BILL ANALYSIS

Senate Research Center
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S.B. 1991
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Health & Human Services
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As Filed

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.

As proposed, S.B. 1991 amends current law relating to claims and overpayment recoupment processes imposed on health care providers under Medicaid and other public benefits programs.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission 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 Subsection (g-1), 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 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 substantive changes to these subdivisions.
> >
> > (3) deletes this subdivision 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 been in use by the health care provider since at least June 1, 2014.

(g-1) Requires HHSC or a managed care organization to reimburse a health care provider providing services to a Medicaid recipient at the same reimbursement rate for the same service regardless of whether the provider uses the electronic visit verification system implemented under Subsection (b) (relating to requiring HHSC to implement an electronic verification system for certain services) or the provider's own proprietary electronic visit verification system under Subsection (g).

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

(f) Requires the executive commissioner of HHSC (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 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 provide:

(1) written notice to a provider of the organization's intent to recoup overpayments; and

(2) a provider described by Subdivision (1) at least 60 days to cure any defect in a claim before the organization may 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. 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 a provision of this Act, and authorizes the agency to delay implementation until such a waiver or authorization is granted.

SECTION 5. Effective date: September 1, 2019.