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S.B. No. 1207

A BILL TO BE ENTITLED

AN ACT

relating to the coordination of private health benefits with Medicaid benefits.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.038 to read as follows:

Sec. 533.038. COORDINATION OF BENEFITS. (a) In this section:

(1) "Medicaid managed care organization" means a managed care organization that contracts with the commission under this chapter to provide health care services to recipients.

(2) "Medicaid wrap-around benefit" means a Medicaid-covered service, including a pharmacy or medical benefit, that is provided to a recipient with both Medicaid and primary health benefit plan coverage when the recipient has exceeded the primary health benefit plan coverage limit or when the service is not covered by the primary health benefit plan issuer.

(b) The commission, in coordination with Medicaid managed care organizations, shall develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage.

(c) To further assist with the coordination of benefits, the

1 commission, in coordination with Medicaid managed care  
2 organizations, shall develop and maintain a list of services that  
3 are not traditionally covered by primary health benefit plan  
4 coverage that a Medicaid managed care organization may approve  
5 without having to coordinate with the primary health benefit plan  
6 issuer and that can be resolved through third-party liability  
7 resolution processes. The commission shall review and update the  
8 list quarterly.

9 (d) A Medicaid managed care organization that in good faith  
10 and following commission policies provides coverage for a Medicaid  
11 wrap-around benefit shall include the cost of providing the benefit  
12 in the organization's financial reports. The commission shall  
13 include the reported costs in computing capitation rates for the  
14 managed care organization.

15 (e) If the commission determines that a recipient's primary  
16 health benefit plan issuer should have been the primary payor of a  
17 claim, the Medicaid managed care organization that paid the claim  
18 shall work with the commission on the recovery process and make  
19 every attempt to reduce health care provider and recipient  
20 abrasion.

21 (f) The executive commissioner may seek a waiver from the  
22 federal government as needed to:

23 (1) address federal policies related to coordination  
24 of benefits and third-party liability; and

25 (2) maximize federal financial participation for  
26 recipients with both primary health benefit plan coverage and  
27 Medicaid coverage.

1        (g) Notwithstanding Sections 531.073 and 533.005(a)(23) or  
2 any other law, the commission shall ensure that a prescription drug  
3 that is covered under the Medicaid vendor drug program or other  
4 applicable formulary and is prescribed to a recipient with primary  
5 health benefit plan coverage is not subject to any prior  
6 authorization requirement if:

7            (1) the primary health benefit plan issuer will pay at  
8 least \$0.01 on the prescription drug claim; or

9            (2) the prescription drug is covered by the primary  
10 health benefit plan issuer but the primary health benefit plan  
11 issuer will pay nothing on the claim because the recipient has not  
12 met the deductible.

13        (h) Except as provided by Subsection (g)(2), a prescription  
14 drug prescribed to a recipient with primary health benefit plan  
15 coverage is subject to any applicable Medicaid clinical or  
16 nonpreferred prior authorization requirement if the primary health  
17 benefit plan issuer will pay nothing on the prescription drug  
18 claim.

19        (i) The commission may include in the Medicaid managed care  
20 eligibility files an indication of whether a recipient has primary  
21 health benefit plan coverage or is enrolled in a group health  
22 benefit plan for which the commission provides premium assistance  
23 under the health insurance premium payment program. For recipients  
24 with that coverage or for whom that premium assistance is provided,  
25 the files may include the following up-to-date, accurate  
26 information related to primary health benefit plan coverage to the  
27 extent the information is available to the commission:

1           (1) the health benefit plan issuer's name and address  
2 and the recipient's policy number;

3           (2) the primary health benefit plan coverage start and  
4 end dates; and

5           (3) the primary health benefit plan coverage benefits,  
6 limits, copayment, and coinsurance information.

7           (j) The commission shall maintain processes and policies to  
8 allow a health care provider who is primarily providing services to  
9 a recipient through primary health benefit plan coverage to receive  
10 Medicaid reimbursement for services ordered, referred, prescribed,  
11 or delivered, regardless of whether the provider is enrolled as a  
12 Medicaid provider. The commission shall allow a provider who is not  
13 enrolled as a Medicaid provider to order, refer, prescribe, or  
14 deliver services to a recipient based on the provider's national  
15 provider identifier number and may not require an additional state  
16 provider identifier number to receive reimbursement for the  
17 services. The commission may seek a waiver of Medicaid provider  
18 enrollment requirements for providers of recipients with primary  
19 health benefit plan coverage to implement this subsection.

20           (k) The commission shall develop and implement a clear and  
21 easy process to allow a recipient with complex medical needs who has  
22 established a relationship with a specialty provider in an area  
23 outside of the recipient's Medicaid managed care organization's  
24 service delivery area to continue receiving care from that  
25 provider. If a provider outside of the organization's service  
26 delivery area enters into a single-case agreement with the Medicaid  
27 managed care organization to continue providing that care, the

1 single-case agreement is not considered an out-of-network  
2 agreement.

3 (1) The commission shall develop and implement processes  
4 to:

5 (1) reimburse a recipient with primary health benefit  
6 plan coverage who pays a copayment or coinsurance amount out of  
7 pocket because the primary health benefit plan issuer refuses to  
8 enroll in Medicaid, enter into a single-case agreement, or bill the  
9 recipient's Medicaid managed care organization; and

10 (2) capture encounter data for the Medicaid  
11 wrap-around benefits provided by the Medicaid managed care  
12 organization under this subsection.

13 SECTION 2. If before implementing any provision of this Act  
14 a state agency determines that a waiver or authorization from a  
15 federal agency is necessary for implementation of that provision,  
16 the agency affected by the provision shall request the waiver or  
17 authorization and may delay implementing that provision until the  
18 waiver or authorization is granted.

19 SECTION 3. The Health and Human Services Commission is  
20 required to implement a provision of this Act only if the  
21 legislature appropriates money specifically for that purpose. If  
22 the legislature does not appropriate money specifically for that  
23 purpose, the commission may, but is not required to, implement a  
24 provision of this Act using other appropriations available for that  
25 purpose.

26 SECTION 4. This Act takes effect September 1, 2019.