

## **BILL ANALYSIS**

Senate Research Center  
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S.B. 1207  
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Health & Human Services  
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### **AUTHOR'S / SPONSOR'S STATEMENT OF INTENT**

Many children enrolled in the Medically Dependent Child Program (MDCP) are also covered by commercial primary insurance or another primary insurance, meaning the Medicaid managed care program provides secondary coverage. In these situations, Medicaid is always the payer of last resort.

Before a managed care organization (MCO) will act on a claim or an authorization, it must first be acted upon by the commercial primary if there is one. This can create significant delay between the determination on the part of the primary, notification to the provider, re-submittal by the provider to the MCO, and the time the MCO processes the claim. Many times these authorizations are time-sensitive, and children have had major surgeries cancelled, critical medications denied, and medically necessary services or equipment significantly delayed, resulting in the child's condition deteriorating and causing further complications or increased ER visits.

S.B. 1207 will put in place parameters and framework to remove some of the barriers that are causing delays, conflicts, and lack of coordination, and will require the agency and managed care organizations to implement policies and procedures that will (1) allow maximum utilization of commercial insurance coverage, thus increasing cost-effectiveness; and (2) reduce unnecessary delays and conflicts in processing the child's Medicaid claims under the managed care program.

As proposed, S.B. 1207 amends current law relating to the coordination of private health benefits with Medicaid benefits.

### **RULEMAKING AUTHORITY**

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

### **SECTION BY SECTION ANALYSIS**

SECTION 1. Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.038, as follows:

Sec. 533.038. COORDINATION OF BENEFITS. (a) Defines "medicaid managed care organization" and "medicaid wrap-around benefit."

(b) Requires the Health and Human Services Commission (HHSC), in coordination with Medicaid managed care organizations, to develop and adopt a clear policy for a Medicaid managed care organization to ensure the coordination and timely delivery of Medicaid wrap-around benefits for recipients with both primary health benefit plan coverage and Medicaid coverage.

(c) Requires HHSC, in coordination with Medicaid managed care organizations, to further assist with the coordination of benefits, to develop and maintain a list of services that are not traditionally covered by primary health benefit plan coverage that a Medicaid managed care organization is authorized to approve without having to coordinate with the primary health benefit plan issuer and that can be

resolved through third-party liability resolution processes. Requires HHSC to review and update the list quarterly.

(d) Requires a Medicaid managed care organization that in good faith and following HHSC policies provides coverage for a Medicaid wrap-around benefit to include the cost of providing the benefit in the organization's financial reports. Requires HHSC to include the reported costs in computing capitation rates for the managed care organization.

(e) Requires the Medicaid managed care organization that paid the claim, if HHSC determines that a recipient's primary health benefit plan issuer should have been the primary payor of a claim, to work with HHSC on the recovery process and make every attempt to reduce health care provider and recipient abrasion.

(f) Authorizes the executive commissioner of HHSC to seek a waiver from the federal government as needed to address federal policies related to coordination of benefits and third-party liability and to maximize federal financial participation for recipients with both primary health benefit plan coverage and Medicaid coverage.

(g) Requires HHSC, notwithstanding Sections 531.073 (Prior Authorization for Certain Prescription Drugs) and 533.005(a)(23) (relating to a managed care organization's development of pharmacy benefit plans) or any other law, to ensure that a prescription drug that is covered under the Medicaid vendor drug program or other applicable formulary and is prescribed to a recipient with primary health benefit plan coverage is not subject to any prior authorization requirement if the primary health benefit plan issuer will pay at least \$0.01 on the prescription drug claim. Provides that if the primary insurer will pay nothing on a prescription drug claim, the prescription drug is subject to any applicable Medicaid clinical or nonpreferred prior authorization requirement.

(h) Requires HHSC to ensure that the daily Medicaid managed care eligibility files indicate whether a recipient has primary health benefit plan coverage or health insurance premium payment coverage. Requires the files for a recipient who has that coverage to include the following up-to-date, accurate information related to primary health benefit plan coverage:

- (1) the health benefit plan issuer's name and address and the recipient's policy number;
- (2) the primary health benefit plan coverage start and end dates;
- (3) the primary health benefit plan coverage benefits, limits, copayment, and coinsurance information; and
- (4) any additional information that would be useful to ensure the coordination of benefits.

(i) Requires HHSC to develop and implement processes and policies to allow a health care provider who is primarily providing services to a recipient through primary health benefit plan coverage to receive Medicaid reimbursement for services ordered, referred, prescribed, or delivered, regardless of whether the provider is enrolled as a Medicaid provider. Requires HHSC to allow a provider who is not enrolled as a Medicaid provider to order, refer, prescribe, or deliver services to a recipient based on the provider's national provider identifier number and prohibits HHSC from requiring an additional state provider identifier number to receive reimbursement for the services. Authorizes HHSC to seek a waiver of Medicaid provider enrollment requirements for providers of recipients with primary health benefit plan coverage to implement this subsection.

(j) Requires HHSC to develop and implement a clear and easy process to allow a recipient with complex medical needs who has established a relationship with a specialty provider in an area outside of the recipient's Medicaid managed care organization's service delivery area to continue receiving care from that provider if the provider will enter into a single-case agreement with the Medicaid managed care organization. Provides that a single-case agreement with a provider outside of the organization's service delivery area in accordance with this subsection is not considered an out-of-network agreement and is required to be included in the organization's network adequacy determination.

(k) Requires HHSC to develop and implement processes to:

(1) reimburse a recipient with primary health benefit plan coverage who pays a copayment or coinsurance amount out of pocket because the primary health benefit plan issuer refuses to enroll in Medicaid, enter into a single-case agreement, or bill the recipient's Medicaid managed care organization; and

(2) capture encounter data for the Medicaid wrap-around benefits provided by the Medicaid managed care organization under this subsection.

SECTION 2. Requires a state agency affected by the provision, if before implementing any provision of this Act the agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, to request a waiver or authorization and authorizes the agency to delay implementing that provision until the waiver or authorization is granted.

SECTION 3. Effective date: September 1, 2019.