BILL ANALYSIS

H.B. 1720
By: Davis, John
Public Health
Committee Report (Unamended)

BACKGROUND AND PURPOSE

Though the Texas Legislature has enacted numerous bills over the past decade aimed at curbing health care fraud, concerned parties suggest that Medicaid fraud still accounts for a sizable percentage of the state's health care spending. Considering recent federal mandates aimed at reducing fraud at the state level, the legislature must consider additional measures to deal with this problem.

H.B. 1720 seeks to address the problem by, among other provisions, making a managing care organization responsible for reporting potentially fraudulent activity to the Health and Human Services Commission, requiring a national provider number to be provided in certain referrals or orders for health care services, establishing a program under which the state contracts with one or more recovery audit contractors for the purpose of identifying overpayments, and providing for the exclusion of individuals or entities suspected of fraudulent activity from participation as providers under Medicaid for a specified period of time.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 1, 2, 3, 4, and 5 of this bill.

ANALYSIS

H.B. 1720 amends the Government Code to require the name and associated national provider identifier number of the supervised provider, if a provider, including a nurse practitioner or physician assistant, under Medicaid or the child health plan program (CHIP) 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, to be included on any claim for reimbursement submitted by a provider based on the referral or order. The bill provides for the meaning of "national provider identifier" by reference to existing federal law and requires the executive commissioner of the Health and Human Services Commission (HHSC) to adopt rules necessary to implement this requirement.

H.B. 1720 requires a managed care organization's special investigative unit or the entity with which the managed care organization contracts for purposes of investigating fraudulent claims and other types of program abuse that discovers fraud or abuse in the Medicaid or CHIP programs to immediately notify the commission's office of inspector general and, subject to a provision of the bill prohibiting certain payment recovery efforts, begin payment recovery efforts. The bill prohibits the managed care organization's special investigative unit or contracted entity from engaging in payment recovery efforts if the amount sought to be recovered exceeds $200,000 and if, not later than the 10th day after the date the unit or entity notified the commission's office of inspector general, the unit or entity receives a notice from the office indicating that the unit or entity is not authorized to proceed with recovery efforts. The bill

authorizes a managed care organization to retain any money recovered by the organization's special investigative unit or contracted entity and requires an organization to submit a quarterly report to the commission's office of inspector general detailing the amount of money recovered. The bill requires the executive commissioner of HHSC to adopt rules necessary to implement the provisions relating to fraud and abuse recovery. The bill requires HHSC, to the extent required under federal law, to establish a program under which HHSC contracts with one or more recovery audit contractors for purposes of identifying underpayment and overpayments under Medicaid and recovering the overpayments.

H.B. 1720 amends the Health and Safety Code and the Human Resources Code to require the executive commissioner of HHSC to adopt rules for prohibiting a person from participating in CHIP or Medicaid as a health care provider for a reasonable period, as determined by the executive commissioner, if the person fails to repay overpayments under either program or owns, controls, manages, or is otherwise affiliated with a provider who has been suspended or prohibited from participating in either program.

H.B. 1720 amends the Human Resources Code to authorize a Medicaid 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. The bill 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 to certify on the order or other authorization that the person conducted an in-person evaluation of the recipient within that six-month period or that other authorization was issued. The bill requires the executive commissioner of HHSC to adopt rules necessary to implement provisions requiring in-person evaluations.

H.B. 1720 requires a state agency that is affected by a provision of the bill to request a federal waiver or authorization if the agency determines that a waiver or authorization is necessary for the implementation of the provision, and it authorizes the agency to delay implementation until the federal waiver or authorization is obtained.

EFFECTIVE DATE

September 1, 2011.