

By: Spiller

H.B. No. 4585

A BILL TO BE ENTITLED

1 AN ACT
2 relating to the submission, payment, and audit of certain claims
3 for and utilization review of health services, including services
4 provided under the Medicaid managed care and child health plan
5 programs.

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

7 SECTION 1. The heading to Section 540.0265, Government
8 Code, as effective April 1, 2025, is amended to read as follows:

9 Sec. 540.0265. SUBMISSION AND ~~[PROMPT]~~ PAYMENT OF CLAIMS.

10 SECTION 2. Section 540.0265, Government Code, as effective
11 April 1, 2025, is amended by amending Subsection (a) and adding
12 Subsections (c), (d), (e), and (f) to read as follows:

13 (a) A contract to which this subchapter applies must require
14 the contracting Medicaid managed care organization to determine
15 whether a claim is payable and pay a physician or provider for
16 health care services provided to a recipient under a Medicaid
17 managed care plan on any clean claim for payment the organization
18 receives ~~[with documentation reasonably necessary for the~~
19 ~~organization to process the claim]~~:

20 (1) not later than:

21 (A) the 10th day after the date the organization
22 receives the claim if the claim relates to services a nursing
23 facility, intermediate care facility, or group home provided;

24 (B) the 30th day after the date the organization

1 receives the claim if the claim relates to the provision of
2 long-term services and supports not subject to Paragraph (A); and

3 (C) the 45th day after the date the organization
4 receives the claim if the claim is not subject to Paragraph (A) or
5 (B); or

6 (2) within a period, not to exceed 60 days, specified
7 by a written agreement between the physician or provider and the
8 organization.

9 (c) A contract to which this subchapter applies must require
10 a contracting Medicaid managed care organization to disclose to a
11 physician or provider:

12 (1) the address, including a physical address, where a
13 claim is sent for processing;

14 (2) the telephone number a physician or provider may
15 call regarding a question or concern about a claim;

16 (3) the name and physical address of any entity to
17 which the organization has delegated claim payment functions;

18 (4) the mailing address, physical address, and
19 telephone number of any separate claims processing center used to
20 process claims for specific services; and

21 (5) by providing written notice not later than the
22 61st day before the change, any change to an address, telephone
23 number, or entity described by Subdivisions (1)-(4).

24 (d) A contract to which this subchapter applies must specify
25 that the contracting Medicaid managed care organization:

26 (1) must allow a physician or provider to submit a
27 claim for payment during a period of not less than 95 days beginning

1 on the date the service for which the claim is made was provided;
2 and

3 (2) is subject to the applicable penalties prescribed
4 by Section 1301.137, Insurance Code, if the organization fails to
5 comply with the payment requirements of this section.

6 (e) For purposes of this section:

7 (1) a claim a physician or provider submits to a
8 Medicaid managed care organization is considered to be a clean
9 claim if the claim meets the requirements of Section 1301.131,
10 Insurance Code, and rules adopted under that section; and

11 (2) the organization is considered to be the insurer
12 and the physician or provider is considered to be the preferred
13 provider with respect to the application of a provision of Chapter
14 1301, Insurance Code, to the organization, physician, or provider.

15 (f) The provisions required under this section may not be
16 waived, modified, or voided under a contract to which this
17 subchapter applies or under a contract between a contracting
18 Medicaid managed care organization and a physician or provider,
19 except as provided by Subsection (a)(2).

20 SECTION 3. Subchapter F, Chapter 540, Government Code, as
21 effective April 1, 2025, is amended by adding Section 540.02651 to
22 read as follows:

23 Sec. 540.02651. AUDIT OF CLAIM; OVERPAYMENT RECOVERY. (a)
24 A contract to which this subchapter applies must require the
25 contracting Medicaid managed care organization to comply with
26 Sections 1301.105(b), (c), and (d), 1301.1051, and 1301.132,
27 Insurance Code.

1 (b) For purposes of this section, the contracting Medicaid
2 managed care organization is considered to be the insurer and the
3 physician or provider is considered to be the preferred provider
4 with respect to the application of a provision of Chapter 1301,
5 Insurance Code, to the organization, physician, or provider.

6 (c) The provisions required under this section may not be
7 waived, modified, or voided under a contract to which this
8 subchapter applies or under a contract between a contracting
9 Medicaid managed care organization and a physician or provider.

10 SECTION 4. Section 540.0267(a), Government Code, as
11 effective April 1, 2025, is amended to read as follows:

12 (a) A contract to which this subchapter applies must require
13 the contracting Medicaid managed care organization to develop,
14 implement, and maintain a system for tracking and resolving
15 provider appeals related to claims payment. The system must
16 include a process that requires:

17 (1) a tracking mechanism to document the status and
18 final disposition of each provider's claims payment appeal;

19 (2) contracting with physicians who are not network
20 providers and who are of the same or related specialty as the
21 appealing physician to resolve claims disputes that:

22 (A) relate to denial on the basis of medical
23 necessity; and

24 (B) remain unresolved after a provider appeal;

25 (3) contracting with an independent review
26 organization overseen by the commission to resolve claims disputes
27 in the manner provided by Subchapter I, Chapter 4201, Insurance

1 Code, that remain unresolved after an appeal under Subdivision (2),
2 if applicable;

3 (4) the determination of the independent review
4 organization [physician] resolving the dispute to be binding on the
5 organization and provider; and

6 (5) [~~4~~] the organization to allow a provider to
7 initiate an appeal of a claim that has not been paid before the time
8 prescribed by Section 540.0265(a)(1)(B).

9 SECTION 5. Subchapter B, Chapter 62, Health and Safety
10 Code, is amended by adding Section 62.0551 to read as follows:

11 Sec. 62.0551. REQUIRED CONTRACT PROVISIONS. (a) A
12 contract between the commission and a child health plan provider
13 under Section 62.155 must include the requirements specified by
14 Sections 540.0265, 540.02651, and 540.0267, Government Code.

15 (b) Sections 540.0265, 540.02651, and 540.0267, Government
16 Code, apply to a child health plan provider and health care provider
17 providing health care services under the child health plan in the
18 same manner and to the same extent those provisions apply to a
19 Medicaid managed care organization and a physician or provider
20 under the Medicaid program.

21 SECTION 6. Section 4201.251, Insurance Code, is amended to
22 read as follows:

23 Sec. 4201.251. DELEGATION OF UTILIZATION REVIEW. (a) A
24 utilization review agent may delegate utilization review to
25 qualified personnel in the hospital or other health care facility
26 in which the health care services to be reviewed were or are to be
27 provided. The delegation does not release the agent from the full

1 responsibility for compliance with this chapter or other applicable
2 law, including the conduct of those to whom utilization review has
3 been delegated.

4 (b) A utilization review agent may not delegate utilization
5 review to an artificial intelligence application or other similar
6 computer software.

7 SECTION 7. Section 4201.252(a), Insurance Code, is amended
8 to read as follows:

9 (a) Personnel employed by or under contract with a
10 utilization review agent to perform utilization review:

11 (1) must be appropriately trained and qualified and
12 meet the requirements of this chapter and other applicable law,
13 including applicable licensing requirements; and

14 (2) may not delegate utilization review to an
15 artificial intelligence application or other similar computer
16 software.

17 SECTION 8. (a) Sections 540.0265 and 540.0267, Government
18 Code, as amended by this Act, and Section 540.02651, Government
19 Code, as added by this Act, apply only to a contract between the
20 Health and Human Services Commission and a managed care
21 organization that is entered into or renewed on or after the
22 effective date of this Act.

23 (b) To the extent permitted by the terms of the contract,
24 the Health and Human Services Commission shall seek to amend a
25 contract entered into before the effective date of this Act with a
26 managed care organization to comply with Sections 540.0265 and
27 540.0267, Government Code, as amended by this Act, and Section

1 540.02651, Government Code, as added by this Act.

2 SECTION 9. (a) Section 62.0551, Health and Safety Code, as
3 added by this Act, applies only to a contract between the Health and
4 Human Services Commission and a child health plan provider under
5 Chapter 62, Health and Safety Code, that is entered into or renewed
6 on or after the effective date of this Act.

7 (b) To the extent permitted by the terms of the contract,
8 the Health and Human Services Commission shall seek to amend a
9 contract entered into before the effective date of this Act with a
10 child health plan provider to comply with Section 62.0551, Health
11 and Safety Code, as added by this Act.

12 SECTION 10. The changes to Chapter 4201, Insurance Code, as
13 amended by this Act, apply only to a health benefit plan delivered,
14 issued for delivery, or renewed on or after January 1, 2026. A
15 health benefit plan delivered, issued for delivery, or renewed
16 before January 1, 2026, is governed by the law as it existed
17 immediately before the effective date of this Act, and that law is
18 continued in effect for that purpose.

19 SECTION 11. If before implementing any provision of this
20 Act a state agency determines that a waiver or authorization from a
21 federal agency is necessary for implementation of that provision,
22 the agency affected by the provision shall request the waiver or
23 authorization and may delay implementing that provision until the
24 waiver or authorization is granted.

25 SECTION 12. This Act takes effect September 1, 2025.