BILL ANALYSIS

C.S.H.B. 3917
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Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

In many cases, the state must recoup improper Medicaid payments made to health care providers for performing Medicaid services. Many times, interested parties note, this is necessary because of mistakes made by the Health and Human Services Commission, not by the health care providers. The parties assert that providers often must resort to legal means to reobtain the money they are owed and that those actions are expensive and time-consuming. Thus, the parties contend that the financial strain this problem places on health care providers can make it difficult for them to stay in business and should be corrected. C.S.H.B. 3917 seeks to address this issue.

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. 3917 amends the Human Resources Code to require the Health and Human Services Commission (HHSC) to develop and implement policies to prevent recoupment of an improper payment that was made to a provider for a claim for medical services made under the Medicaid program if the provider actually provided a medical service reimbursable under Medicaid and submitted a clean claim as required by Medicaid. The bill requires the policies to allow the recoupment of an improper payment in the case of fraud or abuse and to require that, when recoupment is allowed, the amount of a recouped payment may be no greater than the difference between the payment amount made to the provider that is subject to recoupment and the reimbursement rate in effect on the date the service was provided.

C.S.H.B. 3917 requires HHSC, to reduce the incidence of improper Medicaid payments, to develop and implement methods to improve communication between HHSC, Medicaid providers, entities with which HHSC contracts to administer Medicaid claims, and managed care organizations with which HHSC contracts to provide medical services to Medicaid recipients. The bill requires the methods to improve communication to include requirements to provide necessary information to a provider regarding how, and to whom, the provider must submit a clean claim and how the provider may file a complaint with HHSC regarding a payment dispute.

C.S.H.B. 3917 requires HHSC to conduct separate studies for the following purposes: to evaluate the feasibility of implementing a process that allows an entity with which HHSC contracts to administer Medicaid claims, or a managed care organization with which HHSC contracts to provide services to Medicaid recipients, that makes an improper payment on a claim under the

bill's provisions to have a right of subrogation against another entity, including a managed care organization, that is or would have been responsible for payment of the claim had the claim been properly filed with that entity and to identify improvements that should be made to eligibility determination processes and other administrative procedures in order to reduce the incidence of retroactive disenrollment from Medicaid that can result in improper payments. The bill requires HHSC to implement an applicable process or improvements if HHSC determines as a result of each study that implementation of the studied process or improvements would be feasible and cost-effective. The bill requires HHSC, if implementing the process or improvements, to modify contracts with an entity with which HHSC contracts to administer claims and managed care organizations to the extent possible and as necessary for that implementation.

C.S.H.B. 3917 adds a temporary provision, set to expire September 1, 2017, to require HHSC, not later than December 1, 2016, to submit a report to each standing committee of the senate and house of representatives having primary jurisdiction over Medicaid detailing the results of each study and, if HHSC implemented the applicable process or improvements, an analysis of the effectiveness of the implementation in reducing overpayments.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2015.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 3917 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0631 to read as follows:	SECTION 1. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Sections 32.0631 and 32.0632 to read as follows:
Sec. 32.0631. RECOUPMENT OF CERTAIN PAYMENTS PROHIBITED.	Sec. 32.0631. POLICIES RELATED TO RECOUPMENT OF PAYMENTS. (a) Notwithstanding any other law the commission shall, subject to Subsection (b), develop and implement policies to prevent recoupment of an improper payment that was made to a provider for a claim for medical services made under the medical assistance program if the provider:
The department may not recoup any part of an improper payment that was made to a provider for a claim for medical services made under the medical assistance program if:	(1) actually provided a medical service reimbursable under the medical assistance program; and
(1) the provider actually provided a medical service reimbursable under the medical assistance program;	(2) submitted a clean claim as required under the medical assistance program.
(2) the provider submitted a clean claim as required under the medical assistance program; and	
(3) the reason for the improper payment was an error made by the department or an organization that has contracted with the department for the administration of payments under the medical assistance program.	

No equivalent provision.	(b) The policies developed under Subsection (a) must: (1) allow the recoupment of an improper payment in the case of fraud or abuse; and (2) require that when recoupment is allowed, the amount of a recouped payment may be no greater than the difference between the payment amount made to the provider that is subject to recoupment and the reimbursement rate in effect on the date the service was provided.
No equivalent provision.	(c) To reduce the incidence of improper payments under the medical assistance program, the commission shall develop and implement methods to improve communication between: (1) the commission; (2) providers under the program; (3) entities with which the commission contracts to administer claims under the program; and (4) managed care organizations with which the commission contracts to provide medical services to recipients under the program.
No equivalent provision.	(d) The methods to improve communication under Subsection (c) must include requirements to provide necessary information to a provider regarding: (1) how, and to whom, the provider must submit a clean claim; and (2) how the provider may file a complaint with the commission regarding a payment dispute, including a complaint that may be filed after the provider has exhausted all rights to appeal.
No equivalent provision.	Sec. 32.0632. PROCESSES AND IMPROVEMENTS RELATED TO OVERPAYMENT OF CLAIMS. (a) The commission shall conduct separate studies to: (1) evaluate the feasibility of implementing a process that allows an entity with which the commission contracts to administer claims under the medical assistance program, or a managed care organization with which the commission contracts to provide services to recipients under the medical assistance program, that makes an improper payment on a claim that is subject to Section 32.0631, to have a right of subrogation against another entity, including a managed care organization, that is or would have been responsible for payment of the claim had the claim been properly filed with that entity; and

	(2) identify improvements that should be made to eligibility determination processes and other administrative procedures in order to reduce the incidence of retroactive disenrollment from the medical assistance program that can result in improper payments. (b) If, as a result of each study conducted under this section, the commission determines that implementation of the studied process or improvements, as applicable, would be feasible and cost-effective to implement, the commission shall, notwithstanding any other law, implement the process or improvements. If the commission implements the process or improvements, the commission shall modify contracts with an entity with which the commission contracts to administer claims and managed care organizations to the extent possible and as necessary for that implementation. (c) Not later than December 1, 2016, the commission shall submit a report to each standing committee of the senate and house of representatives having primary jurisdiction over the medical assistance program detailing the results of each study conducted under this section and, if the commission implemented the applicable process or improvements in accordance with Subsection (b), an analysis of the effectiveness of the implementation in reducing overpayments. This subsection expires September 1, 2017.
SECTION 2. Section 32.0631, Human Resources Code, as added by this Act, applies only to improper payments for claims made under the medical assistance program under Chapter 32, Human Resources Code, that are made on or after the effective date of this Act. A claim made before the effective date of this Act is governed by the law as it existed immediately before the effective date of this Act, and that law is continued in effect for that purpose.	SECTION 2. Same as introduced version.
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	SECTION 3. Same as introduced version.

may delay implementing that provision until the waiver or authorization is granted.	
SECTION 4. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2015.	SECTION 4. Same as introduced version.