TO: Medical Care Advisory Committee

DATE: August 12, 2021

FROM: Jennie Costilow
Director, Policy and Program Development

SUBJECT: Electronic Visit Verification Payment Recoupments

Agenda Item No.: 6

New: §§353.1451 - 353.1454 in Texas Administrative Code, Title 1, Part 15, Chapter 353, Medicaid Managed Care, Subchapter Q, Process to Recoup Certain Overpayments.

BACKGROUND: ☐ Federal Requirement ☒ Legislative Requirement ☐ Other: (e.g., Program Initiative)

Senate Bill 1991, 86th Legislature, Regular Session, 2019, amended Texas Government Code by adding new §§531.1131(f) and 531.1135 requiring HHSC to adopt rules describing the due process procedures a managed care organization (MCO) must follow to recoup an overpayment made to a health care provider related to missing electronic visit verification information; and requiring that, as part of the process to recoup such an overpayment, an MCO give a provider at least 60 days to correct a deficiency in a claim before the MCO begins any efforts to recoup overpayments.

Texas Government Code, §531.1131(e) requires HHSC to adopt rules describing the due process procedures an MCO must follow when engaging in recoupment efforts related to fraud or abuse.

The purpose of the proposal is to implement Texas Government Code, §§531.1131(e) and (f) and 531.1135.

ISSUES AND ALTERNATIVES:

HHSC does not anticipate that stakeholders will raise concerns about the proposed rules because HHSC worked informally with stakeholders in the development of the rules.

STAKEHOLDER INVOLVEMENT:

The draft rules were sent to external stakeholders for review and published on the HHSC website for informal comment from January 14 - January 27, 2021. Comments received from stakeholders were reviewed by staff and taken into consideration. External stakeholders included contracted managed care organizations, Texas Association of Health Plans, Texas Association for Home Care and Hospice, and licensed home and community support services agencies.

Several MCOs requested clarification about how a deficiency related to an electronic visit verification (EVV) visit transaction is corrected by a provider or financial management services agency (FMSA). In response, HHSC revised the proposed rules to explain that a deficiency to an EVV visit transaction or claim is corrected in accordance with HHSC or MCO policies.

One MCO requested that HHSC make the time period for providers and FMSAs to respond to a notice of intended recoupment 60 days, instead of 30 days, to be consistent with the 60-day time period required for providers and FMSAs to correct a deficiency to an EVV visit transaction or claim. HHSC did not make changes in response to this request because the time periods are required by Texas Government Code, §531.1131 and §531.1135.

Another MCO requested that HHSC revise the rule to state that the claims that are the basis of an intended recoupment because of a discovery of fraud or abuse were identified using an approved methodology of the Office of Inspector General. HHSC did not make changes in response to this request because the Office of Inspector General does not specify the methodologies MCOs must use in reviewing claims.

One provider expressed support of the proposed rules and remarked that they were consistent with legislative intent.

FISCAL IMPACT:

☒ None

RULE DEVELOPMENT SCHEDULE:

August 12, 2021	Present to the Medical Care Advisory Committee
August 19, 2021	Present to HHSC Executive Council
September 2021	Publish proposed rules in *Texas Register*
January 2022	Publish adopted rules in *Texas Register*
January 2022	Effective date

REQUESTED ACTION:

☒ The MCAC recommends approval of the proposed rules for publication.

☐ Information Only

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER Q PROCESS TO RECOUP CERTAIN OVERPAYMENTS

PROPOSED PREAMBLE

The Executive Commissioner of the Texas Health and Human Services Commission (HHSC) proposes new §353.1451, concerning Purpose and Authority; §353.1452, concerning Definitions; §353.1453, concerning Due Process Procedures to Recoup an Overpayment Related to an EVV Visit Transaction that is not Fraud or Abuse and Limitation on Audit Period; and §353.1454, concerning Due Process Procedures to Recoup an Overpayment Because of a Discovery of Fraud or Abuse, in Chapter 353, new Subchapter Q, Process to Recoup Certain Overpayments.

BACKGROUND AND PURPOSE

Senate Bill 1991, 86th Legislature, Regular Session, 2019, amended Texas Government Code by adding new §§531.1131(f) and 531.1135 requiring HHSC to adopt rules describing the due process procedures a managed care organization (MCO) must follow to recoup an overpayment made to a health care provider related to missing electronic visit verification information; and requiring that, as part of the process to recoup such an overpayment, an MCO gives a provider at least 60 days to correct a deficiency in a claim before the MCO begins any efforts to recoup overpayments.

Texas Government Code, §531.1131(e) requires HHSC to adopt rules describing the due process procedures an MCO must follow when engaging in recoupment efforts related to fraud or abuse.

The purpose of the proposal is to implement Texas Government Code §§531.1131(e) and (f) and 531.1135.

SECTION-BY-SECTION SUMMARY

Proposed new §353.1451 describes the purpose of new Subchapter Q and explains that Texas Government Code, §531.1131 and §531.1135 provide the statutory basis for the new subchapter.

Proposed new §353.1452 defines the terms used in the subchapter.

Proposed new §353.1453(a) requires an MCO to, in an audit of a provider or financial management services agency (FMSA), limit the review of EVV visit transactions to those that occurred during the 24 months prior to the audit. Subsection (b) of the proposed rule requires that, if based on an audit or investigation, an MCO identifies a deficiency related to an EVV visit transaction that is not fraud or abuse and the MCO decides to recoup an overpayment because of

the deficiency, the MCO gives a provider or FMSA written notice of the MCO's intent to recoup overpayments not later than the 30th day after the date the audit or investigation is completed. Subsection (c) of the proposed rule describes the information that must be in the written notice, including the specific number of days allowed to correct and explain the deficiency before the MCO begins any efforts to collect overpayments, which must be no fewer than 60 days from the notice date; the provider's or FMSA's option to seek an informal resolution with the MCO of the intended recoupment; and the MCO's process to appeal the intended recoupment. Subsection (d) of the proposed rule provides that a corrected deficiency is one that a provider or FMSA makes by performing visit maintenance to correct an EVV visit transaction in accordance with HHSC EVV policy or correcting and resubmitting a claim in accordance with MCO policies and procedures. Subsection (e) of the proposed rule allows an MCO to recoup an overpayment only if a provider or FMSA does not correct the deficiency related to an EVV visit transaction and does not appeal the alleged overpayment or appeals the alleged overpayment and the final decision from the appeal is favorable to the MCO. Subsection (f) of the proposed rule requires an MCO to comply with the proposed new §353.1454 if the MCO determines that a deficiency related to an EVV visit transaction is fraud or abuse.

Proposed new §353.1454(a) requires an MCO to have due process procedures in place if the MCO decides to recoup an overpayment from a provider or FMSA because of a discovery of fraud or abuse, as permitted by §353.505 (relating to Recovery of Funds). Subsection (a) also requires that the due process procedures include a written notice to the provider or FMSA of the MCO's intent to recoup overpayments and that such notice include a description of the basis for the intended recoupment; the provider's or FMSA's option to seek an informal resolution with the MCO of the intended recoupment; and the MCO's process for the provider or FMSA to appeal the intended recoupment. Subsection (b) of the proposed rule allows an MCO to recoup an overpayment only if the provider or FMSA does not appeal the alleged overpayment or appeals the alleged overpayment and the final decision from the appeal is favorable to the MCO.

FISCAL NOTE

Trey Wood, HHSC Chief Financial Officer has determined that for each year of the first five years that the rules will be in effect, enforcing or administering the rules does not have foreseeable implications relating to costs or revenues of state or local governments because all actions required by the proposed rules will be taken by MCOs and no changes to state procedures are required.

GOVERNMENT GROWTH IMPACT STATEMENT

HHSC has determined that during the first five years that the rules will be in effect:
(1) the proposed rules will not create or eliminate a government program;
(2) implementation of the proposed rules will not affect the number of HHSC employee positions;
(3) implementation of the proposed rules will result in no assumed change in future legislative appropriations;

(4) the proposed rules will not affect fees paid to HHSC;
(5) the proposed rules will create new rules;
(6) the proposed rules will expand existing rules;
(7) the proposed rules will not change the number of individuals subject to the rules; and
(8) the proposed rules will not affect the state's economy.

SMALL BUSINESS, MICRO-BUSINESS, AND RURAL COMMUNITY IMPACT ANALYSIS

Trey Wood has also determined that there will be no adverse economic effect on small businesses, micro-businesses, or rural communities. There are no Texas Medicaid MCOs that fall into the categories of small businesses, micro-businesses, or rural communities.

LOCAL EMPLOYMENT IMPACT

The proposed rules will not affect a local economy.

COSTS TO REGULATED PERSONS

Texas Government Code §2001.0045 does not apply to these rules because the rules are necessary to implement legislation that does not specifically state that §2001.0045 applies to the rules.

PUBLIC BENEFIT AND COSTS

Stephanie Stephens, State Medicaid Director, has determined that for each year of the first five years the rules are in effect, the public will benefit from rules that require MCOs to have due process procedures in place regarding recoupment of overpayments from providers and FMSAs because of errors related to an EVV visit transaction or because of fraud or abuse.

Trey Wood has also determined that for the first five years the rules are in effect, persons who are required to comply with the proposed rules may incur economic costs because an MCO may need to develop the written notice required by the proposed rules, train staff who will be responsible for implementing the new requirements, and make any necessary information systems changes. HHSC lacks sufficient data to determine an estimate of these costs.

TAKINGS IMPACT ASSESSMENT

HHSC has determined that the proposal does not restrict or limit an owner's right to his or her property that would otherwise exist in the absence of government action and, therefore, does not constitute a taking under Texas Government Code §2007.043.

PUBLIC COMMENT

Written comments on the proposal may be submitted to Rules Coordination Office, P.O. Box 13247, Mail Code 4102, Austin, Texas 78711-3247, or street address 4900 North Lamar Boulevard, Austin, Texas 78751; or emailed to *HHSRulesCoordinationOffice@hhs.texas.gov*.

To be considered, comments must be submitted no later than 31 days after the date of this issue of the *Texas Register*. Comments must be: (1) postmarked or shipped before the last day of the comment period; (2) hand-delivered before 5:00 p.m. on the last working day of the comment period; or (3) emailed before midnight on the last day of the comment period. If the last day to submit comments falls on a holiday, comments must be postmarked, shipped, or emailed before midnight on the following business day to be accepted. When emailing comments, please indicate "Comments on Proposed Rule 20R082" in the subject line.

STATUTORY AUTHORITY

The new sections are authorized by Texas Government Code §531.0055, which provides that the Executive Commissioner of HHSC shall adopt rules for the operation and provision of services by the health and human services agencies; Texas Government Code §531.033, which provides the Executive Commissioner of HHSC with broad rulemaking authority; Human Resources Code §32.021, which provides that HHSC shall adopt necessary rules for the proper and efficient operation of the Medicaid program; Texas Government Code §531.1131(e) which provides that the Executive Commissioner of HHSC shall adopt rules describing the due process procedures an MCO must follow when engaging in recoupment efforts related to fraud or abuse; and Texas Government Code §531.1135 which provides that the Executive Commissioner of HHSC shall adopt rules to standardize the process an MCO must follow to recoup an overpayment made to a health care provider related to missing electronic visit verification information.

The new sections affect Texas Government Code §531.0055, §531.033, §531.1131(e), and §531.1135 and Texas Human Resources Code §32.021.

This agency hereby certifies that this proposal has been reviewed by legal counsel and found to be a valid exercise of the agency's legal authority.

ADDITIONAL INFORMATION

For further information, please call: (512) 707-6132.

Legend:
Single Underline = Proposed new language
[~~Strikethrough and brackets~~] = Current language proposed for deletion
Regular print = Current language (No change.) = No changes are being considered for the designated subdivision

TITLE 1 ADMINISTRATION
PART 15 TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 353 MEDICAID MANAGED CARE
SUBCHAPTER Q PROCESS TO RECOUP CERTAIN OVERPAYMENTS

§353.1451. Purpose and Authority.

The purpose of this subchapter is to describe the due process a managed care organization (MCO) must give to recoup an overpayment related to an electronic visit verification visit transaction in accordance with Texas Government Code, §531.1135 and the due process an MCO must give to recoup an overpayment related to a determination of fraud or abuse in accordance with Texas Government Code, §531.1131.

§353.1452. Definitions.

The following words and terms, when used in this subchapter, have the following meanings, unless the context clearly indicates otherwise:

(1) Abuse--This term has the meaning set forth in §371.1 of this title (relating to Definitions).

(2) EVV visit transaction--Electronic visit verification visit transaction. This term has the meaning set forth in §354.4003 of this title (relating to Definitions).

(3) FMSA--Financial management services agency. An entity that contracts with a managed care organization to provide financial management services to a consumer directed services employer as described in Title 40, Texas Administrative Code, Chapter 41 (relating to Consumer Directed Services Option).

(4) Fraud--This term has the meaning set forth in §371.1 of this title.

§353.1453. Due Process Procedures to Recoup an Overpayment Related to an EVV Visit Transaction that is not Fraud or Abuse and Limitation on Audit Period.

(a) In an audit of a provider or FMSA conducted by a managed care organization (MCO), the MCO must limit the review of EVV visit transactions to those that occurred during the 24 months prior to the audit.

(b) If, based on an audit or investigation of a provider or FMSA, an MCO identifies a deficiency related to an EVV visit transaction that is not fraud or abuse and the

MCO decides to recoup an overpayment because of the deficiency, the MCO must give the provider or FMSA written notice of the MCO's intent to recoup overpayments not later than the 30th day after the date the audit or investigation is completed.

(c) An MCO must include the following in the written notice required by subsection (b) of this section:

(1) a description of the basis for the intended recoupment;

(2) if the basis of the intended recoupment is an EVV visit transaction, the specific EVV visit transaction and associated claim that are the basis of the intended recoupment;

(3) if the basis of the intended recoupment is a missing EVV visit transaction, the claim for which there is no associated EVV visit transaction;

(4) that the MCO must receive a response to the notice from the provider or FMSA no later than the 30th day after the date the provider or FMSA receives the written notice, if the provider or FMSA intends to respond;

(5) the specific number of days allowed to correct and explain the deficiency before the MCO begins any efforts to collect overpayments, which must be no fewer than 60 days from the notice date;

(6) the process by which the provider or FMSA should communicate with and send information to the MCO about the EVV visit transactions that are the basis of the intended recoupment;

(7) the provider's or FMSA's option to seek an informal resolution with the MCO of the intended recoupment; and

(8) the MCO's process for the provider or FMSA to appeal the intended recoupment.

(d) A corrected deficiency is one that a provider or FMSA makes by doing one or both of the following:

(1) performing visit maintenance to correct an EVV visit transaction in accordance with HHSC EVV policy; or

(2) correcting and resubmitting a claim in accordance with MCO policies and procedures.

(e) An MCO may recoup an overpayment only if a provider or FMSA:

(1) does not correct the deficiency and does not appeal the alleged overpayment; or

(2) appeals the alleged overpayment and the final decision from the appeal is favorable to the MCO.

(f) If an MCO determines that a deficiency related to an EVV visit transaction is fraud or abuse, the MCO must comply with §353.1454 of this subchapter (relating to Due Process Procedures to Recoup an Overpayment Because of a Discovery of Fraud or Abuse).

§353.1454. Due Process Procedures to Recoup an Overpayment Because of a Discovery of Fraud or Abuse.

(a) If a managed care organization (MCO) decides to recoup an overpayment from a provider or FMSA because of a discovery of fraud or abuse as permitted by §353.505 of this chapter (relating to Recovery of Funds), the MCO must have due process procedures that include the following:

(1) written notice to the provider or FMSA of the MCO's intent to recoup overpayments that includes the following:

(A) a description of the basis for the intended recoupment;

(B) the specific claims that are the basis of the intended recoupment;

(C) the process by which the provider or FMSA should send information to the MCO about claims that are the basis of the intended recoupment;

(D) the provider's or FMSA's option to seek an informal resolution with the MCO of the intended recoupment; and

(E) the MCO's process for the provider or FMSA to appeal the intended recoupment;

(2) a process for the provider or FMSA to seek informal resolution; and

(3) a process for the provider or FMSA to appeal the intended recoupment.

(b) An MCO may recoup an overpayment only if a provider or FMSA:

(1) does not appeal the alleged overpayment; or

(2) appeals the alleged overpayment and the final decision from the appeal is favorable to the MCO.