By: Perry S.B. No. 1207

(In the Senate - Filed February 27, 2019; March 7, 2019, read first time and referred to Committee on Health & Human Services; April 11, 2019, reported adversely, with favorable Committee Substitute by the following vote: Yeas 9, Nays 0; April 11, 2019, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Kolkhorst	X			
Perry	X			
Buckingham	X			
Campbell	X			
Flores	X			
Johnson	X			
Miles	X			
Powell	X			
Seliger	X			

COMMITTEE SUBSTITUTE FOR S.B. No. 1207 By: Perry

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

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

(e) If the commission determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, the Medicaid managed care organization that paid the claim

shall work with the commission on the recovery process and make every attempt to reduce health care provider and recipient abrasion.

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

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

(2) maximize federal financial participation for recipients with both primary health benefit plan coverage and 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:

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

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

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

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

(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; and

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

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

(k) The commission shall develop and implement a clear and easy process to allow a recipient with complex medical needs who has established a relationship with a specialty provider in an area outside of the recipient's Medicaid managed care organization's service delivery area to continue receiving care from that provider. If a provider outside of the organization's service delivery area enters into a single-case agreement with the Medicaid managed care organization to continue providing that care, the single-case agreement is not considered an out-of-network agreement.

(l) The commission shall develop and implement processes to:

(1) reimburse a recipient with primary health benefit

plan coverage who pays a copayment or coinsurance amount out of pocket because the primary health benefit plan issuer refuses to enroll in Medicaid, enter into a single-case agreement, or bill the recipient's Medicaid managed care organization; and

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

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

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

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

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