid program regulations, that are reasonably accessible and available in a timely manner to each covered person;

(3) in providing the right to reasonably accessible health care services that are available in a timely manner, a managed health care plan shall ensure that:

(a) the plan offers sufficient numbers and types of credentialed and adequately staffed health care providers at reasonable hours of service to meet the health needs of the enrolled population, and takes into account cultural aspects and limited English capacity of enrollees;

(b) health care providers that are specialists may act as primary care providers for patients with chronic medical conditions, provided the specialists offer all reasonable primary care services required by a managed health care plan and are credentialed by the managed health care plan to provide primary care services;

(c) as medically indicated, reasonable access is provided to out-of-network specialty health care providers; and

(d) emergency care is immediately available without prior authorization requirements, and appropriate out-of-network emergency care is not subject to additional costs;

(4) a managed health care plan offered through the medicaid program shall adopt and implement a prompt and fair grievance procedure for resolving patient complaints and addressing patient questions and concerns regarding any aspect of the plan, including the quality of and access to health care, the choice of health care provider or treatment and the adequacy of the plan's

provider network. The grievance procedures shall notify patients of their statutory appeal rights, including the option of seeking immediate relief in court, and shall provide for a prompt and fair appeal of a plan's decision to the secretary, including special provisions to govern emergency appeals to the secretary in the case of health emergencies;

(5) a managed health care plan offered through the medicaid program shall adopt and implement a comprehensive utilization review program. The basis of a decision to approve or deny care shall be disclosed to an affected enrollee. The decision to approve or deny care to a patient shall be made in a timely manner, including decisions regarding emergency care, and the final decision shall be made by a qualified health care professional. A plan's utilization review program shall ensure that enrollees have proper access to health care services, including referrals to necessary specialists. A decision made in a plan's utilization review program shall be subject to the plan's grievance procedure and appeal to the secretary;

(6) a managed health care plan offered through the medicaid program shall adopt and implement a continuous quality improvement program that monitors the quality and appropriateness of the health care services provided by the plan; and

(7) a managed health care plan offered through the medicaid program shall at a minimum comply with the department of insurance regulations applicable to managed care.

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C. The department shall maintain and adequately staff at all times a toll-free telephone line to respond to enrollee questions and concerns and to assist enrollees in exercising their rights and protecting their interests as health care consumers and as provided for in the Medicaid Managed Care Act.

Section 6. MEDICAID MANAGED HEALTH CARE PLAN OPERATIONS.--

A. The department shall monitor each managed health care plan offered through the medicaid program and take all reasonable steps necessary to ensure that each plan operates fairly and efficiently, protects patient interests and fulfills the plan's primary obligation to deliver high quality health care services.

B. No managed health care plan offered through the medicaid program may directly solicit new members for enrollment into the medicaid program. All enrollment of eligible persons into the medicaid program shall be arranged directly by the department. The department may provide for enrollment directly at government facilities or other health care facilities.

C. The department, through its own offices and employees, joint powers agreements with other state agencies or by contracting with one or more brokering agencies independent of any managed health care plan offered through the medicaid program, shall fully inform medicaid-eligible persons of their choices for enrollment into a managed health care plan and shall conduct the enrollment process and default assignments of enrollees who do not choose a plan. The department shall ensure that the enrollment process

includes adequate time and information provided in a clear, conspicuous and understandable manner that is appropriate for the medicaid enrollee, or legal guardian in the case of a child, including those with limited English language and reading ability. At a minimum, the information shall include:

(1) the issues to be considered in making an informed decision about which available managed health care plan to choose;

(2) for each managed health care plan offered through the medicaid program, details regarding participating providers, geographic availability of services, benefits, emergency care and out-of-state or out-of-area medical services, terms, conditions, including any copayments or other restrictions, and available valid information pertaining to quality, outcomes, patient satisfaction and grievances;

(3) after the initial year of implementation, comparative information on the quality of care, including medicaid enrollee satisfaction and grievances, on each managed care health plan;

(4) how to operate in and use effectively a managed health care plan; and

(5) enrollee rights to change providers and managed health care plans and challenge and appeal plan decisions.

D. No managed health care plan offered through the medicaid program shall directly market to medicaid recipients or

directly enroll medicaid recipients into its plan.

E. No managed health care plan shall require or establish exclusive contracts with any health care provider, except for salaried employment contracts.

F. Unless the department requires, by regulation, a higher percentage, a managed health care plan offered through the medicaid program shall be required to maintain a medical loss ratio of at least eighty percent, so that at a minimum eighty percent of all capitated medicaid payments paid to a managed health care plan is expended for the direct provision of health care services. The department may establish maximum administrative expenses and profit margins that will be allowed. The department, after consultation with the department of insurance, shall adopt regulations to define the allowable medical loss ratio, administrative expenses and profit margin consistent with the provisions of this subsection.

G. To ensure freedom of choice capacity for enrollees, the department shall seek a waiver from applicable federal requirements to provide for an appropriate mixture of medicaid and commercial, paying patients in any given managed health care plan.

Section 7. SPECIALIZED HEALTH CARE PROGRAMS--PHASE-IN IMPLEMENTATION--LEGISLATIVE APPROVAL REQUIRED.--

A. Except as otherwise provided in Subsection B of this section, until July 1, 1999, no managed health care plan offered through the medicaid program shall offer specialized behavioral or

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developmental disability health care services. The provisions of this section apply to the specialized health care services needed for a person treated for a developmental disability, a developmental delay, a seriously disabling mental illness, a serious emotional disturbance, physical or sexual abuse or neglect, substance abuse or other chronic, serious behavioral health problem.

B. As a pilot project, and pursuant to a waiver from the federal government under Section 1915(b) of the federal Social Security Act, specialized behavioral or developmental disability health care services may be immediately provided by the managed health care plans that are offered through the medicaid program in the greater Albuquerque area.

C. The department shall study the pilot project authorized in Subsection B of this section and assess the operations and impact of the pilot project on the region and the state as a whole prior to extending the system to another region after July 1, 1999. At the same time, the commission shall establish a technical workgroup, which shall include among its members representatives of appropriate behavioral health and developmental disability stakeholders, to gather information, review and conduct an independent assessment of the specialized health care services pilot project of the medicaid managed care system. The department shall make available to the commission all

requested data, information, analysis and reviews.

D. Before each time that specialized behavioral or developmental disability health care services covered in this section are extended beyond the greater Albuquerque area to another region in the state, the department and the commission technical workgroup shall submit their reports to the designated legislative interim committee on the program's effectiveness and its impact on health care services infrastructure and access to care for indigent individuals; outside evaluations, including those of the federal health care financing authority; and the program revisions that will be made based on the experiences. The department's report shall include copies of any relevant reports prepared by outside evaluators, including the federal health care financing administration and the state's medicaid advisory committee, and a description of the program revisions that will be made based on the input received and experience.

E. If the department includes specialized behavioral or developmental disability health care services in its medicaid managed care system pursuant to a waiver from the federal government under Section 1915(b) of the federal Social Security Act, legislative approval shall be obtained each time before the specialized behavioral or developmental disability health care services are extended beyond the greater Albuquerque area to another region in the state. Legislative approval shall also be

obtained before the coverage of specialized behavioral or developmental disability health care services in the medicaid managed care system is revised pursuant to any waiver that may be sought under Section 1115 of the federal Social Security Act.

F. The legislative approvals required in this section may be obtained either by the full legislature, by a resolution adopted by both houses, or preliminarily by the designated legislative interim committee, subject to final approval by the full legislature. If the legislature does not act on the approval in the next regular session following the action taken by the designated legislative interim committee, the action taken by the committee shall be deemed to be approved by the full legislature.

Section 8. NATIVE AMERICAN HEALTH SERVICES.--

A. Native Americans enrolled in a managed health care plan offered through the medicaid program shall at all times retain the option of receiving health services directly from the Indian health service or health services provided by tribes under the federal Indian Self-Determination and Education Assistance Act, the federal urban Indian health program or the federal Indian children's program. The department shall ensure that the Indian health service receives the same payment it would have received for the services rendered if the patient did not participate in the managed health care plan.

B. The department shall pursue alternative mechanisms for

Native Americans in the medicaid managed care program to recognize their sovereignty, their right to self-determination and the dual responsibility of the federal and state governments.

Section 9. HOSPITALS OTHER THAN THE UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER.--

A. Any managed health care plan offered through the medicaid program shall be required to use under reasonable terms and conditions any hospital, except a hospital in an excluded metropolitan statistical area, that elects to participate in the plan, if the hospital meets all reasonable quality of care and service payment requirements imposed by the plan. The terms shall be no less favorable than those offered any other equivalent, similarly situated provider for the same services.

B. The department shall assure continuity of general support for any hospital that provides for medical education or serves a disproportionately large indigent population. Within allowable federal law and regulations, the department shall ensure an adequate and diverse patient population necessary to preserve the health professional education programs in New Mexico.

C. A managed health care plan offered through the medicaid program that offers specialized behavioral or developmental disability health services as provided in Section 7 of the Medicaid Managed Care Act shall include participation by state-operated inpatient facilities. Payment rates for services

provided by the state hospitals providing such specialized services shall be established by the department. The rates shall provide by regulation for payments that are reasonable for an efficiently operated facility providing similar services taking into account the severity of illness and shall include, as determined by the department, retrospective adjustment to account for adverse patient selection.

D. A managed health care plan offered through the medicaid program may not limit the number or location of state facilities or hospitals, except hospitals in an excluded metropolitan statistical area, that elect to participate in the plan. A managed health care plan shall not offer providers or impose on patients financial or other incentives, penalties or barriers to affect the use of any hospital participating in its plan as provided for in Subsection A or C of this section.

Section 10. UNIVERSITY OF NEW MEXICO HEALTH SCIENCES CENTER.--

A. Any managed care health plan offered through the medicaid program shall be required to use the university of New Mexico health sciences center's hospitals and specialty services, as appropriate, including inpatient and outpatient services. Payment rates for services provided by the university of New Mexico health sciences center's hospitals and specialty services shall be established by the department. Such payment rates, which shall be

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adopted by regulation, shall provide for payments that are reasonable for an efficiently operated hospital or outpatient specialty facility providing similar services taking into account the severity of illness and shall provide, as determined by the department, for retrospective adjustment to account for adverse patient selection; provided, however, that nothing in this section shall prohibit the university of New Mexico health sciences center from negotiating alternative rates and payment methodologies with a managed health care plan offered through the medicaid program.

B. The department shall assure continuity of general support for the university of New Mexico health sciences center for medical education and a disproportionately large indigent population. Within allowable federal law and regulations, the department shall ensure an adequate and diverse patient population necessary to preserve the health professional education programs in New Mexico.

C. A managed health care plan shall not offer providers or impose on patients financial or other incentives, penalties or barriers to affect the use of the university of New Mexico health sciences center's hospitals or specialty services, including inpatient and outpatient specialty services.

Section 11. PRIMARY HEALTH CARE CLINICS' PARTICIPATION.--

A. A managed health care plan offered through the medicaid program shall be required to use under reasonable terms

and conditions any primary health care clinic that elects to participate in the plan, if the primary health care clinic meets all reasonable quality of care and service payment requirements imposed by the plan. The terms shall be no less favorable than those offered to any other equivalent, similarly situated provider for the same services.

B. A managed health care plan offered through the medicaid program may not limit the number or location of primary health care clinics that elect to participate in the plan. A managed health care plan shall not offer providers or impose on patients financial or other incentives, penalties or barriers to affect the use of any primary health care clinic participating in its plan.

C. The department shall provide timely payments at least quarterly to each federal qualified health center under the federal Social Security Act, as defined in 42 U.S.C. Section 1396d(1)(2), to cover the difference between the payment that should have been received pursuant to the provisions of 42 U.S.C. Section 1396a(a)(13)(E) and the payments from the managed health care plan offered through the medicaid program that were received by the federally qualified health center. The full amount of that difference shall be paid by the department in fiscal year 1998. To the extent allowable by federal law and regulations, the department's payment for that difference shall be reduced by one-

third annually from the full level of the difference provided in fiscal year 1998 such that by July 1, 2000, no differential payment based on federally qualified health center status shall be required.

D. Nothing in Subsection C of this section shall prohibit a federally qualified health center from negotiating alternative rates and payment methodologies with a managed health care plan offered through the medicaid program.

Section 12. AUTHORIZATION FOR MEDICAID MANAGED CARE CONTRACTS DIRECTLY WITH PUBLIC AGENCIES, HOSPITALS, HEALTH CARE PROVIDERS AND PROVIDER SERVICE NETWORKS.--In administering the medicaid program or a managed health care system for the program, the department may contract directly with a government agency or public body, health care provider or provider service network belonging to and participating in the provider service network guaranty association. In doing so, the department is not required to contract with any such entity only through arrangements with a health care insurer.

Section 13. PLAN ARRANGEMENTS WITH HEALTH CARE PROVIDERS--FAIR DISCLOSURE TO ENROLLEES--PROTECTIONS FOR PROVIDERS.--

A. A managed health care plan offered through the medicaid program may not contract with a health care provider to limit the provider's disclosure to an enrollee, or any person acting on behalf of the enrollee, of any information that relates to the enrollee's medical condition or treatment options.

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B. A health care provider shall not be penalized, or have a contract with a managed health care plan terminated, because the provider offers a referral to, or discusses medically necessary or appropriate care with, an enrollee or any person acting on behalf of the enrollee. A health care provider may not be prohibited by a plan from discussing all treatment options with an enrollee.

C. A health care provider shall not be adversely affected by a managed health care plan for discussing with an enrollee financial incentives or financial arrangements between the provider and the plan.

D. A managed health care plan offered through the medicaid program shall not include in any of its contracts with health care providers any provisions that offer an inducement, financial or otherwise, to provide less than medically necessary health care services. A managed health care plan shall inform its enrollees in writing of the financial arrangements between the plan and participating providers if those arrangements include an incentive or bonus for restricting the amount of health care services provided to the enrollee.

Section 14. GENERAL POLICY DEVELOPMENT OF THE MEDICAID MANAGED CARE SYSTEM.--

A. The department, in conjunction with the commission, shall continue to study and propose how to refine the medicaid managed care program to improve the value derived from public

resources and to further the health policy of New Mexico as provided in Section 9-7-11.1 NMSA 1978. This shall include consideration of:

(1) the benefit structure as provided for in Senate Joint Memorial 50 of the second session of the forty-second legislature in 1996;

(2) cost containment and purchasing methods;

(3) the desirability of a directly state-operated managed care system for medicaid in certain regions of the state; and

(4) a waiver from the federal government pursuant to Section 1115 of the federal Social Security Act.

B. The department and the commission shall report annually to the designated legislative interim committee on the progress and recommendations relevant to the considerations specified in this section.

Section 15. MONITORING AND REPORTING.--

A. The department shall ensure that any managed health care plan offered through the medicaid program provides quality health care consistent with nationally recognized and New Mexico specific standards.

B. The department shall establish appropriate standards to be met by any managed health care plan participating in the medicaid program to ensure and monitor the quality of care

provided. By the use of nationally recognized standards and electronic reporting, all reasonable efforts shall be made to contain the administrative costs of both the participating managed health care plans and the department for its oversight responsibilities. The department shall ensure that:

(1) plans report on the basis of the latest adopted national health plan employer data and information set measures, or other nationally recognized equivalent measures, and the mental health statistics improvement project in the case of behavioral health services, for the enrolled medicaid population in the managed health care plan;

(2) at least annually a standardized patient satisfaction survey is publicly reported;

(3) at least annually an assessment of enrollees' access to services, including waiting time to receive services and geographic availability consistent with contract terms, is publicly reported;

(4) a quality improvement plan is adopted by the board of each managed health care plan and that there is evidence of an effective quality improvement program, including the participation by and monitoring of contract providers;

(5) there is credentialing of all providers and evidence of malpractice coverage, including contract providers, participating in the managed health care plan; and

(6) there is broad participation of the provider network in quality improvement and utilization management processes.

C. Except as provided elsewhere in the Medicaid Managed Care Act, the department shall prepare and submit to the designated legislative interim committee by October 1 of each year a public report that shall include for each managed health care plan offered through the medicaid program a summary of the following:

(1) the quality of care provided, including enrollee satisfaction, grievances, disenrollments and changes in plan enrollment;

(2) the numbers and demographics of medicaid enrollees;

(3) the medical loss ratio and a breakdown of the expenditures by specific service type, including the percent of capitated payments for administrative expenses, and the profits earned;

(4) changes in the provider service network and the turnover of primary care and specialty providers;

(5) additional benefits offered;

(6) utilization management activities, including the number of out-of-network approvals, denials for services and appeals;

(7) any additional information determined by the

department to be relevant to quality, outcomes, financing and utilization required to be reported by each managed health care plan to the department; and

(8) compliance with the provisions of the Medicaid Managed Care Act.

D. Except as provided elsewhere in the Medicaid Managed Care Act, the department shall prepare and submit to the designated legislative interim committee by October 1 of each year a public report that shall address:

(1) the efficiency and effectiveness of the medicaid managed care program in general, including overall compliance with the Medicaid Managed Care Act;

(2) trends in expenditures in the medicaid program;

(3) impact of the medicaid managed care program on health services infrastructure, health services availability throughout the state and health professionals' supply and distribution;

(4) impact of the medicaid managed care program on health services access for indigent persons;

(5) program revisions to be made based on the review of the program and input of the state medicaid advisory committee, providers and public; and

(6) legislative recommendations for the medicaid managed care program to further the health policy of New Mexico.

E. The department shall provide for a yearly independent analysis of medicaid managed care that includes an assessment of the quality and outcomes of care received by medicaid enrollees in each managed care plan and a comparison with commercial enrollees.

F. The department shall implement an information system to provide for the collection of patient-level encounter data to monitor the analysis provided in Subsections C, D and E of this section; provide for actuarially sound cost projections; assist in the development of standards of care and appropriate service provisions for enrollees; and provide sufficient information for the department to effectively and efficiently manage, operate and administer the medicaid program. In cooperation with the commission and the health information alliance established under the Health Information System Act, the department shall pursue an integrated statewide health data network with streamlined administrative transactions, provider reporting and access to information and consumer education. The department shall require that every managed care plan offered through the medicaid program develop information system capacity to meet these requirements and the minimum requirements established pursuant to the Health Information System Act.

Section 16. ENFORCEMENT.--

A. The department or a person who suffers a loss as a result of a violation of a provision in the Medicaid Managed Care

Act may bring an action to recover actual damages or the sum of one hundred dollars ($100), whichever is greater. When the trier of fact finds that the party charged with the violation acted willfully, the court may award up to three times actual damages or three hundred dollars ($300), whichever is greater, to the party complaining of the violation.

B. A person likely to be damaged by a denial of a right protected in the Medicaid Managed Care Act may be granted an injunction under the principles of equity and on terms that the court considers reasonable. Proof of monetary damages or intent to violate a right is not required.

C. To protect and enforce an enrollee's or a health care provider's rights in a managed health care plan offered through the medicaid program, an enrollee and a health care provider participating in or eligible to participate in a medicaid managed health care plan shall each be treated as a third-party beneficiary of the managed health care plan contract between the health care insurer and the party with which the insurer directly contracts. An enrollee or a health care provider may sue to enforce the rights provided in the contract that governs the managed health care plan.

D. The relief provided in this section is in addition to other remedies available against the same conduct under the common law or other statutes of this state.

E. In any class action filed under this section, the

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court may award damages to the named plaintiffs as provided in this section and may award members of the class the actual damages suffered by each member of the class as a result of the unlawful practice.

F. A person shall not be required to complete available grievance procedures or exhaust administrative remedies prior to seeking relief in court regarding a complaint that may be filed under this section.

Section 17. PENALTY.--In addition to any other penalties provided by law, the secretary may impose a civil administrative penalty of up to twenty-five thousand dollars ($25,000) for each violation of the Medicaid Managed Care Act. An administrative penalty shall be imposed by written order of the secretary after holding a hearing as provided for in the Public Assistance Appeals Act.

Section 18. REGULATIONS.--The department may adopt regulations it deems necessary or appropriate to administer the provisions of the Medicaid Managed Care Act.

Section 19. APPLICABILITY.--The provisions of the Medicaid Managed Care Act apply to all contracts for medicaid managed care entered into by the department after July 1, 1997, but do not apply to or invalidate terms in contracts that were entered into prior to July 1, 1997, provided those contracts are completed by July 1, 1999.

Section 20. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 1997.

FORTY-THIRD LEGISLATURE HB 1269/a
FIRST SESSION, 1997

March 18, 1997

Mr. President:

Your FINANCE COMMITTEE, to whom has been referred

HOUSE APPROPRIATION AND FINANCE COMMITTEE SUBSTITUTE
FOR HOUSE BILL 1269, as amended

has had it under consideration and reports same with recommendation that it DO PASS, amended as follows:

1. On page 13, line 10, strike "or developmental disability".

2. On page 14, lines 1 and 2, strike "or developmental disability".

3. On page 14, lines 16 and 17, strike "or developmental disability".

4. On page 14, line 21, strike "or developmental disability".

Respectfully submitted,

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Ben D. Altamirano, Chairman

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[bracketed material] = delete

FORTY-THIRD LEGISLATURE
FIRST SESSION, 1997

Adopted_____ Not Adopted_____

(Chief Clerk) (Chief Clerk)

Date _____

The roll call vote was 9 For 0 Against

Yes: 9

No: None

Excused: McKibben, Smith

Absent: None

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