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SENATE BILL 2328

By Kyle

AN ACT to amend Tennessee Code Annotated, Title 4; Title 33; Title 47; Title 56 and Title 71, relative to network adequacy.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following new part:

56-7-3501. Short title.

This part shall be known as the "Mental Healthcare and Substance Abuse Services Network Adequacy Act."

56-7-3502. Definitions.

As used in this part:

(1) "Commissioner" means the commissioner of commerce and insurance;

(2) "Covered benefit" or "benefit" means those mental healthcare services or substance abuse services to which a covered person is entitled under the terms of a health benefit plan;

(3) "Covered person" means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan;

(4) "Emergency mental health condition" means a mental or behavioral health condition that manifests itself by acute symptoms of sufficient severity to lead a prudent layperson possessing an average knowledge of medicine and health to reasonably expect, in the absence of immediate medical attention, to

place the individual's mental or behavioral health, the individual's physical well-being, or the safety of others in serious jeopardy;

(5) "Emergency services" means, with respect to an emergency mental health condition:

(A) A mental health screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the emergency mental health condition; and

(B) Any further mental health examination and treatment to the extent the examination and treatment are within the capabilities of the staff and facilities available at the hospital to stabilize the patient;

(6) "Essential community provider" or "ECP" means a provider that:

(A) Serves predominantly low-income, medically underserved individuals, including a covered entity defined in § 340B(a)(4) of the Public Health Service Act (PHSA); or

(B) Is described in § 1927(c)(1)(D)(i)(IV) of the Social Security Act, as set forth by § 221 of Pub.L. No. 111-8;

(7) "Health benefit plan" means a policy, contract, certificate, or agreement entered into, offered, or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of mental healthcare services or substance abuse services;

(8) "Health carrier" or "carrier" means an entity subject to the insurance laws of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of healthcare services, including a health insurance company, health maintenance organization, hospital and health service corporation, managed care organization, or any other entity providing a plan of health insurance, health benefits, or healthcare services, and includes

any state or local insurance program, under title 8, chapter 27, and any managed care organization contracting with the state to provide insurance through the TennCare program;

(9) "Healthcare provider" or "provider" means a person who provides mental healthcare services or substance abuse services as permitted under the laws of this state;

(10) "Mental healthcare services" means services for the diagnosis, prevention, treatment, cure, or relief of a mental or behavioral health condition, illness, injury, disease, or disorder;

(11) "Network" means the group or groups of participating providers providing mental healthcare services and substance abuse services under a services network plan;

(12) "Network plan" means a health benefit plan that either requires a covered person to use, or creates incentives, including financial incentives, for a covered person to use healthcare providers managed, owned, under contract with, or employed by the health carrier;

(13) "Participating provider" means a provider who, under a contract with a health carrier or with its contractor or subcontractor, has agreed to provide mental healthcare services or substance abuse services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier;

(14) "Person" means an individual, corporation, partnership, association, joint venture, joint stock company, trust, unincorporated organization, or any similar entity or combination thereof;

(15) "Primary care" means healthcare services for a range of common physical, mental, or behavioral health conditions provided by a physician or non-physician primary care professional;

(16) "Primary care professional" means a participating healthcare professional, as defined in § 56-61-102, designated by the health carrier to supervise, coordinate, or provide initial care or continuing care to a covered person, and who may be required by the health carrier to initiate a referral for specialty care and maintain supervision of healthcare services rendered to the covered person;

(17) "Substance abuse services" means services for the diagnosis, prevention, treatment, cure, or relief of a substance use disorder; and

(18) "Telehealth" or "telemedicine" has the same meaning as defined in § 63-1-155.

56-7-3503. Network adequacy.

(a)

(1) A health carrier providing a network plan shall maintain a network that is sufficient in numbers and appropriate types of providers, including essential community providers, to ensure that all covered mental healthcare services and substance abuse services to covered persons, including children and adults, will be accessible without unreasonable travel or delay.

(2) A health carrier providing a network plan shall ensure that covered persons have access to emergency services twenty-four (24) hours per day, seven (7) days per week.

(b) The commissioner shall determine sufficiency in accordance with the requirements of this section, and may establish sufficiency by reference to any reasonable criteria, which may include, but is not limited to:

(1) Provider-covered person ratios by specialty;

(2) Geographic accessibility of providers;

(3) Geographic variation and population dispersion;

(4) Waiting times for an appointment with participating providers;

(5) Hours of operation;

(6) The ability of the network to meet the needs of covered persons, which may include low-income persons, children, and adults with serious, chronic, or complex mental health or substance abuse needs, or persons with limited English proficiency;

(7) Other healthcare service delivery system options, such as telemedicine or telehealth, mobile clinics, centers of excellence, and other ways of delivering care; and

(8) The volume of technological and specialty care services available to serve the needs of covered persons requiring technologically advanced or specialty care services.

(c)

(1) A health carrier shall have a process to assure that a covered person obtains a covered benefit at an in-network level of benefits, including an in-network level of cost-sharing, from a non-participating provider, or shall make other arrangements acceptable to the commissioner when:

(A) The health carrier has a sufficient network, but does not have a type of participating provider available to provide the covered benefit to

the covered person, or it does not have a participating provider available to provide the covered benefit to the covered person without unreasonable travel or delay; or

(B) The health carrier has an insufficient number or type of participating providers available to provide the covered benefit to the covered person without unreasonable travel or delay.

(2) The health carrier shall specify and inform covered persons of the process a covered person may use to request access to obtain a covered benefit from a nonparticipating provider as provided in subdivision (c)(1), if:

(A) The covered person is diagnosed with a condition or disease that requires mental healthcare services or substance abuse services; and

(B) The health carrier:

(i) Does not have a participating provider of the required specialty with the professional training and expertise to treat or provide the necessary mental healthcare services or substance abuse services; or

(ii) Cannot provide reasonable access to a participating provider with the required specialty with the professional training and expertise to treat or provide the necessary mental healthcare services or substance abuse services without unreasonable travel or delay.

(3) The health carrier shall treat the mental healthcare services or substance abuse services the covered person receives from a nonparticipating provider pursuant to subdivision (c)(2) as if the services were provided by a

participating provider, including applying the covered person's cost-sharing for the services toward any maximum out-of-pocket limit applicable to services obtained from participating providers under the health benefit plan.

(4) The process described under subdivisions (c)(1) and (c)(2) must ensure that requests to obtain a covered benefit from a nonparticipating provider are addressed in a timely fashion appropriate to the covered person's condition.

(5) The health carrier shall have a system in place that documents all requests to obtain a covered benefit from a nonparticipating provider under this subsection (c), and shall provide this information to the commissioner upon request.

(6) Health carriers shall not use the process established in this subsection (c) as a substitute for establishing and maintaining a sufficient provider network in accordance with this part, and covered persons shall not use it to circumvent the use of covered benefits available through a health carrier's network delivery system options.

(7) Nothing in this section prevents a covered person from exercising the rights and remedies available under applicable state or federal law relating to internal and external claims grievance and appeals processes.

(d)

(1) A health carrier shall establish and maintain adequate arrangements to ensure covered persons have reasonable access to participating providers located near their home or business address. In determining whether the health carrier has complied with this subdivision (d)(1), the commissioner shall give due consideration to the relative availability of the healthcare providers with the requisite expertise and training in the service area under consideration.

(2) A health carrier shall monitor on an ongoing basis the ability, clinical capacity, and legal authority of its participating providers to furnish all contracted covered benefits to covered persons.

(e)

(1) Beginning January 1, 2021, a health carrier shall file with the commissioner for review and approval, prior to or at the time it files a newly offered network, in a manner and form defined by the commissioner by rule, an access plan that meets the requirements of this part.

(2) The health carrier may request the commissioner to deem sections of the access plan as a trade secret under the Uniform Trade Secrets Act, compiled in title 47, chapter 25, part 17, to be determined by the commissioner in the commissioner's sole discretion. The health carrier shall make the access plans, absent a trade secret, available online, at its business premises, and to any person upon request.

(3) The health carrier shall prepare an access plan prior to offering a new network plan, and shall notify the commissioner of any material change to any existing network plan within fifteen (15) business days after the change occurs. The carrier shall include in the notice to the commissioner a reasonable timeframe within which it will submit to the commissioner for approval or file with the commissioner, as appropriate, an update to an existing access plan.

(f) The access plan required by subsection (e) must describe or contain the following:

(1) The health carrier's network, including how the use of telehealth or other technology may be used to meet network access standards, if applicable;

(2) The health carrier's procedures for making and authorizing referrals within and outside its network, if applicable;

(3) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the mental healthcare service and substance abuse service needs of populations that enroll in network plans;

(4) The factors used by the health carrier to build its provider network, including a description of the network and the criteria used to select providers;

(5) The health carrier's efforts to address the needs of covered persons, including, but not limited to, children and adults, including those with limited English proficiency or illiteracy, diverse cultural or ethnic backgrounds, physical or mental disabilities, and serious, chronic, or complex medical conditions. This includes the carrier's efforts, when appropriate, to include various types of ECPs in its network;

(6) The health carrier's methods for assessing the mental healthcare service and substance abuse service needs of covered persons and their satisfaction with the services;

(7) The health carrier's method of informing covered persons of the plan's covered mental healthcare services and substance abuse services and features, including, but not limited to:

(A) The plan's grievance and appeals procedures;

(B) Its process for choosing and changing providers;

(C) Its process for updating its provider directories for each of its network plans;

(D) A statement of mental healthcare services and substance abuse services offered, including those services offered through a preventive care benefit, if applicable; and

(E) Its procedures for covering and approving emergency, urgent, and specialty mental healthcare services or substance abuse services;

(8) The health carrier's system for ensuring the coordination and continuity of care:

(A) For covered persons referred to specialty mental healthcare services or substance abuse services; and

(B) For covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning;

(9) The health carrier's process for enabling covered persons to change primary care professionals, if applicable;

(10) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers, or in the event of the health carrier's insolvency or other inability to continue operations. The description must explain how covered persons will be notified of the contract termination, or the health carrier's insolvency or other cessation of operations, and transitioned to other providers in a timely manner; and

(11) Any other information required by the commissioner to determine compliance with this part.

SECTION 2. The governor shall, acting through the commissioner of finance and administration, seek any waiver amendment to the TennCare II medicaid waiver that is

necessary to effectuate the purposes of this act. If a waiver amendment is necessary, then the governor shall, acting through the commissioner of finance and administration, submit the waiver to the federal centers for medicare and medicaid services on or before October 1, 2020.

SECTION 3. The headings to sections in this act are for reference purposes only and do not constitute a part of the law enacted by this act. However, the Tennessee Code Commission is requested to include the headings in any compilation or publication containing this act.

SECTION 4. For the purpose of promulgating rules, this act shall take effect upon becoming a law, the public welfare requiring it. For all other purposes, this act shall take effect January 1, 2021, the public welfare requiring it, and applies to health benefit plans issued, delivered, amended, or renewed on or after that date.