

BILL ANALYSIS

S.B. 1140
By: Watson
Human Services
Committee Report (Unamended)

BACKGROUND AND PURPOSE

It has been suggested that the state should provide for an independent medical review of certain determinations by the Health and Human Services Commission or a Medicaid managed care organization regarding medical necessity, similar to what is done for commercial insurance. S.B. 1140 seeks to establish such an independent appeals procedure.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 2 of this bill.

ANALYSIS

S.B. 1140 amends the Government Code to require the Health and Human Services Commission (HHSC), using money appropriated for that purpose, to contract with at least three independent, third-party arbiters to resolve an appeal of the following:

- a Medicaid managed care organization (MCO) adverse benefit determination made on the basis of medical necessity;
- a denial by HHSC of eligibility for a Medicaid program on the basis of the recipient's or applicant's medical and functional needs; and
- an action by HHSC based on a recipient's medical and functional needs to terminate, suspend, or reduce the recipient's covered benefits or services or to terminate, suspend, or reduce the recipient's Medicaid eligibility or increase the recipient's beneficiary liability.

The bill sets out a timeline for when such an appeal occurs and is granted and requires the arbiter to conduct the appeal within a period specified by HHSC. The bill requires HHSC to establish a common procedure for appeals that provides that a health care service ordered by a health care provider is presumed medically necessary and that HHSC or the Medicaid MCO bears the burden of proof to show the health care service is not medically necessary.

S.B. 1140 requires HHSC to 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. The bill requires HHSC to ensure an appeal is randomly assigned to a third-party arbiter and ensure each arbiter has the necessary medical expertise to resolve an appeal. The bill requires a third-party arbiter to do the following:

- establish and maintain an Internet portal through which a Medicaid recipient may track the status and final disposition of an appeal;

- educate Medicaid recipients regarding appeals processes and options, proper and improper denials of health care services on the basis of medical necessity, and information available through the office of the ombudsman for HHSC; and
- notify HHSC of the final disposition of each appeal.

S.B. 1140 requires HHSC to review aggregate denial data categorized by Medicaid managed care plan to identify trends and determine whether a Medicaid MCO is disproportionately denying prior authorization requests from a single provider or set of providers. The bill authorizes a third-party arbiter to share with Medicaid MCOs information regarding appeals processes and the types of documents the arbiter may require from the MCO to resolve appeals.

S.B. 1140 requires the executive commissioner of HHSC to adopt the rules necessary to implement the bill's provisions.

EFFECTIVE DATE

September 1, 2019.