BILL ANALYSIS

Senate Research Center
84R18354 JSL-F

C.S.S.B. 760
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Health & Human Services
3/25/2015
Committee Report (Substituted)

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.

C.S.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.

C.S.S.B. 760 amends current law relating to provider access and assignment 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) 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 the provider access standards established under Section 533.0061;

(B) as a condition of contract retention and renewal:

(i) continue to comply with the provider access standards established under Section 533.0061; and

(ii) make substantial efforts, as determined by HHSC, to mitigate or remedy any noncompliance with the provider access standards established under Section 533.0061;

(C) pay liquidated damages for each failure, as determined by HHSC, to comply with the provider access standards established under Section 533.0061 in amounts that are reasonably related to the noncompliance; 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 primary care, specialty care, long-term services and supports, nursing services, and therapy services, rather than with respect to Paragraphs (A)(iii), (vi), (vii), and (viii), on the average length of time between:

(i) the date a provider requests prior authorization, rather than makes a referral, for the care or service and the date the organization approves or denies the request, rather than referral; and

(ii) the date the organization approves a request for prior authorization, rather than a referral, for the care or service and the date the care or service is initiated.

(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 the provider access standards established under Section 533.0061:

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

(22) and (23) makes no change to these subdivisions; and

(24) and (25) makes nonsubstantive changes to these subdivisions; and

(26) a requirement that the managed care organization make initial and subsequent primary care provider assignments and changes.

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 that the provider access standards established under this section, to the extent it is feasible:

(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 service delivery area.

(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 and managed care organization compliance with contractual obligations related to provider access standards established under this section. Requires that the report contain:

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

(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; and

(3) a description of, and analysis of the results from, HHSC's monitoring process established under Section 533.007(1).

Sec. 533.0062. PENALTIES AND OTHER REMEDIES FOR FAILURE TO COMPLY WITH PROVIDER ACCESS STANDARDS. Provides that, if a managed care organization that has contracted with HHSC to provide health care services to recipients fails to comply with one or more provider access standards established under Section 533.0061 and HHSC determines the organization has not made substantial efforts to mitigate or remedy the noncompliance, HHSC:

(1) may:

(A) elect to not retain or renew HHSC's contract with the organization; or

(B) require the organization to pay liquidated damages in accordance with Section 533.005(a)(20)(C); and

(2) shall 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.

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) posts on the organization's Internet website:

(A) the organization's provider network directory; and

(B) 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:

(i) identifying in-network providers and services available to the recipient; and

(ii) scheduling an appointment for the recipient with an available in-network provider or to access available in-network services; and

(2) updates the online directory required under Subdivision (1)(A) at least monthly.

(b) Requires a managed care organization, except as provided by Subsection (c), 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.

(c) Requires a managed care organization participating in the STAR + PLUS Medicaid managed care program or STAR Kids Medicaid managed care program established under Section 533.00325 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.

Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) Redefines "applicant provider" to mean a physician or other health care provider applying for expedited credentialing under this section.

(b) Requires a managed care organization that contracts with HHSC, notwithstanding any other law and subject to Subsection (c), 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.

(c) Requires HHSC to identify the types of providers for which an expedited credentialing process must be established and implemented under this section.

(d) Requires an applicant provider, to qualify for expedited credentialing under this section and payment under Subsection (e), to meet the criteria set forth in this subsection.

(e) Requires the organization, on submission by the applicant provider of the information required by the managed care organization under Subsection (d), 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 recipients, subject to Subsections (f) and (g).

(f) Authorizes the organization to recover from the provider the difference between payments for in-network benefits and out-of-network benefits, except as provided by Subsection (g), if, on completion of the credentialing process, a managed care organization determines that the applicant provider does not meet the organization's credentialing requirements.

(g) Authorizes the organization to recover from the provider the entire amount of any payment paid to the provider if a managed care 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.

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

(l) 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. Provides that the process:

(1) must be used to ensure compliance with contractual obligations related to:

(A) the number of providers accepting new patients under the Medicaid managed care program; and

(B) the length of time a recipient must wait between scheduling an appointment with a provider and receiving treatment from the provider;

(2) may use reasonable methods to ensure compliance with contractual obligations, including telephone calls made at random times without notice to assess the availability of providers and services to new and existing recipients; and

(3) may be implemented directly by HHSC or through a contractor.

SECTION 4. (a) Requires HHSC, in a contract between HHSC 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 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.