BILL ANALYSIS

Senate Research Center
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S.B. 760
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Eighty-two percent of individuals enrolled in the Texas Medicaid program are served through contracts with managed care organizations totaling around 12 billion dollars annually. Providing access to care through adequate provider networks is one of the most important functions of these state contractors.

S.B. 760 provides the Health and Human Services Commission (HHSC) the tools necessary to adequately monitor these contracts and ensure that managed care organizations are being held accountable for delivering the care that the state is paying for.

S.B. 760 provisions:

- Establish a $10,000 penalty for failure to comply with provider access requirements;

- Require HHSC to establish minimum provider access standards that differentiate between urban and rural areas;

- Require HHSC to biennially report information about Medicaid managed care organizations' provider networks;

- Establish a premium payment withhold equal to half of one percent to be earned back annually based on quarterly assessments of compliance with provider access standards;

- Require Medicaid managed care organizations to make their provider directories available online and update them on at least a monthly basis;

- Extend expedited credentialing capabilities to any Medicaid provider who is already enrolled in the Medicaid program, has joined a group practice, and is undergoing full credentialing; and

- Require HHSC to conduct direct monitoring of Medicaid managed care networks.

As proposed, S.B. 760 amends current law relating to provider access requirements for a Medicaid managed care organization.

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 Section 533.005(a), Government Code, as follows:

(a) Requires that a contract between a managed care organization and the Health and Human Services Commission (HHSC) for the organization to provide health care services to recipients contain:

(1)-(19) Makes no change to these subdivisions;

(20) Provides a requirement that the managed care organization:

(A) develop and submit to HHSC before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with HHSC's provider access standards established under Section 533.0061;

(B) continue to comply with HHSC's provider access standards established under Section 533.0061 as a condition of contract retention and renewal;

(C) pay liquidated damages in the amount of $10,000 for each failure, as determined by HHSC, to comply with an access standard established under Section 533.0061; and

(D) regularly, as determined by HHSC, submit to HHSC and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a), rather than with respect to Paragraph (A), and specific data with respect to access to specialty care, long-term services and supports, nursing services, and therapy services, rather than Paragraphs (A)(iii), (vi), (vii), and (viii), on the average length of time between:

(i) and (ii) Makes no changes to these subparagraphs,

(21) a requirement that the managed care organization demonstrate to HHSC, before the organization begins to provide health care services to recipients, that, subject to HHSC's provider access standards established under Section 533.0061:

(A)-(C) Makes no change to these paragraphs;

(22)-(25) Makes no changes to these subdivisions.

Deletes text of existing Subdivision (20)(A) providing that the comprehensive plan describe how the managed care organization's provider network will provide recipients sufficient access to preventive care, primary care, specialty care, after-hours urgent care, chronic care, long-term services and supports, nursing services, and therapy services, including services provided in a clinical setting or in a home or community-based setting.

SECTION 2. Amends Subchapter A, Chapter 533, Government Code, by adding Sections 533.0061, 533.0062, 533.0063, and 533.0064, as follows:

Sec. 533.0061. PROVIDER ACCESS STANDARDS; REPORT. (a) Requires 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 recipients. Requires that the access standards ensure that a managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) after-hours urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

(8) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(9) any other services identified by HHSC.

(b) Requires the access standards established under this section, to the extent it is feasible, to:

(1) distinguish between access to providers in urban and rural settings; and

(2) consider the number and geographic distribution of Medicaid-enrolled providers in a particular region.

(c) Requires HHSC to biennially submit to the legislature and 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. Requires that the report contain:

(1) a compilation and analysis of information submitted to HHSC under Section 533.005(a)(20)(D); and

(2) for both primary care providers and specialty providers, information on provider-to-recipient ratios in an organization's provider network, as well as benchmark ratios to indicate whether deficiencies exist in a given network.

Sec. 533.0062. CAPITATION PAYMENTS AT-RISK BASED ON COMPLIANCE WITH PROVIDER ACCESS STANDARDS. Requires that a contract between a managed care organization and HHSC for the organization to provide health care services to recipients place 0.5 percent of the organization's capitation payments at-risk based on compliance with the provider access standards established under Section 533.0061. Requires HHSC to:

(1) on a quarterly basis, assess whether an organization has complied with the provider access standards; and

(2) on an annual basis, pay the organization any money withheld under this section for each quarter in the preceding year in which the organization complied with the standards.

Sec. 533.0063. PROVIDER NETWORK DIRECTORIES. (a) Requires HHSC to ensure that a managed care organization that contracts with HHSC to provide health care services to recipients:

(1) subject to Subsection (c), updates the organization's provider network directory at least monthly; and

(2) in addition to making the directory available in paper form, makes the provider network directory available on the organization's Internet website.

(b) Provides that notwithstanding Subsection (a):

(1) a managed care organization participating in the STAR Medicaid managed care program is required to send, for recipients

in that program, a paper form of the organization's provider network directory for the program only to a recipient who opts to receive the directory in paper form; and

(2) a managed care organization participating in the STAR + PLUS Medicaid managed care program is required to, for a recipient in that program, issue a provider network directory for the program in paper form unless the recipient opts out of receiving the directory in paper form.

(c) Provides that Subsection (a)(1) does not require a managed care organization to republish the organization's provider network directory in paper form each time the directory is updated.

Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) Defines "applicant provider."

(b) Requires a managed care organization that contracts with HHSC to provide health services to recipients to, in accordance with this section, establish and implement an expedited credentialing process that would allow applicant providers to provide services to recipients on a provisional basis, notwithstanding any other law.

(c) Requires an applicant provider, in order to qualify for expedited credentialing under this section and payment under Subsection (d), to:

(1) be a member of an established health care provider group that has a current contract in force with a managed care organization described by Subsection (b);

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described by Subdivision (1); and

(4) 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.

(d) Requires the organization to treat the applicant provider as if the provider were in the organization's provider network when the applicant provider provides services to recipients, on submission by the applicant provider of the information required by the managed care organization under Subsection (c), and for Medicaid reimbursement purposes only.

(e) Prohibits a managed care organization from recovering any payments from an applicant provider if, on completion of the credentialing process, the organization determines that the applicant provider does not meet the organization's credentialing requirements.

SECTION 3. Amends Section 533.007, Government Code, by adding Subsection (l), as follows:

(1) Requires HHSC to conduct direct monitoring of a managed care organization's provider network and providers in the network to ensure compliance with contractual obligations related to:

(1) the number of providers accepting new patients under the Medicaid program; and

(2) patient wait times.

SECTION 4. (a) Requires that HHSC, in a contract between the commission and a managed care organization under Chapter 533, Government Code, that is entered into or renewed on or after the effective date of this Act, to require that the managed care organization comply with:

(1) Section 533.005(a), Government Code, as amended by this Act;

(2) the standards established under Section 533.0061(a), Government Code, as added by this Act; and

(3) Section 533.0063, Government Code, as added by this Act.

(b) Requires that HHSC to seek to amend contracts entered into with managed care organizations under Chapter 533, Government Code, before the effective date of this Act to require that those managed care organizations comply with the provisions specified in Subsection (a) of this section. Provides that the contract provision prevails to the extent of a conflict between those provisions and a provision of a contract with a managed care organization entered into before the effective date of this Act.

SECTION 5. Requires HHSC to submit to the legislature the initial report required under Section 533.0061(c), Government Code, as added by this Act, not later than December 1, 2016.

SECTION 6. 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 7. Effective date: September 1, 2015.