

BILL ANALYSIS

Senate Research Center

S.B. 1991
By: Buckingham
Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Electronic Visit Verification (EVV) is a computer-based system that electronically verifies the occurrence of authorized personal attendant service visits by electronically documenting the precise time a service delivery visit begins and ends. The EVV program was implemented to replace paper-based attendant timesheets.

Texas requires EVV for certain Medicaid-funded home and community-based services provided through the Health and Human Services Commission and health plans. The purpose behind the EVV mandate is to ensure that patients are getting the care they require and that Medicaid is being accurately billed. However, interested parties have raised concerns that the program's current rules are overly burdensome on providers.

S.B. 1991 further refines the EVV system to ensure that providers and the state have the flexibility to implement systems that will comply with the requirements of the Federal Cures Act, while also reducing administrative burdens. (Original Author's/Sponsor's Statement of Intent)

S.B. 1991 amends current law relating to claims processes and reimbursement for, and overpayment recoupment processes imposed on, health care providers under Medicaid.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commissioner; HHSC) or HHSC in SECTION 1 (Section 531.024172, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner in SECTION 3 (Section 531.1135, Government Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTION 2 (Section 531.1131, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.024172, Government Code, by amending Subsection (g) and adding Subsections (g-1) and (g-2), as follows:

(g) Authorizes the Health and Human Services Commission (HHSC) to recognize a health care provider's proprietary electronic visit verification system, whether purchased or developed by the provider, as complying with this section (Electronic Visit Verification System) and allow the health care provider to use that system for a period determined by HHSC if HHSC determines that the system, rather than authorizing HHSC to recognize a health care provider's proprietary electronic visit verification system as complying with this section and allow the health care provider to use that system for a period determined by HHSC if HHSC determines that the system:

(1)–(2) makes nonsubstantive changes to these subdivisions; and

(3) deletes this subdivision and existing text authorizing HHSC to recognize a health care provider's proprietary electronic visit verification system as complying with this section and allow the health care provider to use that system for a period determined by HHSC if HHSC determines that the system has been in use by the health care provider since at least June 1, 2014.

(g-1) Requires the executive commissioner of HHSC (executive commissioner), if feasible, to ensure a health care provider that uses the provider's proprietary electronic visit verification system recognized under Subsection (g) is reimbursed for the use of that system.

(g-2) Requires HHSC or the executive commissioner, as appropriate, for purposes of facilitating the use of proprietary electronic visit verification systems by health care providers under Subsection (g) and in consultation with industry stakeholders and the work group established under Subsection (h) (relating to requiring HHSC to create a work group to provide input on the electronic visit verification system), to:

(1) develop an open model system that mitigates the administrative burdens identified by providers required to use electronic visit verification;

(2) allow providers to use emerging technologies, including Internet-based, mobile telephone-based, and global positioning-based technologies, in the providers' proprietary electronic visit verification systems; and

(3) adopt rules governing data submission and provider reimbursement.

SECTION 2. Amends Section 531.1131, Government Code, by adding Subsection (f), as follows:

(f) Requires the executive commissioner, in adopting rules establishing due process procedures under Subsection (e) (relating to requiring the executive commissioner to adopt rules to implement this section (Fraud and Abuse Recovery by Certain Persons; Retention of Recovered Amounts) including rules establishing due process procedures that are required to be followed by managed care organizations in certain conditions), to require that a managed care organization or an entity with which the managed care organization contracts under Section 531.113(a)(2) (relating to requiring each managed care organization that provides or arranges services under a government-funded program to contract with another entity for the investigation of fraudulent claims and other types of program abuse by recipients and service providers) that engages in payment recovery efforts in accordance with this section and Section 531.1135 provide:

(1) written notice to a provider required to use electronic visit verification of the organization's intent to recoup overpayments in accordance with Section 531.1135; and

(2) a provider described by Subdivision (1) at least 60 days to cure any defect in a claim before the organization is authorized to begin any efforts to collect overpayments.

SECTION 3. Amends Subchapter C, Chapter 531, Government Code, by adding Section 531.1135, as follows:

Sec. 531.1135. MANAGED CARE ORGANIZATIONS: PROCESS TO RECOUP CERTAIN OVERPAYMENTS. (a) Requires the executive commissioner to adopt rules that standardize the process by which a managed care organization collects alleged overpayments that are made to a health care provider and discovered through an audit or investigation conducted by the organization secondary to missing electronic visit verification information. Requires the executive commissioner, in adopting rules under this section, to require that the managed care organization provide written notice of the

organization's intent to recoup overpayments not later than the 30th day after the date an audit is complete and limit the duration of audits to 24 months.

(b) Requires the executive commissioner to require that the notice required under this section inform the provider of certain information.

(c) Prohibits a managed care organization, notwithstanding any other law, from attempting to recover an overpayment described by Subsection (a) until the provider has exhausted all rights to an appeal.

SECTION 4. (a) Requires HHSC, as soon as practicable after the effective date of this Act, to conduct a study to evaluate the impacts and effectiveness of using the Medicare education adjustment factor assigned under 42 C.F.R. Section 412.105 in effect on the effective date of this Act to calculate the medical education add-on used to reimburse teaching hospitals for the provision of inpatient hospital care under Medicaid. Requires HHSC to develop and make recommendations on alternative factors and methodologies for calculating and annually updating the medical education add-on that:

(1) best recognize the higher costs incurred by teaching hospitals; and

(2) mitigate issues identified with using the Medicare education adjustment factor without reducing reimbursements to urban teaching hospitals that have maintained or increased the number of interns and residents enrolled in the hospitals' approved teaching programs.

(b) Requires HHSC, not later than December 1, 2020, to report its findings and recommendations under Subsection (a) of this section to the governor, the standing committees of the senate and the house of representatives having primary jurisdiction over matters relating to state finance and appropriations from the state treasury, the standing committees of the senate and house of representatives having primary jurisdiction over Medicaid, and the Legislative Budget Board.

SECTION 5. Requires HHSC to implement a provision of this Act only if the legislature appropriates money to the commission specifically for that purpose. Authorizes, but does not require, HHSC, if the legislature does not appropriate money specifically for that purpose, to implement a provision of this Act using other appropriations that are available for that purpose.

SECTION 6. Requires a state agency affected by a provision of this Act to request a waiver or authorization from a federal agency if the state agency determines that such a waiver or authorization is necessary for implementation of the provision, and authorizes the agency to delay implementation until such a waiver or authorization is granted.

SECTION 7. Effective date: September 1, 2019.