By: Parker H.B. No. 3677

A BILL TO BE ENTITLED

AN ACT

relating to the coordination of Medicaid and private health benefits for Medicaid recipients with complex medical needs.

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

SECTION 1. Section 533.038, Government Code, is amended by amending Subsections (a) and (g) and adding Subsection (h) to read as follows:

(a) In this section:[~~,~~]

(1) "Durable medical equipment" means equipment, services, and supplies, including repair and replacement parts for the equipment, that:

(A) is primarily and customarily used to serve a medical purpose as prescribed for medical necessity; and

(B) includes, but is not limited to, ventilators, infusion pumps, medical devices, prostheses, complex rehabilitation technology (CRT), and such other medical equipment, supplies, and services as prescribed by the treating provider.

(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.

(3) The guarantee of continuity of care is applicable

to all Medicaid recipients regardless of:

(A) whether the recipient is a Medicaid wrap-around beneficiary;

(B) primary health benefit plan coverage;

(C) date of enrollment of the recipient; or

(D) network status of the provider.

(D-1) In network specialty provider contract cancellation does not void the guarantee of continuity of care. The recipient retains the right to select their preferred specialty provider should contract cancellation occur.

(4) "Specialty provider" means a person who provides health-related goods or services to a recipient, including:

(A) a physician licensed under Subtitle B, Title 3, Occupations Code;

(B) an audiologist licensed under Chapter 401, Occupations Code;

(C) a chiropractor licensed under Chapter 201, Occupations Code;

(D) a dietitian licensed under Chapter 701, Occupations Code;

(E) an optometrist licensed under Chapter 351, Occupations Code;

(F) a podiatrist licensed under Chapter 202, Occupations Code;

(G) a pharmacist licensed under Subtitle J, Title 3, Occupations Code;

(H) a durable medical equipment provider; and

(I) any other provider of health-related goods, including medication, therapy, equipment, and services to a person with complex medical needs.

(g) The commission shall develop a clear and easy process, to be implemented through a contract, that allows a recipient with complex medical needs who has established a relationship at any time with a specialty provider to receive care, including equipment, supplies, and services necessary to provide that care, from that provider. A Medicaid managed care organization shall provide a recipient with access to that care from that specialty provider. A Medicaid managed care organization shall provide reimbursement to the specialty provider as described by 1 T.A.C. Section 353.4(e)(2) and (e)(3).

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. This Act takes effect September 1, 2021.