BILL ANALYSIS

C.S.S.B. 894
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Concerns have been raised regarding deficiencies that exist within the Medicaid process and the Health and Human Services Commission's (HHSC) audit coverage of Medicaid managed care organizations. Interested parties contend that information gathered to appropriately monitor a managed care organization or to address any of the major issues identified in the audit findings of the organization is not being effectively used. C.S.S.B. 894 seeks to address these concerns by providing for an electronic visit verification system relating to the provision of certain services to Medicaid recipients and by requiring HHSC to implement a strategy for improving overall management of audit resources used to verify the accuracy of program and financial information reported by Medicaid managed care organizations.

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 1 of this bill.

ANALYSIS

C.S.S.B. 894 amends the Government Code to remove the requirement that the Health and Human Services Commission (HHSC), if it is cost-effective and feasible, implement an electronic visit verification system to electronically verify and document, through a telephone or computer-based system, basic information relating to the delivery of Medicaid acute nursing services. The bill instead requires HHSC, in accordance with federal law, to implement an electronic visit verification system to electronically verify through a telephone, global positioning, or computer-based system that personal care services or attendant care services provided to Medicaid recipients are provided to recipients in accordance with a prior authorization or plan of care. The bill requires the electronic visit verification system to allow verification of only specified information relating to the delivery of Medicaid services. The bill requires HHSC to establish minimum requirements for third-party entities seeking to provide electronic visit verification system services to health care providers providing Medicaid services and to certify that a third-party entity complies with those minimum requirements before the entity may provide electronic visit verification system services to a health care provider. The bill requires HHSC to inform each Medicaid recipient who receives personal care services or attendant care services that the health care provider providing the services and the recipient are each required to comply with the electronic visit verification system. The bill requires a managed care organization that contracts with HHSC to provide health care services to Medicaid recipients who receive personal care services or attendant care services to also inform recipients enrolled in a managed care plan offered by the organization of those requirements.

C.S.S.B. 894 requires the executive commissioner of HHSC, in implementing the electronic visit verification system, to adopt compliance standards for health care providers. The bill requires HHSC, in implementing the system, to ensure that the information required to be reported by health care providers is standardized across managed care organizations that contract with HHSC to provide health care services to Medicaid recipients and across HHSC programs and to ensure that time frames for the maintenance of electronic visit verification data by health care providers align with claims payment time frames. The bill requires the executive commissioner, in establishing the compliance standards, to consider the administrative burdens placed on health care providers required to comply with the standards and the benefits of using emerging technologies for ensuring compliance. The bill sets out certain requirements for a health care provider that provides personal care services or attendant care services to Medicaid recipients. The bill authorizes HHSC to recognize a health care provider's proprietary electronic visit verification system as complying with the bill's electronic visit verification system provisions and, contingent on HHSC making certain determinations regarding the system, to allow the health care provider to use that system for a period determined by HHSC. The bill prohibits HHSC or a managed care organization that contracts with HHSC to provide health care services to Medicaid recipients from paying a reimbursement claim for personal care services or attendant care services provided to a recipient unless the information from the electronic visit verification system corresponds with the information contained in the claim and the services were provided consistent with a prior authorization or plan of care. The bill subjects a previously paid claim to retrospective review and recoupment if unverified. The bill requires HHSC to create a stakeholder work group comprised of representatives of affected health care providers, managed care organizations, and Medicaid recipients and to periodically solicit from that work group input regarding the ongoing operation of the electronic visit verification system. The bill authorizes the executive commissioner to adopt rules necessary to implement the bill's provisions relating to the electronic visit verification system and reimbursement of certain related claims.

C.S.S.B. 894 requires HHSC to provide to a provider that is a hospital written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation regarding Medicaid or other health and human services not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid.

C.S.S.B. 894 requires HHSC to develop and implement an overall strategy for planning, managing, and coordinating audit resources that HHSC uses to verify the accuracy and reliability of program and financial information reported by managed care organizations. The bill requires HHSC, in order to improve HHSC processes for performance audits of managed care organizations, to document the process by which HHSC selects managed care organizations to audit, to include previous audit coverage as a risk factor in selecting managed care organizations to audit, and to prioritize the highest risk managed care organizations to audit. The bill requires HHSC, in order to verify that managed care organizations correct negative performance audit findings, to establish a process to document how HHSC follows up on negative performance audit findings and verify that managed care organizations implement performance audit recommendations and to establish and implement policies and procedures to determine under what circumstances HHSC must issue a corrective action plan to a managed care organization based on a performance audit and follow up on the managed care organization's implementation of the corrective action plan.

C.S.S.B. 894 requires HHSC, in order to enhance HHSC use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, to ensure that financial risks identified in agreed-upon procedures engagements are adequately and consistently addressed and to establish policies and procedures to determine under what circumstances HHSC must issue a corrective action plan based on an agreed-upon procedures engagement. The bill requires HHSC, in order to obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, to

periodically audit each pharmacy benefit manager that contracts with a managed care organization and to develop, document, and implement a monitoring process to ensure that managed care organizations correct and resolve negative findings reported in performance audits or agreed-upon procedures engagements of pharmacy benefit managers.

C.S.S.B. 894 requires HHSC to develop, document, and implement billing processes in the Medicaid and CHIP services department of HHSC to ensure that managed care organizations reimburse HHSC for audit-related services as required by contract. The bill requires HHSC, in order to strengthen the HHSC process for collecting shared profits from managed care organizations, to develop, document, and implement monitoring processes in the Medicaid and CHIP services department of HHSC to ensure that HHSC identifies experience rebates deposited in the HHSC suspense account and timely transfers those rebates to the appropriate accounts and timely follows up on and resolves disputes over experience rebates claimed by managed care organizations.

C.S.S.B. 894 requires HHSC, in order to enhance HHSC monitoring of managed care organizations, to use the information provided by the external quality review organization and requires HHSC to document how HHSC uses that information to monitor managed care organizations. The bill requires HHSC to strengthen user access controls for the HHSC accounts receivable tracking system and network folders that HHSC uses to manage the collection of experience rebates; document daily reconciliations of deposits recorded in the accounts receivable tracking system to the transactions processed in the HHSC cost accounting system for all health and human services agencies and the uniform statewide accounting system; and develop, document, and implement a process to ensure that HHSC formally documents all programming changes made to the accounts receivable tracking system and the authorization and testing of changes in the HHSC cost accounting system.

C.S.S.B. 894 specifies that its provisions relating to a strategy for managing audit resources do not apply to and may not be construed as affecting the conduct of audits by the HHSC's office of inspector general under the authority provided by statutory provisions relating to Medicaid and other health and human services fraud, abuse, or overcharges. The bill requires the executive commissioner of HHSC to adopt the rules necessary to implement those bill provisions.

EFFECTIVE DATE

September 1, 2017.

COMPARISON OF SENATE ENGROSSED AND SUBSTITUTE

While C.S.S.B. 894 may differ from the engrossed in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the engrossed and committee substitute versions of the bill.

SENATE ENGROSSED	HOUSE COMMITTEE SUBSTITUTE
No equivalent provision.	SECTION 1. Section 531.024172, Government Code, is amended to read as follows: Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM; REIMBURSEMENT OF CERTAIN RELATED CLAIMS. (a) Subject to Subsection (g), [~~In this section, "acute nursing services" has the meaning assigned by Section 531.02417.~~

[~~(b) If it is cost-effective and feasible,~~] the commission shall, in accordance with federal law, implement an electronic visit verification system to electronically verify [~~and document,~~] through a telephone, global positioning, or computer-based system that personal care services or attendant care services provided to recipients under Medicaid, including personal care services or attendant care services provided under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) or any other Medicaid waiver program, are provided to recipients in accordance with a prior authorization or plan of care. The electronic visit verification system implemented under this subsection must allow for verification of only the following[~~, basic~~] information relating to the delivery of Medicaid [~~acute nursing~~] services[~~, including~~]:

(1) the type of service provided [~~the provider's name~~];

(2) the name of the recipient to whom the service is provided [~~the recipient's name~~]; [~~and~~]

(3) the date and times [~~time~~] the provider began [~~begins~~] and ended the [~~ends each~~] service delivery visit;

(4) the location, including the address, at which the service was provided;

(5) the name of the individual who provided the service; and

(6) other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims.

(b) The commission shall establish minimum requirements for third-party entities seeking to provide electronic visit verification system services to health care providers providing Medicaid services and must certify that a third-party entity complies with those minimum requirements before the entity may provide electronic visit verification system services to a health care provider.

(c) The commission shall inform each Medicaid recipient who receives personal care services or attendant care services that the health care provider providing the services and the recipient are each required to comply with the electronic visit verification system. A managed care

organization that contracts with the commission to provide health care services to Medicaid recipients described by this subsection shall also inform recipients enrolled in a managed care plan offered by the organization of those requirements.

(d) In implementing the electronic visit verification system:

(1) subject to Subsection (e), the executive commissioner shall adopt compliance standards for health care providers; and

(2) the commission shall ensure that:

(A) the information required to be reported by health care providers is standardized across managed care organizations that contract with the commission to provide health care services to Medicaid recipients and across commission programs; and

(B) time frames for the maintenance of electronic visit verification data by health care providers align with claims payment time frames.

(e) In establishing compliance standards for health care providers under this section, the executive commissioner shall consider:

(1) the administrative burdens placed on health care providers required to comply with the standards; and

(2) the benefits of using emerging technologies for ensuring compliance, including Internet-based, mobile telephone-based, and global positioning-based technologies.

(f) A health care provider that provides personal care services or attendant care services to Medicaid recipients shall:

(1) use an electronic visit verification system to document the provision of those services;

(2) comply with all documentation requirements established by the commission;

(3) comply with applicable federal and state laws regarding confidentiality of recipients' information;

(4) ensure that the commission or the managed care organization with which a claim for reimbursement for a service is filed may review electronic visit verification system documentation related to the claim or obtain a copy of that documentation at no charge to the commission or the organization; and

(5) at any time, allow the commission or a managed care organization with which a health care provider contracts to provide

	health care services to recipients enrolled in the organization's managed care plan to have direct, on-site access to the electronic visit verification system in use by the health care provider. (g) The commission may 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 the commission if the commission determines that the system: (1) complies with all necessary data submission, exchange, and reporting requirements established under this section; (2) meets all other standards and requirements established under this section; and (3) has been in use by the health care provider since at least June 1, 2014. (h) The commission or a managed care organization that contracts with the commission to provide health care services to Medicaid recipients may not pay a claim for reimbursement for personal care services or attendant care services provided to a recipient unless the information from the electronic visit verification system corresponds with the information contained in the claim and the services were provided consistent with a prior authorization or plan of care. A previously paid claim is subject to retrospective review and recoupment if unverified. (i) The commission shall create a stakeholder work group comprised of representatives of affected health care providers, managed care organizations, and Medicaid recipients and periodically solicit from that work group input regarding the ongoing operation of the electronic visit verification system under this section. (j) The executive commissioner may adopt rules necessary to implement this section.
No equivalent provision.	SECTION 2. Section 531.120, Government Code, is amended by adding Subsection (c) to read as follows: (c) The commission shall provide the notice required by Subsection (a) to a provider that is a hospital not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid.
SECTION 1. Chapter 533, Government	SECTION 3. Same as engrossed version.

Code, is amended.	
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 the rules necessary to implement Subchapter B, Chapter 533, Government Code, as added by this Act.	SECTION 4. As soon as practicable after the effective date of this Act: (1) the Health and Human Services Commission shall implement an electronic visit verification system in accordance with Section 531.024172, Government Code, as amended by this Act; and (2) the executive commissioner of the Health and Human Services Commission shall adopt the rules necessary to implement Subchapter B, Chapter 533, Government Code, as added by this Act.
No equivalent provision.	SECTION 5. 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 3. This Act takes effect September 1, 2017.	SECTION 6. Same as engrossed version.