BILL ANALYSIS

C.S.H.B. 5018
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The Centers for Medicare and Medicaid Services has proposed codifying guidance regarding the effect of prior authorization or pre-service approval. Under this guidance, if the managed care organization (MCO) approved the furnishing of a covered item or service through a prior authorization or pre-service determination of coverage or payment, it may not deny coverage later on the basis of lack of medical necessity unless the MCO has the authority to reopen the decision for good cause, fraud, or similar fault. However, some MCOs are waiving authorization for access to care issues where the treating physician or clinician has already deemed medical necessity. The prior authorization process under current law is overly burdensome and delays access to critical care and the audits by managed care organizations denying reimbursement has a large negative cash effect on the businesses. C.S.H.B. 5018 seeks to address this issue by revising provisions regarding the prior authorization process.

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

ANALYSIS

C.S.H.B. 5018 amends the Government Code to revise the providers to which a Medicaid managed care organization (MCO) or an applicable contracting entity must provide notice under rules adopted by the executive commissioner of the Health and Human Services Commission regarding due process procedures in payment recovery efforts as follows:

- expands the providers to which the MCO must provide the notice, from a provider required to use electronic visit verification of the MCO's intent to recoup overpayments, to any provider;
- clarifies that the 60 days that the rules must require the MCO to provide a provider to cure any defect in a claim before the MCO may begin any efforts to collect overpayment is at least 60 days after the provider has exhausted all rights to an appeal; and
- establishes submitting necessary documentation for a claim or resubmitting the claim is included in such rights to an appeal for the purposes of curing any defect in a claim.

The bill prohibits an MCO or an entity with which the MCO contracts that engages in payment recovery efforts, in conducting an audit or other review of a claim for which the MCO granted prior authorization, from reviewing the medical necessity determination or an error in the claim documentation, if the error was not made by the provider.

C.S.H.B. 5018 provides for the delayed implementation of any provision for which an applicable state agency determines a federal waiver or authorization is necessary for implementation until the waiver or authorization is requested and granted.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 5018 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute includes a prohibition that did not appear in the introduced against an MCO or an entity with which the MCO contracts that engages in payment recovery efforts, in conducting an audit or other review of a claim for which the MCO granted prior authorization, from reviewing the medical necessity determination or an error in the claim documentation if the error as not made by the provider.