

BILL ANALYSIS

Senate Research Center
86R23981 LED-D

C.S.S.B. 1140
By: Watson
Health & Human Services
4/10/2019
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 1140 creates an independent external medical review for denials of service to determine medical necessity, just as is already done for commercial insurance. Currently, when a medical service is denied by a managed care organization (MCO), the patient must appeal within the insurance company. If that is unsuccessful, the next step is to appeal to the Health and Human Services Commission (HHSC) to determine not whether the service is medically necessary, but whether the policy followed by the MCO resulting in the denial is proper. There is therefore no independent party considering whether the service is medically necessary.

S.B. 1140 provides that independent review in the same manner as is done for those with commercial insurance. Under the bill, a patient will have the right to have an independent clinical expert in the relevant area of medicine as the disputed service determine whether that service is medically necessary following the internal appeal by the MCO. If successful, the patient will then be entitled to that service. If not, the patient can proceed to the fair hearing process before HHSC that is already in place. (Original Author's/Sponsor's Statement of Intent)

C.S.S.B. 1140 amends current law relating to an independent medical review of certain determinations by the Health and Human Services Commission or a Medicaid managed care organization.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 2 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter A, Chapter 533, by adding Section 533.00715, as follows:

Sec. 533.00715. INDEPENDENT APPEALS PROCEDURE. (a) Defines "third-party arbiter."

(b) Requires the Health and Human Services Commission (HHSC), using money appropriated for the purpose, to contract with at least three independent, third-party arbiters to resolve recipient appeals of any HHSC or a Medicaid managed care organization adverse benefit determination or reduction in or denial of health care services on the basis of medical necessity.

(c) Requires HHSC to establish a common procedure for appeals. Requires the procedures to provide that a health care service ordered by a health care provider is presumed medically necessary and HHSC or the Medicaid managed care organization bears the burden of proof to show the health care service is not medically necessary. Requires HHSC to also establish a procedure for expedited appeals that allows a third-party arbiter to identify an appeal that requires an expedited resolution and resolve the appeal within a specified period.

(d) Requires HHSC, subject to Subsection (e), to ensure an appeal is randomly assigned to a third-party arbiter.

(e) Requires HHSC to ensure each third-party arbiter has the necessary medical expertise to resolve an appeal.

(f) Requires a third-party arbiter to establish and maintain an Internet portal through which a recipient is authorized to track the status and final disposition of an appeal.

(g) Requires a third-party arbiter to educate recipients regarding:

(1) appeals processes and options,

(2) proper and improper denials of health care services on the basis of medical necessity; and

(3) information available through HHSC's office of the ombudsman.

(h) Authorizes a third-party arbiter to share with Medicaid managed care organizations information regarding:

(1) appeals processes; and

(2) the types of documents the arbiter may require from the organization to resolve appeals.

(i) Requires a third-party arbiter to notify HHSC of the final disposition of each appeal. Requires HHSC to review aggregate denial data categorized by Medicaid managed care plan to identify trends and determine whether a Medicaid managed care organization is disproportionately denying prior authorization requests from a single provider or set of providers.

SECTION 2. Requires the executive commissioner of HHSC, as soon as practicable after the effective date of this Act, to adopt the rules necessary to implement this Act.

SECTION 3. Requires a state agency affected by any provision of this Act, if before implementing the provision the agency determines that a waiver or authorization from a federal agency is necessary for implementation of that provision, to request the waiver or authorization and authorizes the agency to delay implementing that provision until the waiver or authorization is granted.

SECTION 4. Effective date: September 1, 2019.