BILL ANALYSIS

C.S.H.B. 2969
By: Raymond
Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

Interested parties contend that state law regarding the detection and reporting of fraud in the Medicaid program lacks clarity and does not afford the Health and Human Services Commission (HHSC) adequate flexibility regarding the use of technology in detecting such fraud. C.S.H.B. 2969 seeks to provide HHSC additional flexibility by giving HHSC the option to use other technology in addition to learning or neural network technology in detecting and deterring fraud in the Medicaid program.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 2969 amends the Government Code to require the office of inspector general of the Health and Human Services Commission (HHSC) to prepare a final report on each inspection of fraud, waste, and abuse in the provision and delivery of Medicaid and other health and human services in Texas. The bill makes the final report subject to disclosure under state public information law but makes all information and materials subpoenaed or compiled by the office in connection with such an inspection confidential and not subject to disclosure under state public information law or any other means of legal compulsion for their release. The bill authorizes a confidential draft report on an inspection that concerns the death of a child to be shared with the Department of Family and Protective Services.

C.S.H.B. 2969 expands the forms of technology HHSC is required to use to identify and deter fraud in Medicaid throughout Texas to include the option to use other technology in addition to learning or neural network technology.

C.S.H.B. 2969 changes the entities responsible for immediately notifying the HHSC office of inspector general and the office of the attorney general on discovering fraud or abuse in Medicaid or the child health plan program (CHIP) and for taking certain payment recovery actions from a Medicaid managed care organization's special investigative unit or a contracting entity to that organization in general or the contracting entity. The bill specifies that the notification is written notice submitted in the form and manner prescribed by the inspector general's office and containing a detailed description of the fraud or abuse and each payment made to a provider as a result of the fraud or abuse. The bill changes the amount of money recovered from the payment recovery efforts begun following the discovery of the fraud or abuse

that a managed care organization may retain from any money recovered to one-half of any money recovered and requires the organization to remit the remaining amount of money recovered to the inspector general's office.

C.S.H.B. 2969 entitles a managed care organization to one-half of the amount recovered for each payment the organization identified after any applicable federal share is deducted if the HHSC inspector general's office notifies the organization that the organization is not authorized to proceed with recovery efforts due to the amount sought to be recovered, proceeds with recovery efforts, and recovers all or part of the payments the organization identified as resulting from fraud or abuse. The bill prohibits the managed care organization from receiving more than one-half of the total amount of money recovered after any applicable federal share is deducted. The bill authorizes the HHSC inspector general's office, if the office discovers fraud, waste, or abuse in Medicaid or CHIP in the performance of its duties, to recover payments made to a provider as a result of the fraud, waste, or abuse. The bill requires the HHSC inspector general's office, with respect to fraud or abuse alleged in a notice received from a managed care organization, to coordinate with appropriate managed care organizations to ensure that the office and an organization or an entity with which an organization contracts for the investigation of fraudulent claims and other types of program abuse by recipients and service providers do not both simultaneously pursue recovery efforts for the same case of fraud, waste, or abuse.

EFFECTIVE DATE

On passage, or, if the bill does not receive the necessary vote, September 1, 2017.

COMPARISON OF ORIGINAL AND SUBSTITUTE

While C.S.H.B. 2969 may differ from the original in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the introduced and committee substitute versions of the bill.

INTRODUCED	HOUSE COMMITTEE SUBSTITUTE
SECTION 1. Sections 531.102(j) and (k), Government Code, are amended.	SECTION 1. Same as introduced version.
SECTION 2. Section 531.1021(g), Government Code, is amended.	SECTION 2. Same as introduced version.
SECTION 3. The heading to Section 531.106, Government Code, is amended.	SECTION 3. Same as introduced version.
SECTION 4. Sections 531.106(a), (c), and (g), Government Code, are amended.	SECTION 4. Same as introduced version.
SECTION 5. Section 531.1061(b), Government Code, is amended.	SECTION 5. Same as introduced version.
No equivalent provision.	SECTION 6. Section 531.1131, Government Code, is amended by amending Subsections (a), (b), and (c) and adding Subsections (c-1), (c-2), and (c-3) to read as follows: (a) If a managed care <u>organization</u> [~~organization's special investigative unit under Section 531.113(a)(1)~~] or <u>an</u> [~~the~~]

entity with which the managed care organization contracts under Section 531.113(a)(2) discovers fraud or abuse in Medicaid or the child health plan program, the organization [~~unit~~] or entity shall:

(1) immediately submit written notice to [~~and contemporaneously notify~~] the commission's office of inspector general and the office of the attorney general in the form and manner prescribed by the office of inspector general and containing a detailed description of the fraud or abuse and each payment made to a provider as a result of the fraud or abuse;

(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) If the amount sought to be recovered under Subsection (a)(2) exceeds $100,000, the managed care organization [~~organization's special investigative unit~~] or the contracted entity described by Subsection (a) may not engage in payment recovery efforts if, not later than the 10th business day after the date the organization [~~unit~~] or entity notified the commission's office of inspector general and the office of the attorney general under Subsection (a)(1), the organization [~~unit~~] or entity receives a notice from either office indicating that the organization [~~unit~~] or entity is not authorized to proceed with recovery efforts.

(c) A managed care organization may retain one-half of any money recovered under Subsection (a)(2) by the organization [~~organization's special investigative unit~~] or the contracted entity described by Subsection (a). The managed care organization shall remit the remaining amount of money recovered under Subsection (a)(2) to the commission's office of inspector general for deposit to the credit of the general revenue fund.

(c-1) If the commission's office of inspector general notifies a managed care organization under Subsection (b), proceeds with recovery efforts, and recovers all or part of the payments the organization identified as required by Subsection (a)(1), the organization is entitled to one-half of the amount recovered for each payment the organization identified after any applicable

	federal share is deducted. The organization may not receive more than one-half of the total amount of money recovered after any applicable federal share is deducted. (c-2) Notwithstanding any provision of this section, if the commission's office of inspector general discovers fraud, waste, or abuse in Medicaid or the child health plan program in the performance of its duties, the office may recover payments made to a provider as a result of the fraud, waste, or abuse as otherwise provided by this subchapter. All payments recovered by the office under this subsection shall be deposited to the credit of the general revenue fund. (c-3) The commission's office of inspector general shall coordinate with appropriate managed care organizations to ensure that the office and an organization or an entity with which an organization contracts under Section 531.113(a)(2) do not both begin payment recovery efforts under this section for the same case of fraud, waste, or abuse.
No equivalent provision.	SECTION 7. Section 531.1131, Government Code, as amended by this Act, applies only to an amount of money recovered on or after the effective date of this Act. An amount of money recovered before the effective date of this Act is governed by the law in effect immediately before that date, and that law is continued in effect for that purpose.
SECTION 6. 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 8. Same as introduced version.
SECTION 7. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2017.	SECTION 9. Same as introduced version.