BILL ANALYSIS

Senate Research Center

C.S.S.B. 8
By: Nelson et al.
Health & Human Services
2/20/2013
Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

C.S.S.B. 8 enhances the state's ability to detect and prevent fraud, waste, and abuse in Medicaid and across the health and human services system. These changes will help ensure that public funds are expended on services for individuals who truly need them, and not on fraud, waste, and abuse.

Specifically, C.S.S.B. 8:

- Requires the Health and Human Services Commission (HHSC) to establish a unit with dedicated staff that will use data analytical processes to improve contract management and identify anomalies, outliers, or red flags in the Medicaid program that could indicate fraud, waste, or abuse;
- Carves nonemergency medical transportation services into managed care;
- Validates the authority of the Office of Inspector General to prevent, detect, audit, inspect, review, and investigate fraud, waste, and abuse across all health and human services programs;
- Strengthens state policies prohibiting the solicitation of Medicaid clients by providers;
- Directs HHSC, the Department of State Health Services, and the Texas Medical Board to review and strengthen agency policies related to ambulance providers;
- Validates the legislature's intent that a provider may not serve as the adult authorized by a parent or legal guardian to accompany a child to a Medicaid visit or screening;
- Clarifies that a provider is ineligible to participate in the Texas Medicaid program once found liable by a court for Medicaid fraud; and
- Permanently excludes from the Texas Medicaid program any provider who has been excluded or debarred from a state or federal health care program for fraud, or for injury to a child, senior, or individual with a disability.

C.S.S.B. 8 amends current law relating to the provision and delivery of certain health and human services in this state, including the provision of those services through the Medicaid program and the prevention of fraud, waste, and abuse in that program and other programs.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commissioner) in SECTION 2 (Section 531.02115, Government Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTION 8 (Section 32.0322, Human Resources Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter A, Chapter 531, Government Code, by adding Section 531.0082, as follows:

> Sec. 531.0082. DATA ANALYSIS UNIT. (a) Requires the executive commissioner of the Health and Human Services Commission (executive commissioner) to establish a data analysis unit within the Health and Human Services Commission (HHSC) to establish, employ, and oversee data analysis processes designed to:

(1) improve contract management;

(2) detect data trends; and

(3) identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid and child health plan program managed care and fee-for-service contracts.

(b) Requires HHSC to assign staff to the data analysis unit who perform duties only in relation to the unit.

(c) Requires the data analysis unit to use all available data and tools for data analysis when establishing, employing, and overseeing data analysis processes under this section.

(d) Requires the data analysis unit, not later than the 30th day following the end of each calendar quarter, to provide an update on the unit's activities and findings to certain persons and legislative entities.

SECTION 2. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.02115, as follows:

Sec. 531.02115. MARKETING ACTIVITIES BY PROVIDERS PARTICIPATING IN MEDICAID OR CHILD HEALTH PLAN PROGRAM. (a) Prohibits a provider participating in the Medicaid or child health plan program, including a provider participating in the network of a managed care organization that contracts with HHSC to provide services under the Medicaid or child health plan program, from engaging in any marketing activity, including any dissemination of material or other attempt to communicate, that:

(1) involves unsolicited personal contact, including by door-to-door solicitation, solicitation at a child-care facility or other type of facility, direct mail, or telephone, with a Medicaid client or a parent whose child is enrolled in the Medicaid or child health plan program;

(2) is directed at the client or parent solely because the client or the parent's child is receiving benefits under the Medicaid or child health plan program; and

(3) is intended to influence the client's or parent's choice of provider.

(b) Requires a provider participating in the network of a managed care organization described by Subsection (a), in addition to the requirements of that subsection, to comply with the marketing guidelines established by HHSC under Section 533.008 (Marketing Guidelines).

(c) Provides that nothing in this section prohibits:

(1) a provider participating in the Medicaid or child health plan program from:

(A) engaging in a marketing activity, including any dissemination of material or other attempt to communicate, that is intended to influence the choice of provider by a Medicaid client or a parent whose child is enrolled in the Medicaid or child health plan program, if the marketing activity involves only the general dissemination of information, including by television, radio, newspaper, or billboard advertisement, and does not involve unsolicited personal contact.

(B) as permitted under the provider's contract, engaging in the dissemination of material or another attempt to communicate with a Medicaid client or a parent whose child is enrolled in the Medicaid or child health plan program, including communication in person or by direct mail or telephone, for the purpose of:

(i) providing an appointment reminder;

(ii) distributing promotional health materials;

(iii) providing information about the types of services offered by the provider; or

(iv) coordinating patient care; or

(2) a provider participating in the Medicaid STAR + PLUS program from, as permitted under the provider's contract, engaging in a marketing activity, including any dissemination of material or other attempt to communicate, that is intended to educate a Medicaid client about available long-term care services and supports.

(d) Authorizes the executive commissioner to adopt rules as necessary to implement this section.

SECTION 3. Amends Section 531.02414, Government Code, by amending Subsection (d) and adding Subsections (g) and (h), as follows:

(d) Authorizes HHSC, subject to Section 533.00254, to contract with certain transportation entities for the provision of public transportation services, as defined by Section 461.002 (Definitions), Transportation Code, under the medical transportation program.

(g) Requires HHSC to enter into a memorandum of understanding with the Texas Department of Motor Vehicles and the Texas Department of Public Safety for purposes of obtaining the motor vehicle registration and driver's license information of:

(1) a recipient of medical transportation services, or another medical assistance recipient requesting those services, to confirm that the recipient meets the eligibility criteria for the services requiring that recipients have no other means of transportation; and

(2) a provider of medical transportation services, including a regional contracted broker and a subcontractor of the broker, to confirm that the provider complies with applicable requirements adopted under Subsection (e) (relating to requiring the executive commissioner to adopt certain rules to ensure the safe and efficient provision of nonemergency transportation services under the medical transportation program by regional contracted brokers and subcontractors of regional contracted brokers).

(h) Requires HHSC to establish a process by which providers of medical transportation services, including providers under a full-risk managed care delivery model, that contract with HHSC are authorized to request and obtain the information described under Subsection (g) for purposes of:

(1) similarly confirming a medical assistance recipient's eligibility for medical transportation services; and

(2) ensuring that subcontractors providing medical transportation services meet applicable requirements adopted under Subsection (e).

SECTION 4. Amends Subchapter B, Chapter 531, Government Code, by adding Section 531.076, as follows:

Sec. 531.076. REVIEW OF PRIOR AUTHORIZATION AND UTILIZATION REVIEW PROCESS. (a) Requires HHSC to periodically review in accordance with an established schedule the prior authorization and utilization review processes within the Medicaid fee-for-service delivery model to determine if those processes need modification to reduce authorizations of unnecessary services and inappropriate use of services. Requires HHSC to also monitor the processes described in this subsection for anomalies and, on identification of an anomaly in a process, to review the process for modification earlier than scheduled.

(b) Requires HHSC to monitor Medicaid managed care organizations to ensure that the organizations are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services.

SECTION 5. Amends Section 531.102, Government Code, by amending Subsection (a) and adding Subsection (l), as follows:

(a) Provides that HHSC's office of inspector general (OIG) is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and the enforcement of state law relating to the provision of those services, rather than providing that HHSC, through OIG, is responsible for the investigation of fraud and abuse in the provision of health and human services and the enforcement of state law relating to the provision of those services.

(l) Provides that nothing in this section limits the authority of any other state agency or governmental entity.

SECTION 6. (a) Amends Subchapter A, Chapter 533, Government Code, by adding Section 533.00254, as follows:

Sec. 533.00254. DELIVERY OF MEDICAL TRANSPORTATION PROGRAM SERVICES. (a) Defines "medical transportation program" in this section.

(b) Requires HHSC, subject to Subsection (c), to provide medical transportation program services on a regional basis through a full-risk managed care delivery model.

(c) Authorizes HHSC to delay providing medical transportation program services through a full-risk managed care delivery model in areas of this state in which HHSC on September 1, 2013, is piloting a full-risk transportation broker model until the date the contract entered into with the broker expires, or an earlier date, if HHSC determines that earlier implementation is feasible.

(b) Requires HHSC to begin providing medical transportation program services through the delivery model required by Section 533.00254, Government Code, as added by this section, not later than March 1, 2014, subject to Section 533.00254(c), Government Code, as added by this section.

SECTION 7. Amends Section 773.0571, Health and Safety Code, to require the Department of State Health Services (DSHS) to issue to an emergency medical services provider a license that is valid for two years if DSHS is satisfied that certain criteria are met, including that the emergency medical services provider has a letter of credit evidencing that the provider has

sufficient financial resources, and that the emergency medical services provider employs a medical director.

SECTION 8. Amends Section 32.0322, Human Resources Code, by amending Subsection (b) and adding Subsections (b-1), (e), (f), and (g), as follows:

(b) Requires the executive commissioner by rule, subject to Subsections (b-1) and (e), to establish criteria for HHSC or OIG to suspend a provider's billing privileges under the medical assistance program, revoke a provider's enrollment under the program, or deny a person's application to enroll as a provider under the program based on certain criteria.

(b-1) Requires the executive commissioner, in adopting rules under this section and except as provided by Subsection (g), to require revocation of a provider's enrollment or denial of a person's application for enrollment as a provider under the medical assistance program if the person has been excluded or debarred from participation in a state or federally funded health care program as a result of:

(1) a criminal conviction or finding of civil or administrative liability for committing a fraudulent act, theft, embezzlement, or other financial misconduct under a state or federally funded health care program; or

(2) a criminal conviction for committing an act under a state or federally funded health care program that caused bodily injury to a person who is 65 years of age or older, a person with a disability, or a person under 18 years of age.

(e) Authorizes HHSC or an agency operating part of the medical assistance program (department) to reinstate a provider's enrollment under the medical assistance program or grant a person's previously denied application to enroll as a provider, including a person described by Subsection (b-1), if the department finds:

(1) good cause to determine that it is in the best interest of the medical assistance program; and

(2) the person has not committed an act that would require revocation of a provider's enrollment or denial of a person's application to enroll since the person's enrollment was revoked or application was denied, as appropriate.

(f) Requires the department to support a determination made under Subsection (e) with written findings of good cause for the determination.

SECTION 9. Amends Section 36.005, Human Resources Code, as follows:

(b-1) Provides that the period of ineligibility begins on the date on which the judgment finding the provider liable under Section 36.052 (Civil Remedies) is entered by the trial court, rather than the date on which the determination that the provider is liable becomes final.

(b-2)-(d) Makes no changes to these subsections.

(e) Provides that the period of ineligibility for an individual licensed by a health care regulatory agency or a physician, notwithstanding Subsection (b-1), begins on the date on which the determination that the individual or physician is liable becomes final.

(f) Defines "physician" for purposes of Subsection (e).

(g) Defines "health care regulatory agency" for purposes of Subsection (e).

SECTION 10. Amends Subchapter C, Chapter 36, Human Resources Code, by adding Section 36.1041, as follows:

Sec. 36.1041. NOTIFICATION OF SETTLEMENT. (a) Requires a person, not later than the 10th day after the date a person described by Section 36.104(b) (relating to the state's declination to take over civil action brought by a private person against a violation of Medicaid fraud) reaches a proposed settlement agreement with a defendant, to notify the attorney general. Provides that, if the person fails to notify the attorney general as required by this section, the proposed settlement is void.

(b) Requires the attorney general, not later than the 30th day after the date the attorney general receives notice under Subsection (a), to file any objections to the terms of the proposed settlement agreement with the court.

(c) Requires the court, on filing of objections under Subsection (b), to conduct a hearing. Authorizes the hearing, on showing of good cause, to be held in camera. Authorizes the court to allow the parties to settle, notwithstanding the attorney general's objection, if, after the hearing, the court determines that the proposed settlement is fair, adequate, and reasonable under all the circumstances.

(d) Prohibits the settlement, if, after the hearing, the court determines that the attorney general's objection is well founded, from being approved by the court. Authorizes the court to order the parties to renegotiate the settlement to address the attorney general's objection.

SECTION 11. (a) Requires HHSC, in cooperation with DSHS and the Texas Medical Board (TMB), to:

(1) as soon as practicable after the effective date of this Act, conduct a thorough review of and solicit stakeholder input regarding the laws and policies related to the use of non-emergent services provided by ambulance providers under the medical assistance program established under Chapter 32 (Medical Assistance Program), Human Resources Code;

(2) not later than January 1, 2014, make recommendations to the legislature regarding suggested changes to the law that would reduce the incidence of and opportunities for fraud, waste, and abuse with respect to the activities described by Subdivision (1) of this subsection; and

(3) amend the policies described by Subdivision (1) of this subsection as necessary to assist in accomplishing the goals described by Subdivision (2) of this subsection.

(b) Provides that this section expires September 1, 2015.

SECTION 12. (a) Requires DSHS, in cooperation with HHSC and TMB, to:

(1) as soon as practicable after the effective date of this Act, conduct a thorough review of and solicit stakeholder input regarding the laws and policies related to the licensure of nonemergency transportation providers;

(2) not later than January 1, 2014, make recommendations to the legislature regarding suggested changes to the law that would reduce the incidence of and opportunities for fraud, waste, and abuse with respect to the activities described by Subdivision (1) of this subsection; and

(3) amend the policies described by Subdivision (1) of this subsection as necessary to assist in accomplishing the goals described by Subdivision (2) of this subsection.

(b) Provides that this section expires September 1, 2015.

SECTION 13. (a) Requires TMB, in cooperation with DSHS and HHSC, to:

(1) as soon as practicable after the effective date of this Act, conduct a thorough review of and solicit stakeholder input regarding the laws and policies related to:

(A) the delegation of health care services by physicians or medical directors to qualified emergency medical services personnel; and

(B) physicians' assessment of patients' needs for purposes of ambulatory transfer or transport or other purposes;

(2) not later than January 1, 2014, make recommendations to the legislature regarding suggested changes to the law that would reduce the incidence of and opportunities for fraud, waste, and abuse with respect to the activities described by Subdivision (1) of this subsection; and

(3) amend the policies described by Subdivision (1) of this subsection as necessary to assist in accomplishing the goals described by Subdivision (2) of this subsection.

(b) Provides that this section expires September 1, 2015.

SECTION 14. (a) Provides that this section is a clarification of legislative intent regarding Section 32.024(s) (relating to the periodicity of visits for children on Medicare and the eligibility of reimbursement for these visits), Human Resources Code, and a validation of certain HHSC acts and decisions.

(b) Provides that the legislature, in 1999, became aware that certain children enrolled in the Medicaid program were receiving treatment under the program outside the presence of a parent or another responsible adult. Provides that the treatment of unaccompanied children under the Medicaid program resulted in the provision of unnecessary services to those children, the exposure of those children to unnecessary health and safety risks, and the submission of fraudulent claims by Medicaid providers.

(c) Provides that the legislature, in addition, in 1999, became aware of allegations that certain Medicaid providers were offering money and other gifts in exchange for a parent's or child's consent to receive unnecessary services under the Medicaid program. Provides that a child, in some cases, was offered money or gifts in exchange for the parent's or child's consent to have the child transported to a different location to receive unnecessary services. Provides that the child, in some of those cases, once transported, received no treatment and was left unsupervised for hours before being transported home. Provides that the provision of money and other gifts by Medicaid providers in exchange for parents' or children's consent to services deprived those parents and children of the right to choose a Medicaid provider without improper inducement.

(d) Provides that the legislature, in response, in 1999, enacted Chapter 766 (H.B. 1285), Acts of the 76th Legislature, Regular Session, which amended Section 32.024, Human Resources Code, by amending Subsection (s) and adding Subsection (s-1). Provides that Section 32.024(s), Human Resources Code, as amended, requires that a child's parent or guardian or another adult authorized by the child's parent or guardian accompany the child at a visit or screening under the early and periodic screening, diagnosis, and treatment program in order for a Medicaid provider to be reimbursed for services provided at the visit or screening. Provides that the bill, as filed, required a child's parent or guardian to accompany the child. Provides that the house committee report added the language allowing an adult authorized by the child's parent or guardian to accompany the child in order to accommodate a parent or guardian for whom accompanying the parent's or guardian's child to each visit or screening would be a hardship.

(e) Provides that the principal purposes of Chapter 766 (H.B. 1285), Acts of the 76th Legislature, Regular Session, 1999, were to prevent Medicaid providers from committing fraud, encourage parental involvement in and management of health care of children

enrolled in the early and periodic screening, diagnosis, and treatment program, and ensure the safety of children receiving services under the Medicaid program. Provides that the addition of the language allowing an adult authorized by a child's parent or guardian to accompany the child furthered each of those purposes.

(f) Provides that the legislature, in amending Section 32.024(s), Human Resources Code, understood that:

(1) the effectiveness of medical, dental, and therapy services provided to a child improves when the child's parent or guardian actively participates in the delivery of those services;

(2) a parent is responsible for the safety and well-being of the parent's child, and that a parent cannot casually delegate this responsibility to a stranger;

(3) a parent may not always be available to accompany the parent's child at a visit to the child's doctor, dentist, or therapist; and

(4) Medicaid providers and their employees and associates have a financial interest in the delivery of services under the Medicaid program and, accordingly, cannot fulfill the responsibilities of a parent or guardian when providing services to a child.

(g) Provides that the legislature declares that a Medicaid provider, or an employee or associate of the Medicaid provider, is not "another adult" within the meaning of Section 32.024(s), Human Resources Code, from the date the section was amended, and may not be authorized by the parent or guardian of a child to accompany the child at a visit or screening under the early and periodic screening, diagnosis, and treatment program at which the Medicaid provider provides services to the child. Provides that any interpretation of Section 32.024(s), Human Resources Code, that allows a Medicaid provider, or an employee or associate of the Medicaid provider, to be authorized to accompany a child at a visit or screening at which the Medicaid provider provides services is contrary to the intent of the legislature.

(h)(1) Provides that HHSC, on March 15, 2012, notified certain Medicaid providers that state law and HHSC policy require a child's parent or guardian or another properly authorized adult to accompany a child receiving services under the Medicaid program. Provides that this notice followed HHSC's discovery that some providers were transporting children from schools to therapy clinics and other locations to receive therapy services. Provides that, although the children were not accompanied by a parent or guardian during these trips, the providers were obtaining reimbursement for the trips under the Medicaid medical transportation program. Provides that HHSC clarified in the notice that in order for a provider to be reimbursed for transportation services provided to a child under the Medicaid medical transportation program, the child must be accompanied by the child's parent or guardian or another adult who is not the provider and whom the child's parent or guardian has authorized to accompany the child by submitting signed, written consent to the provider.

(2) Provides that a lawsuit was filed, in May 2012, to enjoin HHSC from enforcing Section 32.024(s), Human Resources Code, and 1 T.A.C. Section 380.207, as interpreted in certain notices issued by HHSC. Provides that a state district court enjoined HHSC from denying eligibility to a child for transportation services under the Medicaid medical transportation program if the child's parent or guardian does not accompany the child, provided that the child's parent or guardian authorizes any other adult to accompany the child. Provides that the court also enjoined HHSC from requiring as a condition for a provider to be reimbursed for services provided to a child during a visit or screening under the early and periodic screening, diagnosis, and treatment program that the child be accompanied by the child's parent or guardian, provided that the child's parent or

guardian authorizes another adult to accompany the child. Provides that the state has filed a notice of appeal of the court's order.

(3) Provides that OIG, additionally, has found that several Medicaid providers have knowingly offered and provided inducements to individuals enrolled in the Medicaid program to influence decisions by the individuals relating to selecting a Medicaid provider and receiving goods and services under the Medicaid program. Provides that some providers, specifically, have offered, arranged for, and provided free transportation services to influence individuals' selection of a provider in violation of federal law. Provides that OIG has the authority to sanction these violations under 1 T.A.C. Chapter 371. Provides that OIG, accordingly, in late July and early August 2012, issued notices of intent to assess penalties against providers whom OIG found to have committed these violations.

(4) Provides that the legislature declares that a governmental action taken or a decision made by HHSC before the effective date of this Act to implement or enforce a policy requiring that, in order for a Medicaid provider to be reimbursed for services provided to a child under the early and periodic screening, diagnosis, and treatment program, the child must be accompanied by the child's parent or guardian or another adult who is not the provider or the provider's employee or associate and whom the child's parent or guardian has authorized to accompany the child by submitting signed, written consent to the provider pursuant to Section 32.024(s), Human Resources Code, is conclusively presumed, as of the date the action was taken or the decision was made, to be valid and to have occurred in accordance with all applicable law.

(5) Provides that the legislature also declares that, without determination of the weight or sufficiency of the evidence relied upon, the imposition of sanctions by OIG on Medicaid providers whom OIG has found to have offered and provided inducements to individuals enrolled in the Medicaid program in violation of federal law is a valid exercise of that office's authority to enforce laws that regulate fraud, waste, and abuse in the Medicaid program.

(6) Provides that this section does not apply to an action or decision that was void at the time the action was taken or the decision was made, an action or decision that violates federal law or the terms of a federal waiver, or an action or decision that, under a statute of this state or the United States, was a misdemeanor or felony at the time the action was taken or the decision was made.

SECTION 15. Requires the executive commissioner to, as soon as practicable after the effective date of this Act, establish the data analysis unit required under Section 531.0082, Government Code, as added by this Act. Requires the data analysis unit to provide the initial update required under Section 531.0082(d), Government Code, as added by this Act, not later than the 30th day after the last day of the first complete calendar quarter occurring after the date the unit is established.

SECTION 16. Makes application of Section 773.0571, Health and Safety Code, as amended by this Act, prospective.

SECTION 17. Requires HHSC, 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 18. Effective date: September 1, 2013.