By: Buckingham (Muñoz, Jr.) S.B. No. 894

Substitute the following for S.B. No. 894:

By: Raymond C.S.S.B. No. 894

A BILL TO BE ENTITLED

AN ACT

relating to the Health and Human Services Commission's auditing of Medicaid managed care organizations and auditing and collection of Medicaid payments, including the commission's management of audit resources.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

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.

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 3. Chapter 533, Government Code, is amended by

adding Subchapter B to read as follows:

SUBCHAPTER B. STRATEGY FOR MANAGING AUDIT RESOURCES

Sec. 533.051. DEFINITIONS. In this subchapter:

(1) "Accounts receivable tracking system" means the system the commission uses to track experience rebates and other payments collected from managed care organizations.

(2) "Agreed-upon procedures engagement" means an evaluation of a managed care organization's financial statistical reports or other data conducted by an independent auditing firm engaged by the commission as agreed in the managed care organization's contract with the commission.

(3) "Experience rebate" means the amount a managed care organization is required to pay the state according to the graduated rebate method described in the managed care organization's contract with the commission.

(4) "External quality review organization" means an organization that performs an external quality review of a managed care organization in accordance with 42 C.F.R. Section 438.350.

Sec. 533.052. APPLICABILITY AND CONSTRUCTION OF SUBCHAPTER. This subchapter does not apply to and may not be construed as affecting the conduct of audits by the commission's office of inspector general under the authority provided by Subchapter C, Chapter 531, including an audit of a managed care organization conducted by the office after coordinating the office's audit and oversight activities with the commission as required by Section 531.102(q), as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015.

Sec. 533.053. OVERALL STRATEGY FOR MANAGING AUDIT RESOURCES. The commission shall develop and implement an overall strategy for planning, managing, and coordinating audit resources that the commission uses to verify the accuracy and reliability of program and financial information reported by managed care organizations.

Sec. 533.054. PERFORMANCE AUDIT SELECTION PROCESS AND FOLLOW-UP. (a) To improve the commission's processes for performance audits of managed care organizations, the commission shall:

(1) document the process by which the commission selects managed care organizations to audit;

(2) include previous audit coverage as a risk factor in selecting managed care organizations to audit; and

(3) prioritize the highest risk managed care organizations to audit.

(b) To verify that managed care organizations correct negative performance audit findings, the commission shall:

(1) establish a process to:

(A) document how the commission follows up on negative performance audit findings; and

(B) verify that managed care organizations implement performance audit recommendations; and

(2) establish and implement policies and procedures to:

(A) determine under what circumstances the commission must issue a corrective action plan to a managed care

organization based on a performance audit; and

(B) follow up on the managed care organization's implementation of the corrective action plan.

Sec. 533.055. AGREED-UPON PROCEDURES ENGAGEMENTS AND CORRECTIVE ACTION PLANS. To enhance the commission's use of agreed-upon procedures engagements to identify managed care organizations' performance and compliance issues, the commission shall:

(1) ensure that financial risks identified in agreed-upon procedures engagements are adequately and consistently addressed; and

(2) establish policies and procedures to determine under what circumstances the commission must issue a corrective action plan based on an agreed-upon procedures engagement.

Sec. 533.056. AUDITS OF PHARMACY BENEFIT MANAGERS. To obtain greater assurance about the effectiveness of pharmacy benefit managers' internal controls and compliance with state requirements, the commission shall:

(1) periodically audit each pharmacy benefit manager that contracts with a managed care organization; and

(2) 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.

Sec. 533.057. COLLECTION OF COSTS FOR AUDIT-RELATED SERVICES. The commission shall develop, document, and implement billing processes in the Medicaid and CHIP services department of

the commission to ensure that managed care organizations reimburse the commission for audit-related services as required by contract.

Sec. 533.058. COLLECTION ACTIVITIES RELATED TO PROFIT SHARING. To strengthen the commission's process for collecting shared profits from managed care organizations, the commission shall develop, document, and implement monitoring processes in the Medicaid and CHIP services department of the commission to ensure that the commission:

(1) identifies experience rebates deposited in the commission's suspense account and timely transfers those rebates to the appropriate accounts; and

(2) timely follows up on and resolves disputes over experience rebates claimed by managed care organizations.

Sec. 533.059. USE OF INFORMATION FROM EXTERNAL QUALITY REVIEWS. (a) To enhance the commission's monitoring of managed care organizations, the commission shall use the information provided by the external quality review organization, including:

(1) detailed data from results of surveys of Medicaid recipients and, if applicable, child health plan program enrollees, caregivers of those recipients and enrollees, and Medicaid and, as applicable, child health plan program providers; and

(2) the validation results of matching paid claims data with medical records.

(b) The commission shall document how the commission uses the information described by Subsection (a) to monitor managed care organizations.

Sec. 533.060. SECURITY AND PROCESSING CONTROLS OVER

INFORMATION TECHNOLOGY SYSTEMS. The commission shall:

(1) strengthen user access controls for the commission's accounts receivable tracking system and network folders that the commission uses to manage the collection of experience rebates;

(2) document daily reconciliations of deposits recorded in the accounts receivable tracking system to the transactions processed in:

(A) the commission's cost accounting system for all health and human services agencies; and

(B) the uniform statewide accounting system; and

(3) develop, document, and implement a process to ensure that the commission formally documents:

(A) all programming changes made to the accounts receivable tracking system; and

(B) the authorization and testing of the changes described by Paragraph (A).

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.

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 6. This Act takes effect September 1, 2017.