BILL ANALYSIS

H.B. 3151
By: Hull
Human Services
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Federally qualified health centers (FQHCs), or community health centers, provide comprehensive primary care, including medical, behavioral health, dental, and pharmacy services, and are a vital part of our health care system, having served 1.8 million Texans in 2023, including over 600,000 Medicaid recipients, as reported by the Texas Association of Community Health Centers. The bill author has informed the committee that when a health center opens a new site or adds a new provider, the new clinic or provider is required to be credentialed with the numerous health plans in the applicable service area and that credentialing processes vary across health plans and can result in lengthy delays that can take months to resolve. Further, some health plans may require the provider to be credentialed before they will pay for services, which leaves FQHCs, which are nonprofits with limited resources that rely on timely reimbursements from payors, including Medicaid and commercial insurance, in order to sustain operations, to continue operations while waiting for payment. H.B. 3151 seeks to address this issue by including FQHCs among the providers eligible for expedited credentialing with respect to both Medicaid and commercial insurance.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

H.B. 3151 amends the Government Code to include a health care provider who is a member of one of the following that has a current contract with a Medicaid managed care organization (MCO) among the providers who may apply and qualify for expedited credentialing and payment by a Medicaid MCO for Medicaid reimbursement purposes upon meeting other statutory requirements:

- a federally qualified health center as defined by federal law; or
- an established medical group or professional practice that is designated by the U.S. Department of Health and Human Services Health Resources and Services Administration as a federally qualified health center.

H.B. 3151 amends the Insurance Code to require a health care provider to meet the following eligibility requirements to qualify for expedited credentialing and payment as a federally qualified health center provider:

- be licensed, certified, or otherwise authorized to provide health care services in Texas by, and be in good standing with, the applicable state board;

- submit all documentation and other information required by the managed care plan issuer to begin the credentialing process required for the issuer to include the health care provider in the plan's network; and
- agree to comply with the terms of the managed care plan's participating provider contract with the applicant's federally qualified health center.

H.B. 3151 requires a managed care plan issuer to take the following actions with respect to the credentialing process:

- not later than the fifth business day after an applicant submits the information required by the issuer to begin the process, confirm that the applicant's application is complete or request from the applicant any missing information required by the issuer;
- regardless of whether an applicant specifically requests expedited credentialing, use an expedited credentialing process for an applicant that has met the eligibility requirements under the bill;
- not later than the 10th business day after the receipt of an applicant's completed application, render a decision regarding the expedited credentialing of the applicant's application;
- after an applicant has submitted the information required by the issuer and for payment purposes only, treat the applicant as if the applicant is a participating provider in the plan's network when the applicant provides services to the plan's enrollees, including by:
    - authorizing the applicant's federally qualified health center to collect copayments from the enrollees for the applicant's services; and
    - making payments, including payments for in-network benefits for services provided by the applicant during the credentialing process, to the applicant's federally qualified health center for the applicant's services; and
- ensure that the issuer's claims processing system is able to process claims from an applicant not later than the 30th day after receipt of the applicant's completed application.

The bill authorizes a managed care plan issuer, pending the approval of a submitted application, to exclude the applicant from the plan's directory, website listing, or other listing of participating providers.

H.B. 3151 authorizes the following, if the managed care plan issuer determines on completion of the credentialing process that the applicant does not meet the issuer's credentialing requirements:

- the issuer may recover from the applicant or the applicant's federally qualified health center an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and
- the applicant or the applicant's federally qualified health center may retain any copayments collected or in the process of being collected as of the date of the issuer's determination.

The bill establishes that an enrollee is not responsible and must be held harmless for the difference between in-network copayments paid by the enrollee to a health care provider who is determined to be ineligible and the enrollee's managed care plan's charges for out-of-network services. The bill prohibits a health care provider and the health care provider's federally qualified health center from charging the enrollee for any portion of the health care provider's fee that is not paid or reimbursed by the plan. The bill establishes that a managed care plan issuer that complies with the bill's provisions is not subject to liability for damages arising out of or in connection with, directly or indirectly, the payment by the issuer of an applicant as if the applicant is a participating provider in the plan's network.

H.B. 3151 establishes that its provisions relating to the expedited credentialing process for federally qualified health center providers apply only to a health care provider who joins an established federally qualified health center that has a contract with a managed care plan and to a medical group or professional practice that has a contract with a managed care plan and becomes a federally qualified health center. The bill defines the following terms for purposes of these provisions:

- "applicant" as a health care provider applying for expedited credentialing under the bill's provisions;
- "enrollee" as an individual who is eligible to receive health care services under a managed care plan;
- "federally qualified health center" by reference to its meaning assigned by federal law;
- "health care provider" as an individual who is licensed, certified, or otherwise authorized to provide health care services in Texas;
- "managed care plan" by reference to statutory provisions relating to the expedited credentialing process for certain podiatrists;
- "medical group" as:
    - a single legal entity owned by two or more physicians;
    - a professional association composed of licensed physicians;
    - any other business entity composed of licensed physicians as permitted under Occupations Code provisions relating to the authority to form certain medical entities; or
    - two or more physicians on the medical staff of, or teaching at, a medical school, medical and dental unit, or teaching hospital, as defined or described by applicable Education Code provisions governing higher education;
- "participating provider" as a health care provider or health care entity that has contracted with a health benefit plan issuer to provide services to enrollees; and
- "professional practice" as a business entity that is owned by one or more health care providers.

If before implementing any provision of the bill 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 must request the waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

EFFECTIVE DATE

September 1, 2025.