By: Hull, et al. H.B. No. 3151

A BILL TO BE ENTITLED

AN ACT

relating to expedited credentialing of certain federally qualified health center providers by managed care plan issuers and Medicaid managed care organizations.

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

SECTION 1. Section 540.0656(d), Government Code, as effective April 1, 2025, is amended to read as follows:

(d) To qualify for expedited credentialing and payment under Subsection (e), an applicant provider must:

(1) be a member of one of the following that has a current contract with a Medicaid managed care organization:

(A) an established health care provider group;

(B) a federally qualified health center as defined by 42 U.S.C. Section 1396d(l)(2)(B); or

(C) an established medical group or professional practice that is designated by the United States Department of Health and Human Services Health Resources and Services Administration as a federally qualified health center [~~an established health care provider group that has a current contract with a Medicaid managed care organization~~];

(2) be a Medicaid-enrolled provider;

(3) agree to comply with the terms of the contract described by Subdivision (1); and

(4) submit all documentation and other information the

Medicaid managed care organization requires as necessary to enable the organization to begin the credentialing process the organization requires to include a provider in the organization's provider network.

SECTION 2. Chapter 1452, Insurance Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. EXPEDITED CREDENTIALING PROCESS FOR FEDERALLY QUALIFIED HEALTH CENTER PROVIDERS

Sec. 1452.251. DEFINITIONS. In this subchapter:

(1) "Applicant" means a health care provider applying for expedited credentialing under this subchapter.

(2) "Enrollee" means an individual who is eligible to receive health care services under a managed care plan.

(3) "Federally qualified health center" has the meaning assigned by 42 U.S.C. Section 1396d(l)(2)(B).

(4) "Health care provider" means an individual who is licensed, certified, or otherwise authorized to provide health care services in this state.

(5) "Managed care plan" has the meaning assigned by Section 1452.151.

(6) "Medical group" means:

(A) a single legal entity owned by two or more physicians;

(B) a professional association composed of licensed physicians;

(C) any other business entity composed of licensed physicians as permitted under Subchapter B, Chapter 162,

Occupations Code; or

(D) 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 Section 61.003, 61.501, or 74.601, Education Code.

(7) "Participating provider" means a health care provider or health care entity that has contracted with a health benefit plan issuer to provide services to enrollees.

(8) "Professional practice" means a business entity that is owned by one or more health care providers.

Sec. 1452.252. APPLICABILITY. This subchapter applies only to:

(1) a health care provider who joins an established federally qualified health center that has a contract with a managed care plan; or

(2) a medical group or professional practice that has a contract with a managed care plan and becomes a federally qualified health center.

Sec. 1452.253. ELIGIBILITY REQUIREMENTS. (a) To qualify for expedited credentialing under this subchapter and payment under Section 1452.255, a health care provider must:

(1) be licensed, certified, or otherwise authorized to provide health care services in this state by, and be in good standing with, the applicable state board;

(2) 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

(3) agree to comply with the terms of the managed care plan's participating provider contract with the applicant's federally qualified health center.

(b) Not later than the fifth business day after an applicant submits the information required under Subsection (a), the managed care plan issuer shall:

(1) confirm that the applicant's application is complete; or

(2) request from the applicant any missing information required by the managed care plan issuer.

(c) Regardless of whether an applicant specifically requests expedited credentialing, a managed care plan issuer shall use an expedited credentialing process for an applicant that has met the eligibility requirements under Subsection (a).

Sec. 1452.254. EXPEDITED CREDENTIALING DECISION. Not later than the 10th business day after the receipt of an applicant's completed application under Section 1452.253, a managed care plan issuer shall render a decision regarding the expedited credentialing of the applicant's application.

Sec. 1452.255. PAYMENT FOR SERVICES OF APPLICANT DURING CREDENTIALING PROCESS. (a) After an applicant has submitted the information required by the managed care plan issuer under Section 1452.253, the managed care plan issuer shall, 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:

(1) authorizing the applicant's federally qualified health center to collect copayments from the enrollees for the applicant's services; and

(2) 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.

(b) A managed care plan issuer must 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 under Section 1452.253.

Sec. 1452.256. DIRECTORY ENTRIES. Pending the approval of an application submitted under Section 1452.253, the managed care plan issuer may exclude the applicant from the plan's directory, Internet website listing, or other listing of participating providers.

Sec. 1452.257. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on completion of the credentialing process, the managed care plan issuer determines that the applicant does not meet the issuer's credentialing requirements:

(1) 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

(2) 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.

Sec. 1452.258. ENROLLEE HELD HARMLESS. An enrollee is not responsible and shall 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 under Section 1452.257 and the enrollee's managed care plan's charges for out-of-network services. The health care provider and the health care provider's federally qualified health center may not charge the enrollee for any portion of the health care provider's fee that is not paid or reimbursed by the plan.

Sec. 1452.259. LIMITATION ON MANAGED CARE PLAN ISSUER LIABILITY. A managed care plan issuer that complies with this subchapter 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.

SECTION 3. 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 4. This Act takes effect September 1, 2025.