BILL ANALYSIS

Senate Research Center

S.B. 1150
By: Hinojosa; Schwertner
Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Medicaid managed care system in Texas has brought some cost certainty to the state. However, as Medicaid managed care has transformed from a regional program into a statewide model the need from some modernization has become clear. This legislation makes reforms to the program that will allow for increased efficiency and enhanced provider engagement and protection.

S.B. 1150 adds protections to Medicaid health care providers. These protections include prompt payment and reimbursement, prompt credentialing, and "red tape" elimination.

S.B. 1150 amends current law relating to a provider protection plan that ensures efficiency and reduces administrative burdens on providers participating in a Medicaid managed care model or arrangement.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.0055, as follows:

> Sec. 533.0055. PROVIDER PROTECTION PLAN. (a) Requires the Health and Human Services Commission (HHSC) or an agency operating part of the state Medicaid managed care program, as appropriate, to develop and implement a provider protection plan that is designed to reduce administrative burdens placed on providers participating in a Medicaid managed care model or arrangement implemented under this chapter and to ensure efficiency in provider enrollment and reimbursement. Requires HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, to incorporate the measures identified in the plan, to the greatest extent possible, into each contract between a managed care organization and HHSC for the provision of health care services to recipients.
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> (b) Requires that the provider protection plan required under this section provide for:
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> (1) prompt payment and proper reimbursement of providers by managed care organizations;
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> (2) prompt and accurate adjudication of claims through:
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> (A) provider education on the proper submission of clean claims and on appeals;

(B) acceptance of uniform forms, including HCFA Forms 1500 and UB-92 and subsequent versions of those forms, through an electronic portal; and

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

(3) adequate and clearly defined provider network standards that are specific to provider type, including physicians, general acute care facilities, and other provider types defined in HHSC's, or an agency's that is operating part of the state Medicaid managed care program, as appropriate, network adequacy standards in effect on January 1, 2013, and that ensure choice among multiple providers to the greatest extent possible;

(4) a prompt credentialing process for providers;

(5) uniform efficiency standards and requirements for managed care organizations for the submission and tracking of preauthorization requests for services provided under the Medicaid program;

(6) establishment of an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network are authorized to:

(A) 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

(B) obtain electronic remittance advice, explanation of benefits statements, and other standardized reports;

(7) the measurement of the rates of retention by managed care organizations of significant traditional providers;

(8) the creation of a work group to review and make recommendations to HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, concerning any requirement under this subsection for which immediate implementation is not feasible at the time the plan is otherwise implemented, including the required process for submission and acceptance of attachments for claims processing and prior authorization requests through an electronic processing under Subdivision (6) and, for any requirement that is not implemented immediately, recommendations regarding the expected fiscal impact of implementing the requirement and timeline for implementation of the requirement; and

(9) any other provision that HHSC or an agency operating part of the state Medicaid managed care program, as appropriate, determines will ensure efficiency or reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement.

SECTION 2. Requires HHSC, as soon as possible, but not later than September 1, 2014, to implement the provider protection plan required under Section 533.0055, Government Code, as added by this Act.

SECTION 3. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 4. Effective date: September 1, 2013.