AN ACT

RELATING TO HEALTH; ENACTING THE MEDICAID MANAGED CARE ACCOUNTABILITY ACT; ESTABLISHING DUTIES AND RESPONSIBILITIES.

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 Accountability Act".

Section 2. DEFINITIONS.--As used in the Medicaid Managed Care Accountability Act:

A. "committee" means the legislative finance committee;

B. "department" means the department of health, or the human services department, or both, as the context requires; and

C. "medicaid managed care" means a program of health services provided to eligible clients by a managed care organization under a contract with a department.

Section 3. REVIEW AND ACCOUNTABILITY--RECOMMENDATIONS.--

A. The committee shall annually review the operations, management and impact of the medicaid managed care program and report its findings and recommendations to the legislature.

B. The departments shall advise the committee on the nature and progress of requests for proposals for

provision of medicaid managed care services. Prior to publishing requests for proposals, the department shall advise the committee on possible contract terms, including:

(1) scope of work;

(2) performance standards; and

(3) terms, conditions and deadlines of the request for proposal process.

C. By January 1 of the year preceding the fiscal year in which a contract for provision of medicaid managed care services is expected to be signed, the general content of responses to the requests for proposals, including cost information, shall be made available to the committee prior to the signing of a contract for the provision of medicaid managed care services. Responses to the requests for proposals and information related to the responses shall be presented to the committee by the department in such a form and manner that the contents of any proposal or negotiation is not disclosed or available to the public or to other persons responding to the request for proposals.

D. Nothing in this section shall be interpreted as giving the committee any authority concerning the determination of the content of the request for proposals or the selection of successful bidders.

Section 4. DATA REQUIRED--COMMITTEE COPIES.--By October 1 each year, all information required to be provided

to the department under medicaid managed care contracts shall also be provided to the committee, except that the form of the material presented to the committee shall prevent identification of individual medicaid clients. For each managed care organization under contract to a department, the department shall include in its report to the committee:

A. an overview of the delivery, operational and financial aspects of the managed care plan, including subcontractors participating and risk-sharing for major categories of services;

B. the quality of care provided, based on nationally accepted standards, client satisfaction survey results, grievances and their determinations, disenrollment and changes in plan enrollment;

C. the numbers and demographics of medicaid clients;

D. the medical loss ratio; the breakdown of expenditures by specific type of services; the percent of capitated payment for administrative expense;

E. changes in the provider service network and the turnover of primary care and specialty providers;

F. additional benefits offered, if any;

G. utilization management activities, including the number of out-of-network approvals, denials for services, appeals and appeal resolutions;

H. utilization rates by types of service, including the number of units of service provided, the number of eligible patients receiving each type of service and drug utilization profiles;

I. performance in terms of contractual obligations and specifications and compliance with the Patient Protection Act;

J. an annual independent assessment of the program that includes:

(1) quality assessment; and

(2) outcomes and client-care satisfaction compared with the managed care organization's non-medicaid clients; and

K. additional information requested by the departments related to quality, outcomes, financing, cost and utilization of the program.

Section 5. CONTRACT RENEWAL REQUIREMENTS.--Prior to any medicaid managed care contract renewal or extension, the department shall, during the last year of the contract's basic term, conduct assessments and make recommendations to the committee on:

A. the efficiency, effectiveness and impact of the medicaid managed care program, including comparisons with the fee for service medicaid program;

B. trends in enrollment, utilization and

expenditures under the contract, compared with similar commercial and national programs and with the fee for service medicaid program;

C. the impact of the program on the health services infrastructure, health services availability statewide and the supply and distribution of health professionals;

D. the impact of the program on access to health services for indigent persons;

E. program revisions, as based on departmental assessment as well as on recommendations of the medicaid advisory committee, providers and the public; and

F. contributions the operation of the program makes to further the:

(1) overall state health policy;

(2) goals of the medicaid program; and

(3) legislative recommendations on the medicaid program.

Section 6. INFORMATION ACCESS.--Except for the information required by Subsection C of Section 3 of the Medicaid Managed Care Accountability Act, all information required to be provided by managed care organizations and the departments shall be available to the public upon request.

Section 7. EFFECTIVE DATE.--The effective date of the provisions of this act is July 1, 1999.