By: Buckingham, Hinojosa S.B. No. 1991

A BILL TO BE ENTITLED

AN ACT

relating to claims and overpayment recoupment processes imposed on health care providers under Medicaid.

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

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

(g) The commission may 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 the commission if the commission determines that the system:

(1) complies with all necessary data submission, exchange, and reporting requirements established under this section; and

(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~~].

(g-1) If feasible, the executive commissioner shall 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) 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), the commission or the executive commissioner, as appropriate, shall:

(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. Section 531.1131, Government Code, is amended by adding Subsection (f) to read as follows:

(f) In adopting rules establishing due process procedures under Subsection (e), the executive commissioner shall require that a managed care organization or an entity with which the managed care organization contracts under Section 531.113(a)(2) 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 may

begin any efforts to collect overpayments.

SECTION 3. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1135 to read as follows:

Sec. 531.1135. MANAGED CARE ORGANIZATIONS: PROCESS TO RECOUP CERTAIN OVERPAYMENTS. (a) The executive commissioner shall 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. In adopting rules under this section, the executive commissioner shall require that the managed care organization:

(1) 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

(2) limit the duration of audits to 24 months.

(b) The executive commissioner shall require that the notice required under this section inform the provider:

(1) of the specific claims and electronic visit verification transactions that are the basis of the overpayment;

(2) of the process the provider should use to communicate with the managed care organization to provide information about the electronic visit verification transactions;

(3) of the provider's option to seek an informal resolution of the alleged overpayment;

(4) of the process to appeal the determination that an overpayment was made; and

(5) if the provider intends to respond to the notice, that the provider must respond not later than the 30th day after the date the provider receives the notice.

(c) Notwithstanding any other law, a managed care organization may not attempt to recover an overpayment described by Subsection (a) until the provider has exhausted all rights to an appeal.

SECTION 4. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money to the commission specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the commission may, but is not required to, implement a provision of this Act using other appropriations that are available for that purpose.

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, 2019.