By: Gonzales H.B. No. 3279

A BILL TO BE ENTITLED

AN ACT

relating to the authority and duties of the office of inspector general of the Health and Human Services Commission.

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

SECTION 1. Section 531.1011(4), Government Code, is amended to read as follows:

(4) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person[~~, including any act that constitutes fraud under applicable federal or state law~~]. The term does not include unintentional technical, clerical, or administrative errors.

SECTION 2. Section 531.102, Government Code, is amended by amending Subsections (a-1), (f), (g), and (k) and adding Subsections (f-1), (p), (q), and (r) to read as follows:

(a-1) The executive commissioner [~~governor~~] shall appoint an inspector general to serve as director of the office. The inspector general serves a one-year term that expires on February 1.

(f)(1) If the commission receives a complaint or allegation of Medicaid fraud or abuse from any source, the office must conduct a preliminary investigation as provided by Section 531.118(c) to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later

than the 30th day, and be completed not later than the 45th day, after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. [~~A preliminary investigation shall be completed not later than the 90th day after it began.~~]

(2) If the findings of a preliminary investigation give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, the office must take the following action, as appropriate, not later than the 30th day after the completion of the preliminary investigation:

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions; or

(B) if there is reason to believe that a recipient has defrauded the Medicaid program, the office may conduct a full investigation of the suspected fraud, subject to Section 531.118(c).

(f-1) The office shall complete a full investigation of a complaint or allegation of Medicaid fraud or abuse against a provider not later than the 180th day after the date the full investigation begins unless the office determines that more time is needed to complete the investigation. Except as otherwise provided by this subsection, if the office determines that more time is

needed to complete the investigation, the office shall provide notice to the provider who is the subject of the investigation stating that the length of the investigation will exceed 180 days and specifying the reasons why the office was unable to complete the investigation within the 180-day period. The office is not required to provide notice to the provider under this subsection if the office determines that providing notice would jeopardize the investigation.

(g)(1) Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

(2) As [~~In addition to other instances~~] authorized under state and [~~or~~] federal law, and except as provided by Subdivisions (8) and (9), the office shall impose without prior notice a payment hold on claims for reimbursement submitted by a provider only to compel production of records, when requested by the state's Medicaid fraud control unit, or on the determination that a credible allegation of fraud exists, subject to Subsections (l) and (m), as applicable. The payment hold is a serious enforcement tool that the office imposes to mitigate ongoing financial risk to the state. A payment hold imposed under this subdivision takes immediate effect. The office must notify the

provider of the payment hold in accordance with 42 C.F.R. Section 455.23(b) and, except as provided by that regulation, not later than the fifth day after the date the office imposes the payment hold. In addition to the requirements of 42 C.F.R. Section 455.23(b), the notice of payment hold provided under this subdivision must also include:

(A) the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation, [~~and~~] a representative sample of any documents that form the basis for the hold, and a detailed summary of the office's evidence relating to the allegation; [~~and~~]

(B) a description of administrative and judicial due process rights and remedies, including the provider's option [~~right~~] to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both; and

(C) a detailed timeline for the provider to pursue the rights and remedies described in Paragraph (B).

(3) On timely written request by a provider subject to a payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, the office shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold not later than the third day after the date the office receives the provider's request. The provider must request an expedited administrative hearing under this subdivision not later than the 10th [~~30th~~] day after the date the provider receives notice from the office under

Subdivision (2). The State Office of Administrative Hearings shall hold the expedited administrative hearing not later than the 45th day after the date the State Office of Administrative Hearings receives the request for the hearing. In a hearing held under this subdivision [~~Unless otherwise determined by the administrative law judge for good cause at an expedited administrative hearing, the state and the provider shall each be responsible for~~]:

(A) the provider and the office are each limited to four hours of testimony, excluding time for responding to questions from the administrative law judge [~~one-half of the costs charged by the State Office of Administrative Hearings~~];

(B) the provider and the office are each entitled to two continuances under reasonable circumstances [~~one-half of the costs for transcribing the hearing~~]; and

(C) the office is required to show probable cause that the credible allegation of fraud that is the basis of the payment hold has an indicia of reliability and that continuing to pay the provider presents an ongoing significant financial risk to the state and a threat to the integrity of the Medicaid program [~~the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, depositions, and subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and~~

[~~(D) all other costs associated with the hearing that are incurred by the party, including attorney's fees~~].

(4) The office is responsible for the costs of a hearing held under Subdivision (3), but a provider is responsible

for the provider's own costs incurred in preparing for the hearing [~~executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before an expedited administrative hearing, to advance security for the costs for which the provider is responsible under that subdivision~~].

(5) In a hearing held under Subdivision (3), the administrative law judge shall decide if the payment hold should continue but may not adjust the amount or percent of the payment hold. The decision of the administrative law judge is final and may not be appealed [~~Following an expedited administrative hearing under Subdivision (3), a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County~~].

(6) The executive commissioner shall adopt rules that allow a provider subject to a payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution of the issues identified by the office in the notice provided under that subdivision. A provider must request an initial informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3) for requesting an expedited administrative hearing. On receipt of a timely request, the office shall decide whether to grant the provider's request for an initial informal resolution meeting, and if the office decides to grant the request, the office shall schedule the [~~an~~] initial informal resolution meeting [~~not~~

~~later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider~~]. The office shall give notice to the provider of the time and place of the initial informal resolution meeting [~~not later than the 30th day before the date the meeting is to be held~~]. A provider may request a second informal resolution meeting [~~not later than the 20th day~~] after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall decide whether to grant the provider's request for a second informal resolution meeting, and if the office decides to grant the request, the office shall schedule the [~~a~~] second informal resolution meeting [~~not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider~~]. The office shall give notice to the provider of the time and place of the second informal resolution meeting [~~not later than the 20th day before the date the meeting is to be held~~]. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office. A provider's decision to seek an informal resolution under this subdivision does not extend the time by which the provider must request an expedited administrative hearing under Subdivision (3). The informal resolution process shall run concurrently with the administrative hearing process, and the informal resolution process shall be discontinued once the State Office of Administrative Hearings issues a final determination on

the payment hold. [~~However, a hearing initiated under Subdivision (3) shall be stayed until the informal resolution process is completed.~~]

(7) The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds or program exclusions:

(A) may permissively be imposed on a provider; or

(B) shall automatically be imposed on a provider.

(8) In accordance with 42 C.F.R. Sections 455.23(e) and (f), on the determination that a credible allegation of fraud exists, the office may find that good cause exists to not impose a payment hold, to not continue a payment hold, to impose a payment hold only in part, or to convert a payment hold imposed in whole to one imposed only in part, if any of the following are applicable:

(A) law enforcement officials have specifically requested that a payment hold not be imposed because a payment hold would compromise or jeopardize an investigation;

(B) available remedies implemented by the state other than a payment hold would more effectively or quickly protect Medicaid funds;

(C) the office determines, based on the submission of written evidence by the provider who is the subject of the payment hold, that the payment hold should be removed;

(D) Medicaid recipients' access to items or services would be jeopardized by a full or partial payment hold because the provider who is the subject of the payment hold:

(i) is the sole community physician or the

sole source of essential specialized services in a community; or

(ii) serves a large number of Medicaid recipients within a designated medically underserved area;

(E) the attorney general declines to certify that a matter continues to be under investigation; or

(F) the office determines that a full or partial payment hold is not in the best interests of the Medicaid program.

(9) The office may not impose a payment hold on claims for reimbursement submitted by a provider for medically necessary services for which the provider has obtained prior authorization from the commission or a contractor of the commission unless the office has evidence that the provider has materially misrepresented documentation relating to those services.

(k) A final report on an audit or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit or investigation remain confidential and not subject to required disclosure in accordance with Section 531.1021(g). A confidential draft report on an audit or investigation that concerns the death of a child may be shared with the Department of Family and Protective Services. A draft report that is shared with the Department of Family and Protective Services remains confidential and is not subject to disclosure under Chapter 552.

(p) The executive commissioner, on behalf of the office, shall adopt rules establishing criteria:

(1) for opening a case;

(2) for prioritizing cases for the efficient

management of the office's workload, including rules that direct the office to prioritize:

(A) provider cases according to the highest potential for recovery or risk to the state as indicated through the provider's volume of billings, the provider's history of noncompliance with the law, and identified fraud trends;

(B) recipient cases according to the highest potential for recovery and federal timeliness requirements; and

(C) internal affairs investigations according to the seriousness of the threat to recipient safety and the risk to program integrity in terms of the amount or scope of fraud, waste, and abuse posed by the allegation that is the subject of the investigation; and

(3) to guide field investigators in closing a case that is not worth pursuing through a full investigation.

(q) The executive commissioner, on behalf of the office, shall adopt rules establishing criteria for determining enforcement and punitive actions with regard to a provider who has violated state law, program rules, or the provider's Medicaid provider agreement that include:

(1) direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions, taking into consideration:

(A) the seriousness of the violation;

(B) the prevalence of errors by the provider;

(C) the financial or other harm to the state or recipients resulting or potentially resulting from those errors;

and

(D) mitigating factors the office determines appropriate; and

(2) a specific list of potential penalties, including the amount of the penalties, for fraud and other Medicaid program violations.

(r) The office shall review the office's investigative process, including the office's use of sampling and extrapolation to audit provider records. The review shall be performed by staff who are not directly involved in investigations conducted by the office.

SECTION 3. Section 531.102(l), Government Code, as added by Chapter 1311 (S.B. 8), Acts of the 83rd Legislature, Regular Session, 2013, is redesignated as Section 531.102(o), Government Code, to read as follows:

(o) [~~(l)~~] Nothing in this section limits the authority of any other state agency or governmental entity.

SECTION 4. Section 531.113, Government Code, is amended by adding Subsection (d-1) and amending Subsection (e) to read as follows:

(d-1) The commission's office of inspector general shall:

(1) investigate, including by means of regular audits, possible fraud, waste, and abuse by managed care organizations subject to this section;

(2) establish requirements for the provision of training to and regular oversight of special investigative units established by managed care organizations under Subsection (a)(1)

and entities with which managed care organizations contract under Subsection (a)(2);

(3) establish requirements for approving plans to prevent and reduce fraud and abuse adopted by managed care organizations under Subsection (b);

(4) evaluate statewide fraud, waste, and abuse trends in the Medicaid program and communicate those trends to special investigative units and contracted entities to determine the prevalence of those trends; and

(5) assist managed care organizations in discovering or investigating fraud, waste, and abuse, as needed.

(e) The executive commissioner shall adopt rules as necessary to accomplish the purposes of this section, including rules defining the investigative role of the commission's office of inspector general with respect to the investigative role of special investigative units established by managed care organizations under Subsection (a)(1) and entities with which managed care organizations contract under Subsection (a)(2). The rules adopted under this section must specify the office's role in:

(1) reviewing the findings of special investigative units and contracted entities;

(2) investigating cases where the overpayment amount sought to be recovered exceeds $100,000; and

(3) investigating providers who are enrolled in more than one managed care organization.

SECTION 5. Section 531.118(b), Government Code, is amended to read as follows:

(b) If the commission receives an allegation of fraud or abuse against a provider from any source, the commission's office of inspector general shall conduct a preliminary investigation of the allegation to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day, and be completed not later than the 45th day, after the date the commission receives or identifies an allegation of fraud or abuse.

SECTION 6. Section 531.120(b), Government Code, is amended to read as follows:

(b) A provider may [~~must~~] request an [~~initial~~] informal resolution meeting under this section, and on [~~not later than the 30th day after the date the provider receives notice under Subsection (a). On~~] receipt of the [~~a timely~~] request, the office shall schedule the [~~an initial~~] informal resolution meeting [~~not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office if requested by the provider~~]. The office shall give notice to the provider of the time and place of the [~~initial~~] informal resolution meeting [~~not later than the 30th day before the date the meeting is to be held~~]. The informal resolution process shall run concurrently with the administrative hearing process, and the administrative hearing process may not be delayed on account of the informal resolution process. [~~A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule~~

~~a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office if requested by the provider. The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.~~]

SECTION 7. Section 531.1201(b), Government Code, is amended to read as follows:

(b) The commission's office of inspector general is responsible for the costs of an administrative hearing held under Subsection (a), but a provider is responsible for the provider's own costs incurred in preparing for the hearing [~~Unless otherwise determined by the administrative law judge for good cause, at any administrative hearing under this section before the State Office of Administrative Hearings, the state and the provider shall each be responsible for:~~

[~~(1) one-half of the costs charged by the State Office of Administrative Hearings;~~

[~~(2) one-half of the costs for transcribing the hearing;~~

[~~(3) the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, depositions, and subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and~~

[~~(4) all other costs associated with the hearing that are incurred by the party, including attorney's fees~~].

SECTION 8. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1203 to read as follows:

Sec. 531.1203. RIGHTS OF AND PROVISION OF INFORMATION TO PHARMACIES SUBJECT TO CERTAIN AUDITS. (a) A pharmacy has a right to request an informal hearing before the commission's appeals division to contest the findings of an audit conducted by the commission's office of inspector general or an entity that contracts with the federal government to audit Medicaid providers if the findings of the audit do not include that the pharmacy engaged in Medicaid fraud.

(b) In an informal hearing held under this section, staff of the commission's appeals division, assisted by staff responsible for the commission's vendor drug program who have expertise in the law governing pharmacies' participation in the Medicaid program, make the final decision on whether the findings of an audit are accurate. Staff of the commission's office of inspector general may not serve on the panel that makes the decision on the accuracy of an audit.

(c) In order to increase transparency, the commission's office of inspector general shall, if the office has access to the information, provide to pharmacies that are subject to audit by the office or an entity that contracts with the federal government to audit Medicaid providers detailed information relating to the extrapolation methodology used as part of the audit and the methods used to determine whether the pharmacy has been overpaid under the

Medicaid program.

SECTION 9. The following provisions are repealed:

(1) Section 531.1201(c), Government Code; and

(2) Section 32.0422(k), Human Resources Code.

SECTION 10. Notwithstanding Section 531.004, Government Code, the Sunset Advisory Commission shall conduct a special-purpose review of the overall performance of the Health and Human Services Commission's office of inspector general. In conducting the review, the Sunset Advisory Commission shall particularly focus on the office's investigations and the effectiveness and efficiency of the office's processes, as part of the Sunset Advisory Commission's review of agencies for the 87th Legislature. The office is not abolished solely because the office is not explicitly continued following the review.

SECTION 11. The change in law made by this Act to Section 531.102(a-1), Government Code, does not affect the entitlement of the person serving as inspector general for the Health and Human Services Commission immediately before the effective date of this Act to continue to serve as inspector general for the remainder of the person's term, unless otherwise removed. The change in law applies only to a person appointed as inspector general on or after the effective date of this Act.

SECTION 12. Section 531.102, Government Code, as amended by this Act, applies only to a complaint or allegation of Medicaid fraud or abuse received by the Health and Human Services Commission or the commission's office of inspector general on or after the effective date of this Act. A complaint or allegation received

before the effective date of this Act is governed by the law as it existed when the complaint or allegation was received, and the former law is continued in effect for that purpose.

SECTION 13. Not later than March 1, 2016, the executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement the changes in law made by this Act to Section 531.102(g)(2), Government Code, regarding the circumstances in which a payment hold may be placed on claims for reimbursement submitted by a Medicaid provider.

SECTION 14. Sections 531.120 and 531.1201, Government Code, as amended by this Act, apply only to a proposed recoupment of an overpayment or debt of which a provider is notified on or after the effective date of this Act. A proposed recoupment of an overpayment or debt that a provider was notified of before the effective date of this Act is governed by the law as it existed when the provider was notified, and the former law is continued in effect for that purpose.

SECTION 15. Not later than March 1, 2016, the executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement Section 531.1203, Government Code, as added by this Act.

SECTION 16. 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 17. This Act takes effect September 1, 2015.