HCS HB 1662 -- MO HEALTHNET MANAGED CARE SERVICES

SPONSOR: Richardson

COMMITTEE ACTION: Voted "Do Pass" by the Special Standing Committee on Emerging Issues in Health Care by a vote of 9 to 3.

This bill changes the laws regarding MO HealthNet managed care services.

COST ESTIMATES (Section 191.875, RSMo)

By January 1, 2015, any patient or consumer of health care services who requests an estimate of the cost of health care services must be provided the estimate of cost or insurance costs prior to the provision of the services, if feasible, but in no event later than three business days after the request. These provisions must not apply to emergency health care services. "Estimate of cost" is defined as an estimate based on the information entered and assumptions about typical utilization and costs for health care services. The estimate of cost must include:

(a) The amount that will be charged to a patient for the health services if all charges are paid in full without a public or private third party paying for any portion of the charges;

(b) The average negotiated settlement on the amount that will be charged to a patient;

(c) The amount of any MO HealthNet reimbursement for the health care services, including claims and pro rata supplemental payments, if known;

(d) The amount of any Medicare reimbursement for the medical services, if known; and

(e) The amount of any insurance co-payments for the health benefit plan of the patient, if known.

Health care providers and health carriers must include with any estimate a specified disclaimer stating that the estimated cost is an estimate and may be different from the actual amount billed. Each health care provider must also make available the percentage or amount of any discounts for cash payment of any charges incurred by a posting on the provider's website and by making it available at the provider's location.

STATEWIDE MANAGED CARE (Section 208.166)

Effective July 1, 2015, the bill requires the Department of Social Services to extend the MO HealthNet Managed Care Program statewide for all benefit and eligibility groups currently enrolled in a managed care plan as of January 1, 2014. The department must seek amy necessary waivers or state plan amendments from the federal Department of Health and Senior Services and the pharmacy benefit for the managed care population receiving coverage under these provisions must remain covered under the MO HealthNet Fee-for-service Program. The department must develop a transitional Medicaid payment plan for the purpose of continuing and preserving payments consistent with current Medicaid levels for community mental health centers (CMHCs)and must also create an implementation working group consisting of CMHCs, the Department of Mental Health, and managed care organizations in the MO HealthNet Program.

The bill prohibits a MO HealthNet managed care organization from refusing to contract with any licensed Missouri medical doctor, doctor of osteopathy, psychiatrist, or psychologist who is located within the geographic coverage area of a MO HealthNet managed care program and is able to meet the credentialing criteria established by the National Committee for Quality Assurance and is willing, as a term of contract, to be paid at rates not less than 100% of the MO HealthNet Medicaid fee schedule.

All provisional licensed clinical social workers, licensed clinical social workers, provisional licensed professional counselors, and licensed professional counselors may provide behavioral health services to all participants in any setting. A MO HealthNet managed care organization is prohibited from refusing to contract with any provider under these provisions so long as the provider is located within the geographic coverage area of a MO HealthNet managed care program, is able to meet the credentialing criteria established by the National Committee for Quality Assurance, and is willing, as a term of contract, to be paid at rates equal to 100% of the MO HealthNet fee schedule. These provisions must not be construed to expand the scope of practice of provisional licensed clinical social workers, licensed clinical social workers, provisional licensed professional counselors, and licensed professional counselors.

For services provided by MO HealthNet managed care organizations, no prior authorization must be required for the receipt of mental health testing and evaluation up to four hours per member per year. To aid the discovery of how and if MO HealthNet recipients covered under managed care organization health plans are improving in health outcomes and to provide data to the state to target health disparities, the State of Missouri must:

(1) Provide a biannual analysis of each of the state managed care organizations to ensure the organizations are meeting required metrics, goals, and quality measurements as defined in the managed care contract such as costs of managed care services as compared to fee-for-service providers and to provide the state with needed data for future contract negotiations and incentive management;

(2) Meet all state health privacy laws and federal Health Insurance Portability and Accountability Act (HIPAA) requirements; and

(3) Meet federal data security requirements.

The bill requires MO HealthNet providers to be reimbursed within 40 days of submitting a clean claim as the term is defined under Section 376.383.

JOINT COMMITTEE ON MO HEALTHNET (Section 208.952)

The Joint Committee on MO HealthNet is required to:

(1) Meet on at least four occasions annually, including at least four before the end of December of the first year the committee is established. Meetings can be held by telephone or video conference at the discretion of the committee;

(2) Review participant and provider satisfaction reports and reports of health outcomes, social and behavioral outcomes, and the use of evidence-based medicine and best practices in the MO HealthNet program;

(3) Review the results from other states of the relative success or failure of various models of health delivery attempted;

(4) Review the results of studies comparing various health plans;

(5) Review the data from health risk assessments;

(6) Review the results of public process input;

(7) Advise and approve proposed design and implementation proposals for new health improvement plans submitted by the department, as well as make recommendations and suggest modifications when necessary;

(8) Determine how best to analyze and present the data reviewed so that the health outcomes, participant and provider satisfaction, results from other states, health plan comparisons, financial impact of the various health improvement plans and models of care,

study of provider access, and results of public input can be used by consumers, health care providers, and public officials;

(9) Present significant findings of the analysis required in these provisions in a report to the General Assembly and Governor, at least annually, beginning January 1, 2016;

(10) Study the demographics of the state and of the MO HealthNet population and how those demographics are changing; and

(11) Perform other tasks as necessary including, but not limited to, making recommendations to the MO HealthNet Division within the Department of Social Services concerning the promulgation of rules and emergency rules so that quality of care, provider availability, and participant satisfaction can be assured.

MANAGED CARE REQUIREMENTS (Section 208.999)

MO HealthNet managed care organizations must be required to provide to the department, on at least a yearly basis, and the department must publicly report within 30 days of receipt, including posting on the department's website, at least the following information:

(1) Medical loss ratios for each managed care organization compared with the 85% medical loss ratio for large group commercial plans under Public Law 111-148 and, where applicable, with the state's administrative costs in its fee-for-service MO HealthNet program; and

(2) Total payments to the managed care organization in any form including, but not limited to, tax breaks and capitated payments to participate in MO HealthNet, and total projected state payments for health care for the same population without the managed care organization.

Managed care organizations must be required to maintain medical loss ratios of at least 85% percent, as defined by the National Association of Insurance Commissioners, for MO HealthNet operations. If a managed care organization's medical loss ratio falls below 85% over a cumulative period of three years, the managed care plan must be required to refund a portion of the capitation rates paid to the managed care plan in a tiered amount equal to the difference between the plan's medical loss ratio and 85% of the capitated payment to the managed care organization. When the medical loss ratio is between 85% and 80%, 25% of the tier must be returned to the state; when the medical loss ratio is less than 80%, 75% of the tier must be returned to the state.

The department must be required to ensure that managed care

organizations establish and maintain adequate provider networks to serve the MO HealthNet population and to include these standards in its contracts with managed care organizations. Managed care organizations must be required to establish and maintain health plan provider networks in geographically accessible locations in accordance with travel distances specified by the department in its managed care contracts and as required by the Department of Insurance, Financial Institutions and Professional Registration.

Managed care plans' networks must consist of, at minimum, hospitals, physicians, advanced practice nurses, behavioral health providers, community mental health centers, substance abuse providers, dentists, emergent and non-emergent transportation services, federally qualified health centers, rural health centers, women's health specialists, local public health agencies, and all other provider types necessary to ensure sufficient capacity to make available all services in accordance with the service accessibility standards specified by the Department of Social Services.

Managed care organizations must be required to post all of their provider networks on-line and must regularly update their postings of these networks on a timely basis regarding all changes to provider networks. A provider who is seeing only existing patients under a given managed care plan must not be listed.

The Department of Social Services must be required to contract with an independent organization that does not contract or consult with managed care plans or insurers to conduct secret shopper surveys of MO HealthNet plans for compliance with provider network adequacy standards on a regular basis, to be funded by insurers out of their administrative budgets. Secret shopper surveys are a quality assurance mechanism under which individuals posing as MO HealthNet enrollees will test the availability of timely appointments with providers listed as participating in the network of a given plan for new patients. The testing must be conducted with various categories of providers, with the specific categories rotated for each survey and with no advance notice provided to the plan. If an attempt to obtain a timely appointment is unsuccessful, the survey records the particular reason for the failure, such as the provider not participating in MO HealthNet at all, not participating in MO HealthNet under the plan that listed it and was being tested, or participating under that plan but only for existing patients.

Inadequacy of provider networks, as determined from the secret shopper surveys or the publication of false or misleading information about the composition of health plan provider networks, may be the basis for sanctions against the offending managed care organization.

The provider compensation rates for each category of provider must also be reported by the managed care organizations to help ascertain whether they are paying enough to engage providers comparable to the number of providers available to commercially insured individuals, as required by federal law, and compared, where applicable, to the state's own provider rates for the same categories of providers.

Managed care organizations must be required to ensure sufficient access to out-of-network providers when necessary to meet the health needs of enrollees in accordance with standards developed by the department and included in the managed care contracts.

Managed care organizations must be required to provide, on a quarterly basis and for prompt publication, at least the following information related to service utilization, approval, and denial:

(1) Service utilization data, including how many of each type of service was requested and delivered, subtotaled by age, race, gender, geographic location, and type of service;

(2) Data regarding denials and partial denials by managed care organizations or their subcontractors each month for each category of services provided to Medicaid enrollees. Denials include partial denials whereby a requested service is approved but in a different amount, duration, scope, frequency, or intensity than requested; and

(3) Data regarding complaints, grievances, and appeals, including numbers of complaints, grievances, and appeals filed, subtotaled by race, age, gender, geographic location, and type of service, including the time frame data for hearings and decisions made and the dispositions and resolutions of complaints, grievances, or appeals.

Managed care organizations must be required to disclose the following information:

(1) Quality measurement data including, at minimum, all health plan employer data and information set (HEDIS) measures, early periodic screening, diagnosis, and treatment (EPSDT) screening data, and other appropriate utilization measures;

(2) Consumer satisfaction survey data;

(3) Provider satisfaction survey data;

(4) Enrollee telephone access reports including average wait time

before managed care organization or subcontractor response, busy signal rate, and enrollee telephone call abandonment rate;

(5) Data regarding the average cost of care of individuals whose care is reported as having been actively managed by the managed care organization versus the average cost of care of the managed care organization's population generally. For purposes of these provisions, the phrase "actively managed by the managed care organization" means the managed care organization has actually developed a care plan for the particular individual and is implementing it as opposed to reacting to prior authorization requests as they come in, reviewing usage data, or monitoring doctors with high utilization;

(6) Data regarding the number of enrollees whose care is being actively managed by the managed care organization, broken down by whether the individuals are hospitalized, have been hospitalized in the last 30 days, or have not recently been hospitalized;

(7) Results of network adequacy reviews including geo-mapping, stratified by factors including provider type, geographic location, urban or rural areas, any findings of adequacy or inadequacy, and any remedial actions taken. This information must also include any findings with respect to the accuracy of networks as published by managed care organizations, including providers found to be not participating and not accepting new patients;

(8) Any data related to preventable hospitalizations, hospital-acquired infections, preventable adverse events, and emergency department admissions; and

(9) Any additional reported data obtained from the managed care plans that relates to the performance of the plans in terms of cost, quality, access to providers or services, or other measures.

PROPONENTS: Supporters say that currently 40 states utilize full risk managed care models to control the cost and quality of their Medicaid programs. Quality is measured by 40 standardized metrics that are then reported and compared nationally. The goal of managed care is not to reduce cost in terms of reimbursement; it's to ensure members get the right access to care in the appropriate setting that then drives down overall costs. Often times managed care organizations have to focus on removing barriers that prevent participants from getting care in the proper setting. To do so, managed care organizations offer transportation at no cost to participants, use predictive modeling to find current and future high risk clients, and try to connect with members today to prevent problems from occurring tomorrow. Managed care organizations try to ensure they have a very broad network. Managed care

organizations are incentivized to keep participants healthy and improve overall health because it saves them money and the managed care organizations are also at risk.

Testifying for the bill were Representative Richardson; Pam Victor, HealthCare USA; Shannon Bagley, Missouri Association of Health Plans; WellCare Health Plans, Inc.; and Anthem Blue Cross Blue Shield of Missouri.

OPPONENTS: Those who oppose the bill say that they don't favor expansion of Medicaid managed care. The bill increases the footprint of the MO HealthNet Managed Care Program without looking at the shortcomings of the program. Opponents feel managed care plans bring hassle and complexity to the provision of health care services rather than the flexibility needed to adequately address the health needs of patients. Managed care falls short due to the lack of provider involvement and engagement on setting standards. There needs to be less emphasis on payment denial and more on the actual management of care. Managed care does not allow for proper mental health treatment, thus mental health services should be carved out of the managed care program. Missouri has had eight years of Medicaid managed care. If managed care were really a solution to the broken Medicaid system, we wouldn't still be talking about the need to fix Medicaid.

Testifying against the bill were James Skinner, Behavioral Health Solutions; Dr. Chuck Hollister, Missouri Psychology Association; BJC Health Care Systems; CoxHealth; Tenet HealthSystem; Truman Medical Centers; Preferred Family Healthcare; St. Luke Health System; Missouri Hospital Association; Missouri State Medical Association; and HCA-Hospital Corporation of America.

OTHERS: Others testifying on the bill say they would prefer a carve out for mental health services. Managed care for mental health statewide will cost more for the state and provide less services and care for patients. If mental health services are not carved out, then there need to be changes. One improvement could be to require electronic billing systems and a day turn around for billing. Currently, managed care takes two months to respond and providers can’t re-bill because of time limits. There should be a 1-800 complaint number that is run by people with authority to make decisions to help with any provider or participant issues. Requiring managed care organizations to report to a legislative oversight entity to hold managed care accountable could also improve care.

Testifying on the bill were Mark Bradford and Dr. Kenneth Bohm, Missouri Psychological Association; and Brent Gilstrap, Missouri Mental Health Counselors Association.