BILL ANALYSIS

H.B. 2647
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Human Services
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Many doctors and other health care providers have reported significant delays in reimbursement since the recent transition of the state's Medicaid program to managed care. Interested parties contend that, before the transition, doctor's claims were often paid within 10 days of submission. The parties assert that, currently, some managed care organizations take up to 25 or 30 days to process and reimburse even the simplest reimbursement claim, noting that this period can become significantly longer if an organization has questions or concerns about a claim.

Such significant delays in reimbursement create a heavy burden for Medicaid health care service providers, who sometimes must advance funds to pay for staff and overhead between the time when services are provided and when reimbursement is received. Concerned parties assert that Medicaid providers should not have to suffer this financial strain due to the unnecessarily delayed reimbursement. H.B. 2647 seeks to improve the delivery time in which health care providers under the Medicaid program are reimbursed for the services provided to Medicaid patients.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

H.B. 2647 amends the Government Code to shorten from not later than the 45th day to not later than the 15th day after the date a claim for payment is received by a managed care organization the deadline by which a contract between a managed care organization and the Health and Human Services Commission (HHSC) must require the organization to make payment to a physician or provider for health care services rendered to a recipient under a managed care plan and removes a provision authorizing such a payment to be made within a period, not to exceed 60 days, specified by a written agreement between the physician or provider and the managed care organization. The bill requires such a contract to include a requirement that the managed care organization allow a physician or provider to electronically submit the documentation necessary for the managed care organization to process such a claim, including additional documentation necessary when the claim is not submitted with documentation reasonably necessary for the managed care organization to process the claim. The bill requires the outpatient pharmacy benefit plan required to be developed, implemented, and maintained by a managed care organization to allow such electronic submission of claims documents.

H.B. 2647 requires HHSC, in a contract between HHSC and a managed care organization under the Medicaid managed care program that is entered into or renewed on or after the bill's effective date, to require that the managed care organization comply with the bill's provisions. The bill requires HHSC to seek to amend contracts entered into with managed care organizations before the bill's effective date to require that those managed care organizations comply with the bill's provisions and specifies that, to the extent of a conflict between a provision of such a contract

and the bill's provisions, the contract provision prevails.

EFFECTIVE DATE

September 1, 2013.