BILL ANALYSIS

Senate Research Center

S.B. 207
By: Hinojosa et al.
Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Health and Human Services Commission (HHSC) Office of Inspector General (OIG) prevents, detects, and investigates fraud, waste, and abuse and other allegations of wrongdoing in the health and human services system. In fiscal year 2014, OIG had 774 staff and operated on a budget of $48.9 million, a growth of nearly 30 percent since 2011.

In its first review of OIG, conducted as part of the HHSC review, the Sunset Advisory Commission (Sunset) found deep management and due process concerns, particularly in OIG's efforts to detect and deter Medicaid fraud, waste, and abuse. OIG's investigative processes lack structure, guidelines, and performance measures to ensure consistent and fair results. Poor communication and a lack of transparency give a perception that OIG makes up rules as it goes. These significant concerns and vague accountability between the governor and the executive commissioner of HHSC (executive commissioner) demand serious attention to set this office right so it can appropriately ensure the integrity of programs in the health and human services system.

Major provisions in sunset legislation:

Strengthens the accountability of OIG.

- Provides that the executive commissioner, not the governor, appoint the inspector general.
- Requires a special-purpose sunset review in six years (in 2021).

Improves the effectiveness of OIG through a series of process improvements to measure and achieve better results.

- Provides timeframes for OIG to complete preliminary and full investigations.
- Allows OIG to share confidential drafts concerning child fatalities with DFPS.
- Requires OIG to improve basic management practices, including establishing prioritization criteria and performance measures for its investigative processes.
- Requires OIG to conduct quality assurance reviews for its sampling methodology used in the investigative process.
- Strengthens oversight of special investigative units in managed care organizations and better defines OIG's role in managed care.

Streamlines the credible allegation of fraud (CAF) payment hold appeal process.

- Limits OIG's ability to place payment holds in cases not involving fraud.
- Shortens timeframes and limits the scope of appeal hearings to more quickly mitigate state financial risks.
- Removes requirements for providers to pay for half of their CAF hold and overpayment hearing costs, consistent with other state hearing procedures.
- Clarifies that "fraud" does not include unintentional technical, clerical, or administrative errors.
- Strengthens the audit appeal process for pharmacies to promote greater independence in decision making.

S.B. 207 amends current law relating to the authority and duties of the office of inspector general of the Health and Human Services Commission.

RULEMAKING AUTHORITY

Rulemaking authority previously jointly granted to the executive commissioner of the Health and Human Services Commission (executive commissioner) and the State Office of Administrative Hearings is rescinded in SECTION 2 (Sec. 531.102, Government Code), and SECTION 13 (Sec. 531.1201, Government Code) of this bill.

Rulemaking authority previously granted to the executive commissioner is modified in SECTION 2 (Sec. 531.102. Government Code) and SECTION 6 (Sec. 531.113, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner, in consultation with the inspector general of the office of inspector general, in SECTION 2 (Sec. 531.102, Government Code), SECTION 6 (Sec. 531.113, Government Code), SECTION 11 (Sec. 531.1024, Government Code), SECTION 12 (Sec. 533.015, Government Code), SECTION 16, SECTION 17, and SECTION 20 of this bill.

Rulemaking authority is expressly granted to the executive commissioner in SECTION 5 (Sec. 531.1032, Government Code) and SECTION 21 of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.1011(4), Government Code, to redefine "fraud."

SECTION 2. Amends Section 531.102, Government Code, by amending Subsections (g) and (k), amending Subsection (f) as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, and adding Subsections (a-2), (a-3), (a-4), (a-5), (a-6), (f-1), (p), (q), (r), (s), (t), (u), (v), and (w), as follows:

> (a-2) Requires the executive commissioner of the Health and Human Services Commission (executive commissioner) (HHSC) to work in consultation with the Office of the Inspector General (OIG) whenever the executive commissioner is required by law to adopt a rule or policy necessary to implement a power or duty of OIG, including a rule necessary to carry out a responsibility of OIG under Subsection (a).
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> (a-3) Provides that the executive commissioner is responsible for performing all administrative support services functions necessary to operate OIG in the same manner that the executive commissioner is responsible for providing administrative support services functions for the health and human services system, including functions of OIG related to the following:
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> > (1) procurement processes;
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> > (2) contracting policies;
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> > (3) information technology services;
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> > (4) legal services;
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> > (5) budgeting; and
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> > (6) personnel and employment policies.
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> (a-4) Requires HHSC's internal audit division to regularly audit OIG as part of HHSC's internal audit program and to include OIG in HHSC's risk assessments.

(a-5) Requires OIG to closely coordinate with the executive commissioner and the relevant staff of health and human services system programs that OIG oversees in performing functions relating to the prevention of fraud, waste, and abuse in the delivery of health and human services and the enforcement of state law relating to the provision of those services, including audits, utilization reviews, provider education, and data analysis.

(a-6) Requires OIG to conduct investigations independent of the executive commissioner and HHSC but to rely on the coordination required by Subsection (a-5) to ensure that OIG has a thorough understanding of the health and human services system for purposes of knowledgeably and effectively performing OIG's duties under this section and any other law.

(f) (1) Requires OIG, if HHSC receives a complaint or allegation of Medicaid fraud or abuse from any source, to conduct a preliminary investigation as provided by Section 531.118(c) (requiring OIG to review allegations of fraud or abuse and prepare a preliminary investigation report) to determine whether there is a sufficient basis to warrant a full investigation. Requires that a preliminary investigation begin not later than the 30th day and be completed not later than the 45th day after the date HHSC receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. Deletes existing text requiring that a preliminary investigation be completed not later than the 90th day after it began.

(2) Makes no change to this subdivision.

(f-1) Requires OIG to 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 OIG determines that more time is needed to complete the investigation. Requires OIG, except as otherwise provided by this subsection, if OIG determines that more time is needed to complete the investigation, to 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 OIG was unable to complete the investigation within the 180-day period. Provides that OIG is not required to provide notice to the provider under this subsection if OIG determines that providing notice would jeopardize the investigation.

(g)(1) Makes no change to this subdivision.

(2) Requires OIG, as authorized under state and federal law, rather than in addition to other instances authorized under state or federal law, and except as provided by Subdivisions (8) and (9), to 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) (requiring OIG to employ a medical director) and (m) (requiring OIG to employ a dental director), as applicable. Provides that the payment hold is a serious enforcement tool that OIG imposes to mitigate ongoing financial risk to the state and that a payment hold imposed under this subdivision takes immediate effect. Requires OIG to 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 OIG imposes the payment hold. Requires that the notice of payment hold provided under this subdivision, in addition to the requirements of 42 C.F.R. Section 455.23(b), also include:

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

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

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

(3) Requires OIG, 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, to file a request with the State Office of Administrative Hearings (SOAH) for an expedited administrative hearing regarding the hold not later than the third day after the date OIG receives the provider's request. Requires the provider to request an expedited administrative hearing under this subdivision not later than the 10th, rather than the 30th, day after the date the provider receives notice from OIG under Subdivision (2). Requires SOAH to hold the expedited administrative hearing not later than the 45th day after the date SOAH receives the request for the hearing. Provides that, in a hearing held under this subdivision:

(A) the provider and OIG are each limited to four hours of testimony, excluding time for responding to questions from the administrative law judge;

(B) the provider and OIG are each entitled to two continuances under reasonable circumstances; and

(C) OIG 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 Medicaid.

Deletes existing text requiring the state and the provider, unless otherwise determined by the administrative law judge for good cause at an expedited administrative hearing, to each be responsible for certain costs as set forth relating to the hearing.

Makes nonsubstantive changes.

(4) Provides that OIG 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, rather than requires the executive commissioner and SOAH to 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) Requires the administrative law judge, in a hearing held under Subdivision (3), to decide if the payment hold should continue but prohibits the administrative law judge from adjusting the amount or percent of the payment hold. Provides that, notwithstanding any other law, including Section 2001.058(e) (authorizes a state agency to change a finding of fact or conclusion of law made by the administrative law judge, or to vacate or modify an order issued by the administrative judge, only if the agency determines that a certain error was made), the decision of the administrative law judge is final and may not be appealed, rather than authorizes a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, to appeal a final administrative order by filing a petition for judicial review in a district court in

Travis County following an expedited administrative hearing under Subdivision (3).

(6) Requires the executive commissioner, in consultation with OIG, to 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 OIG in the notice provided under that subdivision. Requires a provider to request an initial informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3) for requesting an expedited administrative hearing. Requires OIG, on receipt of a timely request, to decide whether to grant the provider's request for an initial informal resolution meeting, and if OIG decides to grant the request, to schedule the initial information resolution meeting. Requires OIG, on receipt of a timely request, to decide whether to grant the provider's request for a second informal resolution meeting, and if OIG decides to grant the request, to schedule the second informal resolution meeting. Requires that the informal resolution process run concurrently with the administrative hearing process and requires that the informal resolution process be discontinued once SOAH issues a final determination on the payment hold.

Deletes existing text requiring OIG, on receipt of a timely request, to schedule an initial formal resolution meeting not later than the 60th day after the date OIG receives the request, but requiring OIG to schedule the meeting on a later date, as determined by OIG, if requested by the provider.

Deletes existing text requiring OIG to 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 and authorizing a provider to request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting.

Deletes existing text requiring OIG, on receipt of a timely request, to schedule a second informal resolution meeting not later than the 45th day after the date OIG receives the request, but requiring OIG to schedule the meeting on a later date, as determined by OIG, if requested by the provider.

Deletes existing text requiring OIG to 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 and requiring that a hearing initiated under Subdivision (3) be stayed until the informal resolution process is completed.

(7) Deletes a reference to payment holds.

(7-a) Requires OIG, in consultation with the state's Medicaid fraud control unit, to establish guidelines regarding the imposition of payment holds authorized under Subdivision (2).

(8) Authorizes OIG, in accordance with 42 C.F.R. Sections 455.23(e) and (f), on the determination that a credible allegation of fraud exists, to 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;
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> (B) available remedies implemented by the state other than a payment hold would more effectively or quickly protect Medicaid funds;

(C) OIG 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 is the sole community physician or the sole source of essential specialized services in a community or 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) OIG determines that a full or partial payment hold is not in the best interests of Medicaid.

(9) Prohibits OIG from imposing a payment hold on claims for reimbursement submitted by a provider for medically necessary services for which the provider has obtained prior authorization from HHSC or a contractor of HHSC unless OIG has evidence that the provider has materially misrepresented documentation relating to those services.

(k) Authorizes a confidential draft report on an audit or investigation that concerns the death of a child to be shared with the Department of Family and Protective Services (DFPS). Provides that a draft report that is shared with DFPS remains confidential and is not subject to disclosure under Chapter 552 (Public Information).

(p) Requires the executive commissioner, in consultation with OIG, to adopt rules establishing criteria:

(1) for opening a case;

(2) for prioritizing cases for the efficient management of OIG's workload, including rules that direct OIG 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) Requires the executive commissioner, in consultation with OIG, to 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 certain criteria as set forth relating to direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions and a specific list of potential penalties for fraud and other Medicaid violations.

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

(s) Requires OIG to arrange for the Association of Inspectors General or a similar third party to conduct a peer review of OIG's sampling and extrapolation techniques. Requires the executive commissioner, based on the review and generally accepted practices among other offices of inspectors general, in consultation with OIG, to by rule adopt sampling and extrapolation standards to be used by OIG in conducting audits.

(t) Requires the inspector general, at each quarterly meeting of any advisory council responsible for advising the executive commissioner on the operation of HHSC, to submit a report to the executive commissioner, the governor, and the legislature on:

(1) OIG's activities;

(2) OIG's performance with respect to performance measures established by the executive commissioner for OIG;

(3) fraud trends identified by OIG; and

(4) any recommendations for changes in policy to prevent or address fraud, waste, and abuse in the delivery of health and human services in this state.

(u) Requires OIG to publish each report required under Subsection (t) on OIG's Internet website.

(v) Requires OIG, in accordance with Section 533.015(b), to consult with the executive commissioner regarding the adoption of rules defining OIG's role in and jurisdiction over, and the frequency of, audits of managed care organizations participating in Medicaid that are conducted by OIG and HHSC.

(w) Requires OIG to coordinate all audit and oversight activities relating to providers, including the development of audit plans, risk assessments, and findings, with HHSC to minimize the duplication of activities. Requires OIG, in coordinating activities under this subsection, to:

(1) on an annual basis, seek input from HHSC and consider previous audits and on-site visits made by HHSC for purposes of determining whether to audit a managed care organization participating in Medicaid; and

(2) request the results of any informal audit or on-site visit performed by HHSC that could inform OIG's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

Makes nonsubstantive changes.

SECTION 3. Amends Section 531.1021(a), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, as follows:

(a) Authorizes OIG to issue a subpoena in connection with an investigation conducted by OIG. Authorizes a subpoena to be issued under this section to compel the attendance of a relevant witness or the production, for inspection or copying, of relevant evidence that is in this state.

Deletes existing text authorizing OIG to request that the executive commissioner or the executive commissioner's designee approve the issuance by OIG of a subpoena in connection with an investigation conducted by OIG. Deletes existing text authorizing OIG, if the request is approved, to issue a subpoena to compel the attendance of a

relevant witness or the production, for inspection or copying, of relevant evidence that is in this state.

SECTION 4. Amends Section 531.1031(a), Government Code, as amended by S.B. 219, Acts of the 84th Legislature, Regular Session, 2015, as follows:

(a) Defines "license," "licensing authority," "office," and "provider" in this section and Sections 531.1032, 531.1033, and 531.1034. Redefines "health care professional" and "participating agency" in this section and Sections 531.1032, 531.1033, and 531.1034.

SECTION 5. Amends Subchapter C, Chapter 531, Government Code, by adding Sections 531.1032, 531.1033, and 531.1034, as follows:

Sec. 531.1032. OFFICE OF INSPECTOR GENERAL: CRIMINAL HISTORY RECORD INFORMATION CHECK. (a) Requires OIG and each licensing authority that requires the submission of fingerprints for the purpose of conducting a criminal history record information check of a health care professional to enter into a memorandum of understanding to ensure that only persons who are licensed and in good standing as health care professionals participate as providers in Medicaid. Authorizes the memorandum under this section to be combined with a memorandum authorized under Section 531.1031(c-1) and requires that the memorandum include a process by which:

(1) OIG may confirm with a licensing authority that a health care professional is licensed and in good standing for purposes of determining eligibility to participate in Medicaid; and

(2) the licensing authority immediately notifies OIG if:

(A) a provider's license has been revoked or suspended; or

(B) the licensing authority has taken disciplinary action against a provider.

(b) Prohibits OIG from, for purposes of determining a health care professional's eligibility to participate in Medicaid as a provider, conducting a criminal history record information check of a health care professional who OIG has confirmed under Subsection (a) is licensed and in good standing. Provides that this subsection does not prohibit OIG from performing a criminal history record information check of a provider that is required or appropriate for other reasons, including for conducting an investigation of fraud, waste, or abuse.

(c) Requires OIG, for purposes of determining eligibility to participate in Medicaid and subject to Subsection (d), after seeking public input, to establish and the executive commissioner by rule to adopt guidelines for the evaluation of criminal history record information of providers and potential providers. Requires that the guidelines outline conduct, by provider type, that may be contained in criminal history record information that will result in exclusion of a person from Medicaid as a provider, taking into consideration:

(1) the extent to which the underlying conduct relates to the services provided under Medicaid;

(2) the degree to which the person would interact with Medicaid recipients as a provider; and

(3) any previous evidence that the person engaged in fraud, waste, or abuse under Medicaid.

(d) Prohibits the guidelines adopted under Subsection (c) from imposing stricter standards for the eligibility of a person to participate in Medicaid than a licensing

authority described by Subsection (a) requires for the person to engage in a health care profession without restriction in this state.

(e) Requires OIG and HHSC to use the guidelines adopted under Subsection (c) to determine whether a provider participating in Medicaid continues to be eligible to participate in Medicaid as a provider.

(f) Requires the provider enrollment contractor, if applicable, and a managed care organization participating in Medicaid to defer to OIG regarding whether a person's criminal history record information precludes the person from participating in Medicaid as a provider.

Sec. 531.1033. MONITORING OF CERTAIN FEDERAL DATABASES. Requires OIG to routinely check appropriate federal databases, including databases referenced in 42 C.F.R. Section 455.436, to ensure that a person who is excluded from participating in Medicaid or in the Medicare program by the federal government is not participating as a provider in Medicaid.

Sec. 531.1034. TIME TO DETERMINE PROVIDER ELIGIBILITY; PERFORMANCE METRICS. (a) Requires OIG, not later than the 10th day after the date OIG receives the complete application of a health care professional seeking to participate in Medicaid, to inform HHSC or the health care professional, as appropriate, of OIG's determination regarding whether the health care professional should be denied participation in Medicaid based on:

(1) information concerning the licensing status of the health care professional obtained as described by Section 531.1032(a);

(2) information contained in the criminal history record information check that is evaluated in accordance with guidelines adopted under Section 531.1032(c);

(3) a review of federal databases under Section 531.1033;

(4) the pendency of an open investigation by OIG; or

(5) any other reason OIG determines appropriate.

(b) Provides that completion of an on-site visit of a health care professional during the period prescribed by Subsection (a) is not required.

(c) Requires OIG to develop performance metrics to measure the length of time for conducting a determination described by Subsection (a) with respect to applications that are complete when submitted and all other applications.

SECTION 6. Amends Section 531.113, Government Code, by adding Subsection (d-1) and amending Subsection (e) as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, as follows:

(d-1) Requires OIG, in consultation with HHSC, to:

(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) (requiring each managed care organization to establish and maintain a special investigative unit) and entities with which managed care organizations contract under Subsection (a)(2) (requiring each managed care

organization to contract with another entity for the investigation of fraudulent claims);

(3) establish requirements for approving plans to prevent and reduce fraud and abuse adopted by managed care organizations under Subsection (b) (requiring each managed care organization to adopt a plan to prevent and reduce fraud and abuse);

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

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

(6) provide ongoing, regular training to appropriate HHSC and OIG staff concerning fraud, waste, and abuse in a managed care setting, including training relating to fraud, waste, and abuse by service providers and recipients.

(e) Requires the executive commissioner, in consultation with OIG, to adopt rules as necessary to accomplish the purposes of this section, including rules defining the investigative role of OIG 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). Requires that the rules adopted under this section specify OIG's role in reviewing the findings of special investigative units and contracted entities, investigating cases in which the overpayment amount sought to be recovered exceeds $100,000, and investigating providers who are enrolled in more than one managed care organization.

SECTION 7. Amends Section 531.118(b), Government Code, as follows:

(b) Requires OIG, if HHSC receives an allegation of fraud or abuse against a provider from any source, to conduct a preliminary investigation of the allegation to determine whether there is a sufficient basis to warrant a full investigation. Requires that a preliminary investigation begin not later than the 30th day, and be completed not later than the 45th day, after the date HHSC receives or identifies an allegation of fraud or abuse.

SECTION 8. Amends Section 531.120, Government Code, as follows:

Sec. 531.120. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) Requires that the notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation include certain information, including information relating to the extrapolation methodology used as part of the investigation and the methods used to determine the overpayment or debt in sufficient detail so that the extrapolation results may be demonstrated to be statistically valid and are fully reproducible, and a description of administrative and judicial due process remedies, including the provider's option, rather than right, to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both.

(b) Authorizes a provider to request an initial informal resolution meeting under this section and requires OIG to schedule the informal resolution meeting on receipt of the request and to give notice to the provider of the time and place of the meeting. Requires that the informal resolution process run concurrently with the administrative hearing process, and prohibits the administrative hearing process from being delayed on account of the informal resolution process.

Deletes existing text requiring a provider to request an initial informal resolution meeting under this section not later than the 30th day after the date the provider receives notice under Subsection (a) (requiring HHSC or OIG to provide a provider with written notice of any proposed recoupment) and requiring OIG to, on receipt of a timely request, schedule an initial informal resolution meeting not later than the 60th day after the date OIG receives the request, but requiring OIG to schedule the meeting on a later date, as determined by OIG if requested by the provider.

Deletes existing text requiring OIG to 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 and authorizing a provider to request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting.

Deletes existing text requiring OIG to schedule a second informal resolution meeting not later than the 45th day after the date OIG receives the request, but requiring OIG to schedule the meeting on a later date, as determined by OIG if requested by the provider.

Deletes existing text requiring OIG to 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 and requiring that a provider have an opportunity to provide additional information before the second informal resolution meeting for consideration by OIG.

Makes nonsubstantive changes.

SECTION 9. Amends Section 531.1201(a) and (b), Government Code, as follows:

(a) Requires a provider to request an appeal under this section not later than the 30th day, rather than the 15th day, after the date the provider is notified that HHSC or OIG will seek to recover an overpayment or debt from the provider. Makes no further change to this subsection.

(b) Provides that OIG is responsible for the costs of an administrative hearing held under Subsection (a) (relating to a provider's request for an appeal and OIG's subsequent required duties), but provides that a provider is responsible for the provider's own costs incurred in preparing for the hearing.

Deletes existing text requiring the state and the provider, unless otherwise determined by the administrative law judge for good cause, at any administrative hearing under this section before SOAH, to each be responsible for certain costs as set forth relating to the hearing.

SECTION 10. Amends Section 531.1202, Government Code, as follows:

Sec. 531.1202. New heading: RECORD AND CONFIDENTIALITY OF INFORMAL RESOLUTION MEETINGS. (a) Requires HHSC, on the written request of the provider, at no expense to the provider who requested the meeting, to provide for an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) to be recorded. Prohibits HHSC from recording an informal resolution meeting unless HHSC receives a written request from a provider under this subsection. Makes no further change to this subsection.

(b) Provides that, notwithstanding Section 531.1021(g) and except as provided by this section, an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) is confidential, and any information or materials obtained by OIG, including OIG's employees or OIG's agents, during or in connection with an informal resolution meeting, including a recording made under Subsection (a), are

privileged and confidential and not subject to disclosure under Chapter 552 or any other means of legal compulsion for release, including disclosure, discovery, or subpoena.

SECTION 11. Amends Subchapter C, Chapter 531, Government Code, by adding Sections 531.1023, 531.1024, 531.1025, and 531.1203, as follows:

Sec. 531.1023. COMPLIANCE WITH FEDERAL CODING GUIDELINES. Requires HHSC's OIG, including office staff and any third party with which OIG contracts to perform coding services, to comply with federal coding guidelines, including guidelines for diagnosis-related group (DRG) validation and related audits.

Sec. 531.1024. HOSPITAL UTILIZATION REVIEWS AND AUDITS: PROVIDER EDUCATION PROCESS. Requires the executive commissioner, in consultation with OIG, to by rule develop a process for OIG, including OIG staff and any third party with which OIG contracts to perform coding services, to communicate with and educate providers about the diagnosis-related group (DRG) validation criteria that OIG uses in conducting hospital utilization reviews and audits.

Sec. 531.1025. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES. (a) Authorizes OIG, notwithstanding any other law, to conduct a performance audit of any program or project administered or agreement entered into by HHSC or a health and human services agency, including an audit related to:

(1) contracting procedures of HHSC or a health and human services agency; or

(2) the performance of HHSC or a health and human services agency.

(b) Requires OIG, in addition to the coordination required by Section 531.102(w), to coordinate OIG's other audit activities with those of HHSC, including the development of audit plans, the performance of risk assessments, and the reporting of findings, to minimize the duplication of audit activities. Requires OIG, in coordinating audit activities with HHSC under this subsection, to:

(1) seek input from HHSC and consider previous audits conducted by HHSC for purposes of determining whether to conduct a performance audit; and

(2) request the results of an audit conducted by HHSC if those results could inform OIG's risk assessment when determining whether to conduct, or the scope of, a performance audit.

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

(b) Provides that, in an informal hearing held under this section, staff of HHSC’s appeals division, assisted by staff responsible for HHSC’s vendor drug program who have expertise in the law governing pharmacies' participation in Medicaid, make the final decision on whether the findings of an audit are accurate. Prohibits staff of OIG from serving on the panel that makes the decision on the accuracy of an audit.

(c) Requires OIG, in order to increase transparency, if OIG has access to the information, to provide to pharmacies that are subject to audit by OIG, or by an entity that contracts with the federal government to audit Medicaid providers,

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 Medicaid in sufficient detail so that the audit results may be demonstrated to be statistically valid and are fully reproducible.

SECTION 12. Amends Section 533.015, Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, as follows:

Sec. 533.015. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. (a) Creates this subsection from existing text. Requires HHSC, to the extent possible, to coordinate all external oversight activities to minimize duplication of oversight of managed care plans under Medicaid and disruption of operations under those plans.

(b) Requires the executive commissioner, after consulting with OIG, to by rule define HHSC's and OIG's roles in and jurisdiction over, and frequency of, audits of managed care organizations participating in Medicaid that are conducted by HHSC and OIG.

(c) Requires HHSC, in accordance with Section 531.102(w), to share with OIG, at the request of OIG, the results of any informal audit or on-site visit that could inform that OIG's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

SECTION 13. Repealer: (1) Section 531.1201(c) (requiring the executive commissioner and SOAH to jointly adopt rules that require a provider to advance security for certain costs), Government Code; and

(2) Section 32.0422(k) (prohibiting HHSC from requiring or permitting an individual who is enrolled in a group health benefit plan to participate in the Medicaid managed care program), Human Resources Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015.

SECTION 14. Requires the Sunset Advisory Commission (Sunset), notwithstanding Section 531.004 (Sunset Provision), Government Code, to conduct a special-purpose review of the overall performance of OIG. Requires Sunset, in conducting the review, to particularly focus on OIG’s investigations and the effectiveness and efficiency of OIG’s processes, as part of Sunset’s review of agencies for the 87th Legislature. Provides that OIG is not abolished solely because OIG is not explicitly continued following the review.

SECTION 15. Makes application of Section 531.102, Government Code, as amended by this Act, prospective.

SECTION 16. Requires the executive commissioner, in consultation with the inspector general of OIG, not later than March 1, 2016, to 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 is authorized to be placed on claims for reimbursement submitted by a Medicaid provider.

SECTION 17. Requires the executive commissioner, as soon as practicable after the effective date of this Act, in consultation with the inspector general of OIG, to adopt the rules establishing the process for communicating with and educating providers about diagnosis-related group (DRG) validation criteria under Section 531.1024, Government Code, as added by this Act.

SECTION 18. Requires the executive commissioner, not later than September 1, 2016, to adopt the guidelines required under Section 531.1032(c), Government Code, as added by this Act.

SECTION 19. Makes application of Sections 531.120 and 531.1201, Government Code, as amended by this Act, prospective.

SECTION 20. Requires the executive commissioner, in consultation with the inspector general of OIG, not later than March 1, 2016, to adopt rules necessary to implement Section 531.1203, Government Code, as added by this Act.

SECTION 21. Requires the executive commissioner, not later than September 1, 2016, to adopt rules required by Section 533.015(b), Government Code, as added by this Act.

SECTION 22. Requires a state agency, 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 23. Effective date: September 1, 2015.