By: Perry 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.

(g) Notwithstanding Sections 531.073 and 533.005(a)(23) or any other law, the commission shall ensure that a prescription drug that is covered under the Medicaid vendor drug program or other applicable formulary and is prescribed to a recipient with primary health benefit plan coverage is not subject to any prior authorization requirement if the primary health benefit plan issuer will pay at least $0.01 on the prescription drug claim. If the primary insurer will pay nothing on a prescription drug claim, the prescription drug is subject to any applicable Medicaid clinical or nonpreferred prior authorization requirement.

(h) The commission shall ensure that the daily Medicaid managed care eligibility files indicate whether a recipient has primary health benefit plan coverage or health insurance premium payment coverage. For a recipient who has that coverage, the files must include the following up-to-date, accurate information related to primary health benefit plan coverage:

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

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

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

(4) any additional information that would be useful to ensure the coordination of benefits.

(i) The commission shall develop and implement processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit

1 plan coverage to receive Medicaid reimbursement for services
2 ordered, referred, prescribed, or delivered, regardless of whether
3 the provider is enrolled as a Medicaid provider. The commission
4 shall allow a provider who is not enrolled as a Medicaid provider to
5 order, refer, prescribe, or deliver services to a recipient based
6 on the provider's national provider identifier number and may not
7 require an additional state provider identifier number to receive
8 reimbursement for the services. The commission may seek a waiver of
9 Medicaid provider enrollment requirements for providers of
10 recipients with primary health benefit plan coverage to implement
11 this subsection.
12 (j) The commission shall develop and implement a clear and
13 easy process to allow a recipient with complex medical needs who has
14 established a relationship with a specialty provider in an area
15 outside of the recipient's Medicaid managed care organization's
16 service delivery area to continue receiving care from that provider
17 if the provider will enter into a single-case agreement with the
18 Medicaid managed care organization. A single-case agreement with a
19 provider outside of the organization's service delivery area in
20 accordance with this subsection is not considered an
21 out-of-network agreement and must be included in the organization's
22 network adequacy determination.
23 (k) The commission shall develop and implement processes
24 to:
25 (1) reimburse a recipient with primary health benefit
26 plan coverage who pays a copayment or coinsurance amount out of
27 pocket because the primary health benefit plan issuer refuses to

1 enroll in Medicaid, enter into a single-case agreement, or bill the
2 recipient's Medicaid managed care organization; and
3 (2) capture encounter data for the Medicaid
4 wrap-around benefits provided by the Medicaid managed care
5 organization under this subsection.
6 SECTION 2. If before implementing any provision of this Act
7 a state agency determines that a waiver or authorization from a
8 federal agency is necessary for implementation of that provision,
9 the agency affected by the provision shall request the waiver or
10 authorization and may delay implementing that provision until the
11 waiver or authorization is granted.
12 SECTION 3. This Act takes effect September 1, 2019.