

By: Cook

S.B. No. 2093

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(1)(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

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

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

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

9 Sec. 1452.251. DEFINITIONS. In this subchapter:

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

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

14 (3) "Federally qualified health center" has the
15 meaning assigned by 42 U.S.C. Section 1396d(1)(2)(B).

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

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

21 (6) "Medical group" means:

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

24 (B) a professional association composed of
25 licensed physicians;

26 (C) any other business entity composed of
27 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

1 in the plan's network; and

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

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

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

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

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

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

21 Sec. 1452.255. PAYMENT FOR SERVICES OF APPLICANT DURING
22 CREDENTIALING PROCESS. (a) After an applicant has submitted the
23 information required by the managed care plan issuer under Section
24 1452.253, the managed care plan issuer shall, for payment purposes
25 only, treat the applicant as if the applicant is a participating
26 provider in the plan's network when the applicant provides services
27 to the plan's enrollees, including by:

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

4 (2) making payments, including payments for
5 in-network benefits for services provided by the applicant during
6 the credentialing process, to the applicant's federally qualified
7 health center for the applicant's services.

8 (b) A managed care plan issuer must ensure that the issuer's
9 claims processing system is able to process claims from an
10 applicant not later than the 30th day after receipt of the
11 applicant's completed application under Section 1452.253.

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

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

21 (1) the issuer may recover from the applicant or the
22 applicant's federally qualified health center an amount equal to
23 the difference between payments for in-network benefits and
24 out-of-network benefits; and

25 (2) the applicant or the applicant's federally
26 qualified health center may retain any copayments collected or in
27 the process of being collected as of the date of the issuer's

1 determination.

2 Sec. 1452.258. ENROLLEE HELD HARMLESS. An enrollee is not
3 responsible and shall be held harmless for the difference between
4 in-network copayments paid by the enrollee to a health care
5 provider who is determined to be ineligible under Section 1452.257
6 and the enrollee's managed care plan's charges for out-of-network
7 services. The health care provider and the health care provider's
8 federally qualified health center may not charge the enrollee for
9 any portion of the health care provider's fee that is not paid or
10 reimbursed by the plan.

11 Sec. 1452.259. LIMITATION ON MANAGED CARE PLAN ISSUER
12 LIABILITY. A managed care plan issuer that complies with this
13 subchapter is not subject to liability for damages arising out of or
14 in connection with, directly or indirectly, the payment by the
15 issuer of an applicant as if the applicant is a participating
16 provider in the plan's network.

17 SECTION 3. If before implementing any provision of this Act
18 a state agency determines that a waiver or authorization from a
19 federal agency is necessary for implementation of that provision,
20 the agency affected by the provision shall request the waiver or
21 authorization and may delay implementing that provision until the
22 waiver or authorization is granted.

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