SUBJECT: Creating managed care credentialing process for certain health providers

COMMITTEE: Insurance — committee substitute recommended

VOTE: 7 ayes — Lucio, Oliverson, S. Davis, Julie Johnson, Lambert, C. Turner, Vo

1 nay — Paul

1 absent — G. Bonnen

WITNESSES: For — Ray Callas, Texas Medical Association, Texas Society of Anesthesiologists; Ashley Johnston; (*Registered, but did not testify*: Cynthia Humphrey, Association of Substance Abuse Programs; Jacob Smith, Doctors for Texans; Will Francis, National Association of Social Workers-Texas; Marshall Kenderdine, Texas Academy of Family Physicians; Price Ashley, Texas College of Emergency Physicians; Lee Johnson, Texas Council of Community Centers; Bobby Hillert, Texas Orthopaedic Association; Jenna Courtney, Texas Radiological Society; Michael Grimes, Texas Society of Pathologists; Audrey Spanko)

Against — Jamie Dudensing, Texas Association of Health Plans

On — (*Registered, but did not testify*: Melissa Hamilton, Office of Public Insurance Counsel; Jamie Walker, Texas Department of Insurance)

BACKGROUND: Insurance Code ch. 1452, subch. C governs the expedited credentialing process for physicians who join an established medical group that has a current contract with certain managed care plans.

DIGEST: CSHB 2631 would establish a credentialing process for a physician or health care practitioner who was not eligible for expedited credentialing under Insurance Code ch. 1452, subch. C.

Affected health plans. The bill would apply to certain health benefit plans including:

- a health maintenance organization;
- a small employer health plan subject to the Health Insurance Portability and Availability Act;
- a consumer choice of benefits plan;
- a basic coverage plan under the Texas Employees Group Benefits Act;
- a basic plan under the Texas Public School Retired Employees Group Benefits Act;
- a primary care coverage plan under the Texas School Employees Uniform Group Health Coverage Act; and
- a health plan issued under the Medicaid managed care program.

Eligibility. To qualify for credentialing and payment, an applicant would have to:

- be licensed to practice in Texas by, and in good standing with, the Texas Medical Board or other appropriate licensing authority; and
- submit all necessary documentation to the managed care plan issuer.

Payment. After an applicant and managed care plan issuer agreed to the participating provider contract terms, the bill would require the issuer to treat the applicant as if they were a participating provider in the plan network when the applicant provided services to enrollees, including:

- authorizing the applicant to collect copayments from enrollees; and
- making payments to the applicant.

Upon receipt of a credentialing application, an issuer would have to provide notice to the applicant regarding the effect of failure to meet the issuer's credentialing requirements.

If an applicant did not meet the issuer's credentialing requirements, the bill would allow the plan to recover from the applicant the difference between

in-network and out-of-network payments. The applicant could retain any copayments collected or in the process of being collected from patients.

The bill would require an enrollee to be held harmless for the difference between in-network copayments and the managed care plan's charges for out-of-network services. An applicant could not charge the enrollee for any portion that was not paid by the enrollee's managed care plan.

Liability. A managed care plan issuer that complied with the bill's provisions would not be subject to liability for certain damages.

Report. The bill would require the Office of Public Insurance Counsel to publish an annual report on its website regarding certain information for each of the largest managed care plan issuers including:

- the issuer's network adequacy;
- the percentage of enrollees receiving a bill from an out-of-network provider due to provider charges unpaid by the issuer and the enrollee's responsibility under the plan; and
- the impact of managed care plan issuer credentialing policies on network adequacy and enrollee payment of out-of-network charges.

The bill would take effect September 1, 2019.

SUPPORTERS SAY:

By establishing another credentialing process, CSHB 2631 would ensure health providers who were not previously eligible under existing managed care credentialing processes could receive payment for services provided to patients. Currently, the time period to become credentialed with private insurance plans averages six to 12 months, which forces many newly licensed physicians to either enter into established credentialed group practices or risk their own financial security by providing care to patients without receiving payment.

The bill also would improve access to health care by allowing patients to see health providers considered in-network pending approval of a provider's credentialing application. The bill would not undermine the

quality of care a managed care plan provided because only licensed physicians and health providers in good standing with regulatory agencies would be eligible for the bill's credentialing process.

OPPONENTS SAY:

CSHB 2631 would be unnecessary because current law already provides an expedited credentialing process for physicians and other health providers. The bill also could jeopardize patient safety by allowing any health provider to receive payment pending approval of their credentialing application. Credentialing is a detailed process that reviews doctors' qualifications and career history and is crucial for ensuring patient safety and preventing fraudulent billing.