By: Perry S.B. No. 1648

(In the Senate - Filed March 11, 2021; March 24, 2021, read first time and referred to Committee on Health & Human Services; May 3, 2021, reported adversely, with favorable Committee Substitute by the following vote: Yeas 9, Nays 0; May 3, 2021, sent to printer.)

COMMITTEE VOTE

	Yea	Nay	Absent	PNV
Kolkhorst	X			
Perry	X			
Blanco	X			
Buckingham	X			
Campbell	X			
Hall	X			
Miles	X			
Powell	X			
Seliger	X			

COMMITTEE SUBSTITUTE FOR S.B. No. 1648 By: Miles

A BILL TO BE ENTITLED
AN ACT

relating to the provision of benefits to certain Medicaid recipients with complex medical needs.

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

SECTION 1. The heading to Section 533.038, Government Code, is amended to read as follows:

Sec. 533.038. COORDINATION OF BENEFITS; CONTINUITY OF SPECIALTY CARE FOR CERTAIN RECIPIENTS.

SECTION 2. Section 533.038, Government Code, is amended by amending Subsection (g) and adding Subsections (h) and (i) to read as follows:

(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 with a specialty provider to continue receiving care from that provider, regardless of whether the recipient has primary health benefit plan coverage in addition to Medicaid coverage.

(h) If a recipient who has complex medical needs and who does not have primary health benefit plan coverage wants to continue to receive care from a specialty provider that is not in the provider network of the Medicaid managed care organization offering the managed care plan in which the recipient is enrolled, the managed care organization shall negotiate a single-case agreement with the specialty provider. Until the Medicaid managed care organization and the specialty provider enter into the single-case agreement, the specialty provider shall be reimbursed in accordance with the applicable reimbursement methodology specified in commission rule, including 1 T.A.C. Chapter 355.

(i) A single-case agreement entered into under this section is not considered accessing an out-of-network provider for the purposes of Medicaid managed care organization network adequacy requirements.

SECTION 3. Section 531.0601(f), Government Code, is repealed.

SECTION 4. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money to the commission 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 that are available for that purpose.

SECTION 5. 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 6. This Act takes effect September 1, 2021.

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