BILL ANALYSIS

C.S.H.B. 2731
By: Raymond
Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties assert that certain changes to provisions relating to the state's administration of contracts under the Medicaid managed care program are necessary to encourage efficient and economical processes related to Medicaid preauthorization requests, compliance with contractual requirements, and adjudication of claims. C.S.H.B. 2731 seeks to enact these changes.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 2731 amends the Government Code to remove the requirement that the Health and Human Services Commission (HHSC), in improving the administration of contracts with managed care organizations, decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks by reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process and instead requires HHSC to decrease those burdens by developing uniform efficiency standards and requirements for managed care organizations for the submission and tracking of preauthorization requests for services provided under the Medicaid program; by requiring the use of standardized application processes and forms for prompt credentialing of providers in a managed care organization's network; and by promoting prompt and accurate adjudication of claims through provider education on the proper submission of clean claims and on appeals, through acceptance of uniform forms through an electronic portal, and through the establishment of standards for claims payments in accordance with a provider's contract. The bill removes the specification that the portal required to be developed by HHSC through which providers in any managed care organization’s provider network may submit claims is a single portal and includes among the portal's purposes a provider's submission of electronic claims, prior authorization requests, claims appeals, and reconsiderations, clinical data, and other documentation that the managed care organization requests for prior authorization and claims processing and a provider's obtaining of electronic remittance advice, explanation of benefits statements, and other standardized reports.

C.S.H.B. 2731 bill requires HHSC, in improving the administration of contracts with managed care organizations, to monitor and evaluate a managed care organization's compliance with contractual requirements regarding the reduction of administrative burdens for network providers and complaints regarding claims adjudication or payment, to measure the rates of retention by managed care organizations of significant traditional providers, and to develop adequate and clearly defined provider network standards that are specific to provider type and that ensure choice among multiple providers to the greatest extent possible.

EFFECTIVE DATE

September 1, 2013.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2731 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and highlighted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Section 533.0071, Government Code, is amended to read as follows: Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve the administration of these contracts, the commission shall: (1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program; (2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program or is covered by another liable third party insurer; (3) maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and other payments made to managed care organizations with respect to enrollees who leave the managed care program; (4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by: (A) where possible, decreasing the duplication of administrative reporting requirements for the managed care organizations, such as requirements for the submission of encounter data, quality reports, historically underutilized business	SECTION 1. Section 533.0071, Government Code, is amended to read as follows: Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve the administration of these contracts, the commission shall: (1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program; (2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program or is covered by another liable third party insurer; (3) maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and other payments made to managed care organizations with respect to enrollees who leave the managed care program; (4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by: (A) where possible, decreasing the duplication of administrative reporting requirements for the managed care organizations, such as requirements for the submission of encounter data, quality reports, historically underutilized business

reports, and claims payment summary reports;

(B) allowing managed care organizations to provide updated address information directly to the commission for correction in the state system;

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to the [~~preauthorization process,~~] lengths of hospital stays, filing deadlines, levels of care, and case management services;

(D) developing efficiency standards and requirements for managed care organizations for submitting and tracking preauthorization requests for services provided under the Medicaid program [~~reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications~~]; [~~and~~]

(E) providing a single portal through which providers in any managed care organization's provider network may submit claims; [~~and~~]

(F) requiring the use of standardized application processes and forms for credentialing providers in a managed care organization's network; and

(G) promoting prompt adjudication of claims through

provider education on the proper submission of clean claims and on appeals;

(5) reserve the right to amend the managed

reports, and claims payment summary reports;

(B) allowing managed care organizations to provide updated address information directly to the commission for correction in the state system;

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to the [~~preauthorization process,~~] lengths of hospital stays, filing deadlines, levels of care, and case management services;

(D) developing uniform efficiency standards and requirements for managed care organizations for the submission and tracking of preauthorization requests for services provided under the Medicaid program [~~reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications~~]; [~~and~~]

(E) providing a [~~single~~] portal through which providers in any managed care organization's provider network may:

(i) submit electronic claims, prior authorization requests, claims appeals, and reconsiderations, clinical data, and other documentation that the managed care organization requests for prior authorization and claims processing; and

(ii) obtain electronic remittance advice, explanation of benefits statements, and other standardized reports; [~~and~~]

(F) requiring the use of standardized application processes and forms for prompt credentialing of providers in a managed care organization's network; and

(G) promoting prompt and accurate adjudication of claims through:

(i) provider education on the proper submission of clean claims and on appeals;

(ii) acceptance of uniform forms, including the Centers for Medicare and Medicaid Services Forms 1500 and UB-92, through an electronic portal; and

(iii) the establishment of standards for claims payments in accordance with a provider's contract;

(5) reserve the right to amend the managed

care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process established by the commission for final determination of these disputes; and (6) monitor and evaluate a managed care organization's compliance with contractual requirements regarding: (A) the reduction of administrative burdens for network providers; and (B) complaints regarding claims adjudication or payment.	care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process established by the commission for final determination of these disputes; (6) monitor and evaluate a managed care organization's compliance with contractual requirements regarding: (A) the reduction of administrative burdens for network providers; and (B) complaints regarding claims adjudication or payment; (7) measure the rates of retention by managed care organizations of significant traditional providers; and (8) develop adequate and clearly defined provider network standards that are specific to provider type and that ensure choice among multiple providers to the greatest extent possible.
SECTION 2. 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 2. Same as introduced version.
SECTION 3. This Act takes effect September 1, 2013.	SECTION 3. Same as introduced version.