BILL ANALYSIS

S.B. 760
By: Schwertner
Human Services
Committee Report (Unamended)

BACKGROUND AND PURPOSE

The vast majority of individuals enrolled in the Texas Medicaid program are served through contracts with managed care organizations, which total approximately $15 billion annually. Many agree that providing access to care through adequate provider networks is one of the most important functions of these state contractors. S.B. 760 seeks to provide the Health and Human Services Commission the tools necessary to adequately monitor these contracts and ensure that managed care organizations are being held accountable for having adequate provider networks to deliver the care for which the state is paying.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

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

S.B. 760 amends the Government Code, including provisions amended by S.B. 219, Acts of the 84th Legislature, Regular Session, 2015, to require the Health and Human Services Commission (HHSC) to establish minimum provider access standards for the provider network of a managed care organization that contracts with HHSC to provide health care services to Medicaid managed care recipients. The bill requires the access standards to ensure that a managed care organization provides recipients sufficient access to preventive care, primary care, specialty care, after-hours urgent care, chronic care, long-term services and supports, nursing services, therapy services, and any other services identified by HHSC. The bill requires the provider access standards, to the extent feasible, to distinguish between access to providers in urban and rural settings and to consider the number and geographic distribution of Medicaid-enrolled providers in a particular service delivery area. The bill requires HHSC to biennially submit to the legislature and to make available to the public a report containing information and statistics about recipient access to providers through the provider networks of the managed care organizations and managed care organization compliance with contractual obligations related to provider access standards and sets out the required content of the report. The bill requires HHSC to submit the first report not later than December 1, 2016.

S.B. 760 authorizes HHSC, if a managed care organization that has contracted with HHSC to provide health care services to Medicaid managed care recipients fails to comply with one or more provider access standards and HHSC determines the organization has not made substantial efforts to mitigate or remedy the noncompliance, to elect to not retain or renew HHSC's contract with the organization or to require the organization to pay liquidated damages. The bill requires

HHSC, in such a case, to suspend default enrollment to the organization in a given service delivery area for at least one calendar quarter if the organization's noncompliance occurs in the service delivery area for two consecutive calendar quarters.

S.B. 760 requires HHSC to ensure that a managed care organization that contracts with HHSC posts on the organization's website the organization's provider network directory, to be updated at least monthly, and a direct telephone number and e-mail address through which a recipient enrolled in the organization's managed care plan or the recipient's provider may contact the organization to receive assistance with identifying in-network providers and services available to the recipient and scheduling an appointment for the recipient with an available in-network provider or to access available in-network services. The bill requires a managed care organization to send a paper form of the organization's provider network directory for the program only to a recipient who requests to receive the directory in paper form. The bill requires a managed care organization participating in the STAR + PLUS Medicaid managed care program or STAR Kids Medicaid managed care program, for a recipient in that program, to issue a provider network directory for the program in paper form unless the recipient opts out of receiving the directory in paper form.

S.B. 760 requires a managed care organization that contracts with HHSC to establish and implement an expedited credentialing process that would allow applicant providers to provide services to Medicaid recipients on a provisional basis and requires HHSC to identify the types of providers for which the expedited credentialing process must be established and implemented. The bill requires an applicant provider, in order to qualify for expedited credentialing, to be a member of an established health care provider group that has a current contract in force with a managed care organization that contracts with HHSC, to be a Medicaid-enrolled provider, to agree to comply with the terms of the contract, and to submit all documentation and other information required by the managed care organization as necessary to enable the organization to begin the credentialing process required by the organization to include a provider in the organization's provider network.

S.B. 760 requires a managed care organization, on submission by the applicant provider of the information required by the organization and for Medicaid reimbursement purposes only, to treat the provider as if the provider were in the organization's provider network when the provider provides services to Medicaid managed care recipients. The bill authorizes a managed care organization, if, on completion of the credentialing process, the organization determines that the applicant provider does not meet the organization's credentialing requirements, to recover from the provider the difference between payments for in-network benefits and out-of-network benefits. The bill authorizes a managed care organization, if the organization determines on completion of the credentialing process that the applicant provider does not meet the organization's credentialing requirements and that the provider made fraudulent claims in the provider's application for credentialing, to recover from the provider the entire amount of any payment paid to the provider.

S.B. 760 requires a contract between a managed care organization and HHSC for the organization to provide health care services to Medicaid managed care recipients to contain a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes. The bill includes among the required contents of such a contract a requirement that the organization, as a condition of contract retention and renewal, continue to comply with the provider access standards established by the bill's provisions and make substantial efforts, as determined by HHSC, to mitigate or remedy any noncompliance with the provider access standards and a requirement that the organization pay liquidated damages for each failure, as determined by HHSC, to comply with the provider access standards in amounts that are reasonably related to the noncompliance. The bill revises the information required to be included in an organization's report to HHSC regarding the sufficiency of the organization's provider network by requiring the data relating to the average length of time between the date a provider makes a referral, the date the organization approves or denies the

referral, and the date a recipient begins receiving the applicable care or service to instead reflect the date prior authorization is requested by a provider, the date the organization approves or denies the request, and the date the recipient begins receiving the applicable care or service.

S.B. 760 requires HHSC to establish and implement a process for the direct monitoring of a managed care organization's provider network and providers in the network. The bill requires the process to be used to ensure compliance with contractual obligations related to the number of providers accepting new patients under the Medicaid managed care program and the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider. The bill authorizes the process to use reasonable methods to ensure compliance with contractual obligations and to be implemented directly by HHSC or through a contractor.

S.B. 760 requires HHSC to seek to amend contracts entered into with managed care organizations before the bill's effective date to require that those managed care organizations comply with the bill's applicable provisions and establishes that, to the extent of a conflict between those applicable provisions and a provision of a contract with a managed care organization entered into before the bill's effective date, the contract provision prevails.

EFFECTIVE DATE

September 1, 2015.