By: Rodríguez S.B. No. 1419

A BILL TO BE ENTITLED

AN ACT

relating to the establishment of the independent provider health plan monitor for certain appeals in the Medicaid managed care program.

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

SECTION 1. Chapter 533, Government Code, is amended by adding Subchapter F to read as follows:

SUBCHAPTER F. INDEPENDENT PROVIDER HEALTH PLAN MONITOR

Sec. 533.301. DEFINITION. In this subchapter, "monitor" means the person serving as the independent provider health plan monitor under this subchapter.

Sec. 533.302. ESTABLISHMENT. (a) The commission shall establish the position of independent provider health plan monitor within the commission.

(b) The independent provider health plan monitor shall create an independent review process that utilizes the standards of the Independent Review Organization process under Section 4202.002, Texas Insurance Code.

Sec. 533.303. REVIEW OF CORRECTIVE ACTIONS. (a) A health care provider in the managed care organization's provider network may petition the monitor in the form and manner provided by commission rule to review a corrective action taken by a managed care organization that is not agreed to by the provider in connection with, but not limited to, pre-authorization denials,

reimbursement, standard of care, a claim payment denial, disagreement about medical or treatment necessity, or compliance with commission rules and contractual terms.

(b) The monitor shall review a case submitted under Subsection (a) and issue a decision in accordance with this subchapter.

Sec. 533.304. PROCEDURES. (a) The monitor shall:

(1) provide written notice of the submission of a petition under Section 533.303 to the party opposing the party that submitted the petition; and

(2) allow the opposing party to submit evidence to the monitor not later than the:

(A) 10th day after the monitor provided the notice for petitions involving pre-authorizations, or medical or treatment necessity denials, or

(B) 30th day after the date the monitor provided the notice for all other petitions.

(b) Not later than the 30th day after the deadline for the submission of evidence under Subsection (a), the monitor shall provide written notice to the parties of the monitor's decision for the case.

(c) While the review process or an appeal by either a provider or the managed care organization is ongoing, the managed care organization shall not recoup any funds or otherwise penalize a provider.

(d) In reaching a decision under Subsection (b), the monitor shall conduct interviews with all relevant parties and review any submitted documentation and other evidence to determine whether:

(1) the managed care organization complied with:

(A) applicable commission rules; and

(B) the organization's internal policies and procedures for auditing or taking a corrective action against a health care provider; and

(2) the health care provider:

(A) complied with applicable commission rules;

(B) submitted required documentation in accordance with the law; and

(C) engaged with a recipient.

(e) The decision made by the monitor shall be binding unless appealed by the provider or the managed care organization.

(f) An adverse decision against a managed care organization shall be registered as a verified complaint within the commission's system and shall be subject to any appropriate penalties by the commission.

(g) An adverse decision against a managed care organization shall be subject to the prompt payment penalty from the beginning date of the late payment.

Sec. 533.305. APPEAL. A managed care organization or health care provider may appeal the monitor's decision under Section 533.304 to the State Office of Administrative Hearings.

Sec. 533.306. REPORT. The monitor shall compile and provide an annual report to the commission on:

(1) the number of corrective actions reviewed by the monitor for which petitions were submitted by a health care provider;

(2) the number of corrective actions reviewed by the monitor for which petitions were submitted by a managed care organization;

(3) the number of corrective actions overturned by the monitor;

(4) the number of corrective actions upheld by the monitor;

(5) the reasons for submissions by health care providers of petitions to the monitor;

(6) the amount of money managed care organizations recovered in corrective actions upheld by the monitor; and

(7) the amount of money reimbursed to health care providers through corrective actions overturned by the monitor.

SECTION 2. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement Subchapter F, Chapter 533, Government Code, as added by this Act, and the commission shall establish the position of independent provider health plan monitor under that subchapter.

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

waiver or authorization is granted.

SECTION 4. This Act takes effect September 1, 2019.