BILL ANALYSIS

Senate Research Center

H.B. 1720
By: Davis, John (Patrick)
Health & Human Services
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Estimates of health care fraud within government programs range from 10 percent to 30 percent of health care spending. The Texas legislature has enacted numerous bills over the past decade aimed at curbing Medicaid fraud. Despite these efforts, Medicaid fraud remains a significant problem that the legislature must continue to take seriously. Additionally, the Affordable Care Act contains mandates aimed at reducing fraud at the state level that the Health and Human Services Commission (HHSC) needs the authority to enact should the federal health care reform be upheld in court.

H.B. 1720 amends current law relating to improving health care provider accountability and efficiency under the child health plan and Medicaid programs.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 1 (Section 531.024161, Government Code), SECTION 2 (Section 531.1131, Government Code), SECTION 3 (Section 62.1561, Health and Safety Code), SECTION 4 (Section 32.047, Human Resources Code), and SECTION 5 (Section 32.068, Human Resources Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.024161, as follows:

Sec. 531.024161. REIMBURSEMENT CLAIMS FOR CERTAIN MEDICAID OR CHIP SERVICES INVOLVING SUPERVISED PROVIDERS. (a) Requires that the names and associated national provider identifier numbers of the supervised provider and the supervising provider, if a provider, including a nurse practitioner or physician assistant, under the Medicaid or child health plan program provides a referral for or orders health care services for a recipient or enrollee, as applicable, at the direction or under the supervision of another provider, and the referral or order is based on the supervised provider's evaluation of the recipient or enrollee, be included on any claim for reimbursement submitted by a provider based on the referral or order. Defines, for purposes of this section, "national provider identifier."

(b) Requires the executive commissioner of the Health and human Services Commission (executive commissioner; HHSC) to adopt rules necessary to implement this section.

SECTION 2. Amends Subchapter C, Chapter 531, Government Code, by adding Sections 531.1131, 531.1132, and 531.117, as follows:

Sec. 531.1131. FRAUD AND ABUSE RECOVERY BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a) Requires a unit or entity, if a managed care organization's special investigative unit under Section 531.113(a)(1) (relating to establishing and maintaining a special investigative unit within the managed care organization to investigate fraudulent claims and other types of program abuse by

recipients and service providers) or the entity with which the managed care organization contracts under Section 531.113(a)(2) (relating to contracting with another entity for the investigation of fraudulent claims and other types of program abuse by recipients and service providers) discovers fraud or abuse in the Medicaid program or the child health plan program, to:

(1) immediately notify HHSC's office of inspector general (OIG);

(2) subject to Subsection (b), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with applicable rules adopted by the executive commissioner.

(b) Prohibits the managed care organization's special investigative unit or contracted entity described by Subsection (a), if the amount sought to be recovered under Subsection (a)(2) exceeds $100,000, from engaging in payment recovery efforts if, not later than the 10th business day after the date the unit or entity notified the HHSC's OIG under Subsection (a)(1), the unit or entity receives a notice from OIG indicating that the unit or entity is not authorized to proceed with recovery efforts.

(c) Authorizes a managed care organization to retain any money recovered under Subsection (a)(2) by the organization's special investigative unit or contracted entity described by Subsection (a).

(d) Requires a managed care organization to submit a quarterly report to the HHSC's OIG detailing the amount of money recovered under Subsection (a)(2).

(e) Requires the executive commissioner to adopt rules necessary to implement this section, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by this section.

Sec. 531.1132. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES. Requires HHSC, not later than December 1 of each year, to prepare and submit a report to the legislature relating to the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts made under Sections 531.113 (Managed Care Organizations: Special Investigative Units or Contracts) and 531.1131 by special investigative units or entities with which a managed care organization contracts under Section 531.113(a)(2). Requires that the report specify the amount of money retained by each managed care organization under Section 531.1131(c).

Sec. 531.117. RECOVERY AUDIT CONTRACTORS. Requires HHSC, to the extent required under Section 1902(a)(42), Social Security Act (42 U.S.C. Section 1396a(a)(42)), to establish a program under which HHSC contracts with one or more recovery audit contractors for purposes of identifying underpayments and overpayments under the Medicaid program and recovering the overpayments.

SECTION 3. Amends Subchapter D, Chapter 62, Health and Safety Code, by adding Section 62.1561, as follows:

Sec. 62.1561. PROHIBITION OF CERTAIN HEALTH CARE PROVIDERS. Requires the executive commissioner to adopt rules for prohibiting a person from participating in the child health plan program as a health care provider for a reasonable period, as determined by the executive commissioner, if the person:

(1) fails to repay overpayments under the program; or

(2) owns, controls, manages, or is otherwise affiliated with and has financial, managerial, or administrative influence over a provider who has been suspended or prohibited from participating in the program.

SECTION 4. Amends Section 32.047, Human Resources Code, as follows:

Sec. 32.047. PROHIBITION OF CERTAIN HEALTH CARE SERVICE PROVIDERS. (a) Creates this subsection from existing text. Provides that a person is permanently prohibited from providing or arranging to provide health care services under the medical assistance program if:

(1) the person is convicted of an offense arising from a fraudulent act under the program; and

(2) the person's fraudulent act results in injury to an elderly person, as defined by Section 48.002(a)(1) (defining "elderly person"), a disabled person, as defined by Section 48.002(a)(8)(A) (relating to a disabled person 18 years of age or older), or a person younger than 18 years of age. Makes nonsubstantive changes.

(b) Requires the executive commissioner to adopt rules for prohibiting a person from participating in the medical assistance program as a health care provider for a reasonable period, as determined by the executive commissioner, if the person:

(1) fails to repay overpayments under the program; or

(2) owns, controls, manages, or is otherwise affiliated with and has financial, managerial, or administrative influence over a provider who has been suspended or prohibited from participating in the program.

SECTION 5. Amends Subchapter B, Chapter 32, Human Resources Code, by adding Section 32.068, as follows:

Sec. 32.068. IN-PERSON EVALUATION REQUIRED FOR CERTAIN SERVICES. (a) Authorizes a medical assistance provider to order or otherwise authorize the provision of home health services for a recipient only if the provider has conducted an in-person evaluation of the recipient within the six-month period preceding the date the order or other authorization was issued.

(b) Requires a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse-midwife that orders or otherwise authorizes the provision of durable medical equipment for a recipient in accordance with Chapter 157 (Authority of Physician to Delegate Certain Medical Acts), Occupations Code, and other applicable law, including rules, to certify on the order or other authorization that the person conducted an in-person evaluation of the recipient within the six-month period preceding the date the order or other authorization was issued.

(c) Requires the executive commissioner to adopt rules necessary to implement this section.

SECTION 6. Makes application of Section 531.1131, Government Code, as added by this Act, prospective.

SECTION 7. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 8. Effective date: September 1, 2011.