By: Raymond H.B. No. 648

A BILL TO BE ENTITLED

AN ACT

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

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

SECTION 1. Section 531.102, Government Code, is amended by amending Subsections (b), (f), (f-1), (h), (n), (p), and (r) and adding Subsection (z) to read as follows:

(b) The [~~commission, in consultation with the~~] inspector general[~~,~~] shall set clear objectives, priorities, and performance standards for the office that emphasize:

(1) coordinating investigative efforts to aggressively recover money;

(2) allocating resources to cases that have the strongest supportive evidence [~~and the greatest potential for recovery of money~~]; and

(3) maximizing opportunities for referral of cases to the office of the attorney general in accordance with Section 531.103.

(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.

(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 Medicaid, 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 or Medicaid managed care organization 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 or Medicaid managed care organization, 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 Medicaid, 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 or Medicaid managed care organization 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 or Medicaid managed care organization that [~~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 or Medicaid managed care organization under this subsection if the office determines that providing notice would jeopardize the investigation.

(h) In addition to performing functions and duties otherwise provided by law, the office may:

(1) assess administrative penalties otherwise authorized by law on behalf of the commission or a health and human services agency;

(2) request that the attorney general obtain an injunction to prevent a person from disposing of an asset identified by the office as potentially subject to recovery by the office due to the person's fraud or abuse;

(3) provide for coordination between the office and special investigative units formed by managed care organizations under Section 531.113 or entities with which managed care organizations contract under that section;

(4) audit the use and effectiveness of state or federal funds, including contract and grant funds, administered by a person, [~~or~~] state agency, or managed care organization receiving the funds from a health and human services agency;

(5) conduct investigations relating to the funds

described by Subdivision (4); and

(6) recommend policies promoting economical and efficient administration of the funds described by Subdivision (4) and the prevention and detection of fraud and abuse in administration of those funds.

(n) To the extent permitted under federal law, the executive commissioner, on behalf of the office, shall adopt rules establishing the criteria for initiating a full-scale fraud or abuse investigation, conducting the investigation, collecting evidence, accepting and approving a provider's request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee, and establishing minimum training requirements for Medicaid [~~provider~~] fraud or abuse investigators.

(p) The executive commissioner, in consultation with 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 and managed care organization 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.

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

(z) Based on the results of an audit, inspection, or investigation of a managed care organization conducted by the office under this section, the office may recommend to the commission that enforcement actions, including the payment of liquidated damages, be taken against the managed care organization and suggest the amount of a penalty to be assessed.

SECTION 2. Sections 531.102(g)(1) and (7), Government Code, are amended to read as follows:

(1) Whenever the office learns or has reason to suspect that a provider's or Medicaid managed care organization'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 or Medicaid managed care

organization, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

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

(A) may permissively be imposed on a provider or Medicaid managed care organization; or

(B) shall automatically be imposed on a provider or Medicaid managed care organization.

SECTION 3. Sections 531.118(a) and (b), Government Code, are amended to read as follows:

(a) The commission shall maintain a record of all allegations of fraud or abuse against a provider or managed care organization containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential under Section 531.1021(g) and is subject to Section 531.1021(h).

(b) If the commission receives an allegation of fraud or abuse against a provider or managed care organization 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 4. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1185 to read as follows:

Sec. 531.1185. REVIEW, RENEGOTIATION, AND REVISION OF CERTAIN FINAL ORDERS AND SETTLEMENT AGREEMENTS. The office of inspector general may, on request by a provider, review, renegotiate, and revise a final order or settlement agreement currently under repayment entered into by the provider and the office between January 1, 2011, and December 31, 2014. In reviewing, renegotiating, and revising a final order or settlement agreement under this section, the office shall consider:

(1) amounts being paid by the provider under the order or agreement;

(2) amounts paid or lost by the provider as a result of any investigation, audit, or inspection that was the basis of the order or agreement; and

(3) amounts of the federal share paid or being paid.

SECTION 5. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0122 to read as follows:

Sec. 533.0122. UTILIZATION REVIEW AUDITS CONDUCTED BY OFFICE OF INSPECTOR GENERAL. (a) If the commission's office of inspector general intends to conduct a utilization review audit of a provider of services under a Medicaid managed care delivery model, the office shall inform both the provider and the Medicaid managed care organization with which the provider contracts of any applicable criteria and guidelines the office will use in the course of the audit.

(b) The commission's office of inspector general shall ensure that each person conducting a utilization review audit under this section has experience and training regarding the operations

of Medicaid managed care organizations.

(c) The commission's office of inspector general may not, as the result of a utilization review audit, recoup an overpayment or debt from a provider that contracts with a Medicaid managed care organization based on a determination that a provided service was not medically necessary unless the office:

(1) uses the same criteria and guidelines that were used by the managed care organization in its determination of medical necessity for the service; and

(2) verifies with the managed care organization and the provider that the provider:

(A) at the time the service was delivered, had reasonable notice of the criteria and guidelines used by the managed care organization to determine medical necessity; and

(B) did not follow the criteria and guidelines used by the managed care organization to determine medical necessity that were in effect at the time the service was delivered.

SECTION 6. Not later than December 31, 2021, the executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement the changes in law made by this Act.

SECTION 7. 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. This Act takes effect September 1, 2021.