TEXAS
Health and Human
Services Commission

Presentation to the Senate Committee on State Affairs

August 11, 2004

Presented by Billy Millwee, MHA

Deputy Medicaid/CHIP Director for Health Services

Presentation Overview

Medicaid Managed Care

- Out-of-Network Background
- HB 2292 Provisions for Out-of-Network Methodology
- HHSC Project Approach
- HHSC Proposed Methodology
- Implementation Timeline

Out-of-Network Background

- HHSC expects HMOs to develop networks that have the breadth and depth to provide all necessary medical services to their enrolled populations.
  - Not having a contract between the health plan and hospital results in increased difficulty with reimbursement, discharge planning and overall coordination of care.

Out-of-Network Background

- There are circumstances in which some out-of-network usage is unavoidable and even appropriate from a quality of care perspective:
  - To prevent disruption of care of newly enrolled members in the midst of a course of treatment
  - Due to difficulties associated with establishing a full-service network in rural regions
  - Due to difficulties in contracting with physicians in particular specialties
  - To allow members to obtain care from the nearest providers in medical emergencies, regardless of network issues.

Out-of-Network Background

- An inordinate volume of out-of-network usage may signal problems with a health plan's network or contracting approaches:
  - Health plan is unwilling to negotiate reasonable payment rates and is therefore unable to establish a strong network.
  - Health plan may be paying lower rates to out-of-network providers than to its network providers and has made a conscious decision not to enforce its rules requiring members to use network providers.
  - Providers may exercise sufficient market power not to contract with health plans, regardless of the contractual arrangement being offered.

Out-of-Network Background

- The majority of hospitals and health plans have broad in-network arrangements, as well as acceptable out-of-network arrangements when it is necessary to utilize an out-of-network provider.

- Some providers have raised issues regarding excessive out-of-network usage by health plans.

HB 2292 Provisions for Out-Of-Network Methodology

HB 2292, 78th Legislature, Regular Session, 2003
Sections 2.203 and 2.35

- Establish maximum limits for out-of-network access by provider type and service delivery area.
- Develop objective standards for determining network adequacy.
- Develop reasonable rate methodology for payment of out-of-network services.
- Develop a standard protocol for a corrective action plan for managed care organizations that fail to maintain an adequate provider network or that do not reimburse providers according to a reasonable rate methodology.
- Develop guidelines on managed care organization reporting of out-of-network services.

HHSC Project Approach

- In December 2003, HHSC competitively awarded a contract to The Lewin Group to complete an analysis and develop recommendations related to the out-of-network provisions in HB 2292.

  - Key contract deliverables:

    - Empirical prevalence analysis of out-of network utilization in Texas
    - Qualitative assessment of managed care delivery system problems associated with out-of-network utilization in Texas
    - Survey of practices in other states
    - Final report with recommendations related to the out-of-network provisions in HB 2292.

HHSC Proposed Methodology

- Establish maximum limits for out-of-network access.
  - No more than 25 percent of a managed care organization's total hospital admissions, by service area, may occur in non-contracted (i.e., out-of-network) facilities.
  - No more than 30 percent of a managed care organization's total emergency room visits, by service area, may occur in non-contracted (i.e., out-of-network) facilities.
  - No more than 30 percent of total dollars billed to a managed care organization for "other outpatient services" by service area may be billed by out-of-network providers.

HHSC Proposed Methodology

- Develop objective standards for determining network adequacy by provider type and service delivery area.

  - Primary Care Physician (PCP) Access
    - Plan members should have access to an age appropriate PCP with an open panel within 30 miles of the member's residence.
  - OB/GYN Access
    - Female plan members should have access to an OB/GYN in the provider network with an open panel within 30 miles of the member's residence.
  - Outpatient Behavioral Health Provider Access
    - Plan members should have access to an outpatient Behavioral Health Service Provider in the network with an open panel with 75 miles of the member's residence.

HHSC Proposed Methodology

- Other Specialist Physician Access
  - Plan members should have access to a network specialist physician with an open panel within 75 miles of the member's residence for common medical specialties.
- Hospital Access
  - Plan members should have access to an acute care hospital in the provider network within 30 miles of the member's residence.
- All Other Services
  - Plan members should have access to at least one network provider with an open panel for all other covered services within 75 miles of the member's residence.

HHSC Proposed Methodology

- Develop reasonable rate methodology for payment of out-of-network services.

  - Out-of-Network, In-Area
    - HMOs must reimburse out-of-network providers in the service delivery area no less than the fee-for-service rate less three percent.
  - Out-of-Network, Out-of-Area
    - HMOs must reimburse out-of-network providers outside the service delivery area the amount mutually negotiated between the HMO and the provider.

HHSC Proposed Methodology

- Develop a standard protocol for a corrective action plan for managed care organizations that fail to maintain an adequate provider network or that do not reimburse providers according to a reasonable rate methodology.

  - HMO will be required to:
    - Submit a corrective action plan
    - Report on a monthly basis
  - If the HMO does not come into compliance then HHSC will withhold from the managed care organization up to five percent of all capitation funds due the HMO until such time as the HMO becomes compliant with the required standard.

HHSC Proposed Methodology

- Develop guidelines on managed care organization reporting of out-of-network services.
  - HMOs will be required to report to HHSC the following:
    - **Hospital Admissions:** Total number of hospital admissions, as well as number of admissions that occur at each out-of-network hospital.
    - **Emergency Room Services:** Total number of emergency room visits, as well as total number of emergency room visits that occur at each out-of-network hospital.
    - **Other Services:** Total dollars billed for all other services, as well as total dollars billed by out-of-network providers for all other services.
      - Compliance with the standard will be assessed using data on dollars billed. If these data indicate that the out-of-network standard for other outpatient services has been exceeded, more detailed encounter data by provider type will be obtained and reviewed.

Implementation Timeline

- **09/04:** HHSC staff present draft proposed rules for discussion with affected professional associations and interest groups
- **11/04:** Present proposed rules to the Medical Care Advisory Committee
  - » Out-of-network payment methodology
  - » Maximum limits for out-of-network access
- **12/04:** Publish proposed rules in Texas Register
- **12/04:** Amend existing HMO contracts
- **02/05:** Publish adopted rules in the Texas Register
- **02/05:** Rules effective