SUBJECT: Provider network requirements for Medicaid managed care organizations

COMMITTEE: Human Services — favorable, without amendment

VOTE: 7 ayes — Raymond, Rose, Keough, Naishtat, Peña, Price, Spitzer

0 nays

2 absent — S. King, Klick

SENATE VOTE: On final passage, April 7 — 31-0

WITNESSES: For — Trey Berndt, AARP; Will Francis, National Association of Social Workers-Texas Chapter; (*Registered, but did not testify*: Mary Nava, Bexar County Medical Society; Carlin Jimenez, Clarity Child Guidance Center; Kathryn Lewis, Disability Rights Texas; Jolene Sanders, Easter Seals Central Texas; Alyse Meyer, LeadingAge Texas; Cate Graziani, Mental Health America of Texas; Greg Hansch, National Alliance on Mental Illness-Texas; Carole Smith, Private Providers Association of Texas; Sandra Frizzell, Providers Alliance for Community Services of Texas; Patty Ducayet, State Long-Term Care Ombudsman Program; Lauren Dimitry, Texans Care for Children; Marina Hench, Texas Association for Home Care and Hospice; Lee Johnson, Texas Council of Community Centers; Scot Kibbe, Texas Health Care Association; Darren Whitehurst, Texas Medical Association; Bobby Hillert, Texas Orthopaedic Association; David Reynolds, Texas Osteopathic Medical Association; Clayton Travis, Texas Pediatric Society; Ginger Mayeaux, The Arc of Texas)

Against — None

On — (*Registered, but did not testify*: Gary Jessee, Health and Human Services Commission)

BACKGROUND: Most Medicaid services in Texas and all Children's Health Insurance Program services are delivered through contracts with managed care

organizations. Under these contracts, the Health and Human Services Commission (HHSC) pays managed care organizations (MCOs) a monthly amount to coordinate health services for individuals enrolled in their health plans. The health plans contract directly with health care providers to create provider networks that enrollees can use.

Government Code, sec. 533.005(a) sets requirements for a contract between HHSC and an MCO to provide health care services to recipients. One requirement stipulates that before an MCO begins to provide health care services to recipients, the organization must develop and submit to the commission a comprehensive plan that describes how the organization's provider network will provide recipients sufficient access to certain types of care. An MCO also must demonstrate to the commission that the organization's provider network has the capacity to serve the number of recipients expected to enroll in a managed care plan offered by the MCO.

DIGEST:

SB 760 would establish provider access standards for Medicaid managed care providers, set remedies for the failure of a managed care organization (MCO) to meet those standards, and require an MCO to create an expedited credentialing process for certain Medicaid managed care providers. The bill additionally would require an MCO to post its provider directory online and would require the Health and Human Services Commission (HHSC) to monitor an MCO's provider network to ensure compliance with contractual obligations. MCOs also would report to the Legislature and the public on Medicaid managed care recipients' access to providers.

Provider access standards. The bill would require HHSC to establish minimum provider access standards for an MCO's provider network if the MCO contracted with the commission to provide health care services. The bill would require the access standards to ensure that an MCO provided 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, including services provided in a clinical setting or in a home or community-based setting; and
- any other services identified by HHSC.

The provider access standards, if feasible, would distinguish between access to providers in urban and rural settings and would consider the number and geographic distribution of Medicaid-enrolled providers in a particular service delivery area.

Remedies for failure to comply with provider access standards. If an MCO contracting with HHSC failed to comply with one or more provider access standards established under the bill and HHSC determined that the MCO had not made substantial efforts to mitigate or remedy the noncompliance, HHSC would suspend default enrollment for an MCO in a given service delivery area for at least one quarter of the year if the MCO was noncompliant in the service delivery area for two consecutive quarters. HHSC also could:

- choose not to retain or renew HHSC's contract with the MCO; or
- require the MCO to pay liquidated damages in amounts that were reasonably related to the noncompliance for each failure to comply with the provider access standards.

Expedited credentialing. The bill would require an MCO that contracted with HHSC to establish and implement an expedited credentialing process to allow providers to apply for eligibility to provide services to MCO plan recipients on a provisional basis. HHSC would identify which types of providers would have an expedited credentialing process.

To qualify for expedited credentialing and reimbursement under Medicaid, a provider would have to:

- be a member of an established health care provider group that had a current contract with an MCO;
- be a Medicaid-enrolled provider;
- agree to comply with the terms of the MCO's contract; and
- submit all documentation and other information required by the MCO as necessary to allow the MCO to begin the credentialing process to include the provider in the MCO's network.

Once a provider had submitted the information required by the MCO as part of the expedited credentialing process, the MCO would treat the provider, for Medicaid reimbursement purposes only, as if the provider were in the organization's provider network when the provider delivered services to recipients of an MCO plan. If the MCO determined, after the provider completed the credentialing process, that the provider did not meet the MCO's credentialing requirements, the MCO could recover from the provider the difference between payments for in-network benefits and out-of-network benefits.

If the provider applied to be part of an MCO's network and did not meet the MCO's credentialing requirements and made fraudulent claims in its application, the MCO could recover from the provider the entire amount of any payment made to the provider.

Provider network directories. HHSC would ensure that an MCO that contracted with HHSC posted the MCO's provider network directory on the MCO's website as well as a direct telephone number and e-mail address through which a managed care plan recipient or the recipient's health care provider could receive assistance with identifying in-network health care providers, scheduling appointments with a provider, or accessing available in-network services. The MCO would be required to send a paper version of the provider network directory only to a recipient who requested to receive the directory in paper form, except for STAR Kids or STAR+PLUS Medicaid managed care recipients, who would automatically receive a paper version of the directory unless they opted out.

The bill would require the MCO to update the online provider network directory at least monthly.

Monitoring. HHSC would establish and implement a process for directly monitoring an MCO's provider network and providers in the network. The process would 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 would be required to wait between scheduling an appointment with a provider and receiving treatment from the provider.

As part of the process, HHSC could 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. The process could be implemented directly by HHSC or through a contractor.

Report to Legislature. Each biennium, HHSC would submit a report to the Legislature and the public that would contain information and statistics about MCO recipients' access to providers in the MCOs' provider networks and MCOs' compliance with contractual obligations related to provider access standards specified in the bill. The report also would contain:

- information on provider-to-recipient ratios in an MCOs' provider network;
- benchmark ratios to indicate whether there were deficiencies in an MCO's network; and
- a description and analysis of the results from HHSC's process for monitoring MCOs.

HHSC would submit the first report to the Legislature by December 1,

2016.

Contract. A contract for health care services between an MCO and HHSC would have to contain a requirement for the MCO to develop and submit to HHSC a comprehensive plan that described how the MCO's provider network would comply with the provider access standards established in the bill and that, as a condition of contract retention and renewal, the MCO would:

- continue to comply with the provider access standards; and
- make substantial efforts, as determined by HHSC, to mitigate or remedy any noncompliance with those provider access standards.

An MCO would be contractually required to regularly submit data to HHSC and make data available to the public regarding access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on:

- the average length of time between the date a provider requested prior authorization for care or a service and the date the MCO approved or denied the request; and
- the date the organization approved a request for prior authorization for the care or service and the date the care or service was initiated.

The contract also would contain a requirement for an MCO to make initial and subsequent primary care provider assignments and changes.

A contract between HHSC and an MCO that was entered into or renewed on or after September 1, 2015, would require the MCO to comply with the provisions of the bill.

HHSC would seek to amend contracts with MCOs that were entered into before September 1, 2015, to require that those MCOs comply with the provisions in the bill. To the extent that a conflict existed between the bill's provisions and a provision of a contract with an MCO that HHSC entered into before September 1, 2015, the contract provision would

prevail.

Waivers. If, before implementing any provision of the bill, a state agency determined that a waiver or authorization from a federal agency was necessary to implement that provision, the agency would be required to request the wavier or authorization and could delay implementation until it received it.

The bill would take effect September 1, 2015.

SUPPORTERS SAY:

SB 760 would provide the Health and Human Services Commission (HHSC) with the tools necessary to monitor Medicaid MCO's provider networks and ensure that MCOs were delivering an appropriate level of care. The state spends billions of dollars on contracts with Medicaid MCOs, which provide health care to the majority of Medicaid enrollees in Texas. The bill would help ensure that the MCOs receiving this money were providing access to care through adequate provider networks.

Medicaid patients and health care providers seeking to refer Medicaid patients to specialists have found that some MCOs have very few providers in their networks, even in large cities that should have enough providers. By requiring all MCOs to meet provider network adequacy standards determined by HHSC, the bill would increase consistency in provider networks between plans and would reduce the wait times for Medicaid appointments. Ensuring that MCOs had adequate provider networks also would reduce the cost to the state of Medicaid patients using more expensive urgent care and emergency care because they could not find a primary care provider that accepted their plan.

The bill also would increase transparency and accountability regarding access to physicians by requiring Medicaid MCOs that contract with HHSC to post their provider directories online and to update the directories monthly. Posting the directory online would reduce the time needed for patients and providers to ensure that a provider listed in an MCO's directory was in-network and would reduce the occurrence of patients traveling to an appointment to find that the provider was not part

of the MCO's network.

Additionally, the bill would increase the number of providers in an MCO's network by creating an expedited credentialing process for certain types of providers as determined by HHSC. This credentialing process would be limited to providers who were enrolled in Medicaid and were part of an established health care provider group that had a current contract with a managed care organization. The bill also would improve oversight and accountability for MCOs by creating remedies for an MCO's failure to comply with provider access standards set by HHSC.

The Senate-engrossed version of the bill addressed stakeholders' concerns with previous versions.

OPPONENTS SAY:

No apparent opposition.