BILL ANALYSIS

Senate Research Center
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C.S.S.B. 1235
By: Buckingham
Health & Human Services
4/16/2019
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 1235 seeks to streamline the process to become enrolled as a Medicaid provider in Texas.

Under current law, all providers participating in state healthcare programs are required to enroll in fee-for-service Medicaid at Texas Medicaid & Healthcare Partnership (TMHP), after which managed care organization (MCO) credentialing occurs. While efforts have been made in recent years to streamline the MCO credentialing process, interested parties contend that the TMHP Medicaid provider enrollment process can take months to complete. Meanwhile, the state continues to face a Medicaid provider shortage, especially in rural and underserved areas.

To address this issue, S.B. 1235 creates a "no wrong door" Medicaid application process for providers, allowing Medicare enrollment and/or the MCO credentialing process to count as Medicaid enrollment in addition to the provider enrollment process that currently exists. The bill would also direct HHSC to track the total number of providers utilizing each type of enrollment process. Finally, S.B. 1235 directs HHSC to develop and adopt processes to fast-track enrollment of non-Medicaid providers into Medicaid when Medicaid patients see a non-Medicaid-enrolled provider from their private insurance network. (Original Author's/Sponsor's Statement of Intent)

C.S.S.B. 1235 amends current law relating to the enrollment of health care providers in Medicaid.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Section 531.02118, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.02118, Government Code, by amending Subsection (c) and adding Subsections (e), (f), (g), (h), and (i), as follows:

> (c) Authorizes the Health and Human Services Commission (HHSC), in streamlining the Medicaid provider credentialing process under this section (Streamlining Medicaid Provider Enrollment and Credentialing Processes), to designate a centralized credentialing entity and to require, rather than to authorize:
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> > (1) that the credentialing entity and the entity serving as the state's Medicaid claims administrator share information to reduce the submission of duplicative information or documents necessary for both Medicaid enrollment and credentialing, rather than share information in the database established under Subchapter C (Medical Assistance Program Provider Database), Chapter 32, Human Resources Code, with the centralized credentialing entity; and
> >
> > (2) all managed care organizations contracting with HHSC to provide health care services to Medicaid recipients under a managed care plan issued by the organization to use the centralized credentialing entity as a hub for the collection and sharing information. Makes a conforming change.

(e) Requires HHSC, subject to Subsection (f), to enroll a provider as a Medicaid provider, without requiring the provider to separately apply for enrollment through the entity serving as the state's Medicaid claims administrator, if the provider is credentialed by a managed care organization that contracts with HHSC under Chapter 533 (Medicaid Managed Care Program) or is enrolled as a Medicare provider.

(f) Authorizes the executive commissioner of HHSC to establish by rule additional enrollment requirements that are necessary to enroll a provider as a Medicaid provider and not otherwise required by managed care organization credentialing or Medicare provider enrollment.

(g) Requires HHSC to track the number of providers that enroll as Medicaid providers through each type of enrollment process described by Subsection (e), including the enrollment process through the entity serving as the state's Medicaid claims administrator.

(h) Requires HHSC to develop a process to streamline the Medicaid enrollment of a provider who provides services through a single case agreement to a recipient who is also enrolled in a private group health benefit plan and who is enrolled as a provider in that group health benefit plan.

(i) Requires HHSC to use a provider's national provider identifier number to enroll a provider under Subsection (h). Defines "national provider identifier number."

SECTION 2. 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 3. Requires HHSC to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. Authorizes, but does not require, HHSC, if the legislature does not appropriate money specifically for that purpose, to implement a provision of this Act using other appropriations available for that purpose.

SECTION 4. Effective date: September 1, 2019.