BILL ANALYSIS

C.S.S.B. 207
By: Hinojosa
Human Services
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The Health and Human Services Commission (HHSC) Office of Inspector General (OIG) was created as part of H.B. 2292 in 2003 to prevent, detect, and investigate 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.

The Sunset Commission found deep management and due process concerns with OIG, 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 inspector general, the governor who makes the appointment, and the executive commissioner who administratively oversees the office demand serious attention to set this office right so it can appropriately ensure the integrity of programs in the health and human services system. This bill contains the Sunset Commission's recommendations to address these concerns and subjects OIG to a special Sunset review in six years.

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 rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTIONS 2, 6, 12, and 13 of this bill.

ANALYSIS

Amends definition of fraud

C.S.S.B 207 changes the definition of "fraud" in the OIG's statute by removing references to other definitions of fraud in other applicable federal and state law and by stating that the definition does not include unintentional technical, clerical, or administrative errors.

Requires consultation on rulemaking

C.S.S.B 207 requires OIG to work in consultation with the executive commissioner, pursuant to federal law, to adopt rules necessary to implement a power or duty of OIG related to OIG's operations. The bill establishes that rules adopted under this section would not affect Medicaid policies.

C.S.S.B 207 amends grants of rulemaking authority and references to existing rulemaking authority throughout the bill to explicitly require the executive commissioner to consult with OIG.

Clarifies oversight roles and ensures investigative independence

C.S.S.B 207 provides that the executive commissioner is responsible for performing all administrative support services necessary to operate OIG in the same manner as for the health and human services system and lists those support services functions. The bill requires HHSC's internal audit division to regularly audit OIG as part of HHSC's internal audit program and include OIG in HHSC's risk assessments. The bill requires OIG to closely coordinate with the executive commissioner and program staff of HHSC programs that OIG oversees in its function preventing fraud, waste, and abuse and the enforcement of state law relating to provision of health and human services, including audits, utilization reviews, provider education, and data analysis. The bill provides that OIG shall conduct its investigations independent of the executive commissioner and HHSC, but shall also coordinate with system programs to ensure that it has a thorough understanding of the health and human services system for purposes of performing its duties.

Changes investigatory timelines

C.S.S.B 207 removes the requirement that a preliminary investigation for Medicaid fraud or abuse must be completed within 90 days of the beginning of the investigation. Instead, the bill adds a requirement where these timeframes are mentioned in OIG's statute that such an investigation must be completed within 45 days of the receipt of the complaint or having reason to believe that fraud or abuse has occurred.

C.S.S.B 207 requires full investigations of Medicaid fraud and abuse to be completed not later than 180 days of the date the full investigation begins, unless the office determines that more time is needed to complete the investigation. If OIG determines additional time is needed to complete the investigation, the bill requires OIG to provide notice to the provider who is the subject of the investigation specifying 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, unless such notice would jeopardize the investigation. The bill provides that changes affecting investigations of fraud or abuse apply only to complaints or allegations received after the effective date of the bill.

Clarifies payment hold authority

C.S.S.B 207 specifies that OIG's authority to place payment holds is limited only to the situations listed in statute, and provides that payment holds are serious enforcement tools imposed to mitigate ongoing financial risk to the state. The bill provides an exception from the requirement to impose the payment hold if specified good cause exists in accordance with federal law not to impose or continue a payment hold or otherwise reduce a payment hold. The bill also provides an exception from having to impose a payment hold for medically necessary services for which the provider has obtained prior authorization by HHSC or its contractor unless OIG has evidence that a provider materially misrepresented the documentation related to the services. The bill provides that a payment hold takes immediate effect. The bill provides that the executive commissioner must adopt rules, in consultation with inspector general of OIG, to implement these changes regarding the circumstances in which a payment hold may be placed on claims for reimbursement submitted by a Medicaid provider no later than March 1, 2016.

Streamlines payment hold appeal process

C.S.S.B 207 requires that notice of a payment hold be sent not later than five days of the hold

being imposed, except as provided by federal law, and that this notice contain a detailed summary of OIG's evidence relating to the allegation and a detailed timeline for the provider to pursue their rights and remedies. The bill also specifies that the description of rights and remedies included in this notice include the option, instead of the right, to informal resolution.

C.S.S.B 207 requires OIG to request a hearing with the State Office of Administrative Hearings (SOAH) within three days of receiving a hearing request from a provider. The bill changes the timeframe for a provider to request a hearing to not later than 10 days, from 30 days, after receiving notice. The bill requires SOAH to hold the hearing not later than 45 days after receiving the request for hearing, and it places the following requirements on the hearing:

- the provider and OIG are each limited to four hours of testimony, excluding time for questions from the judge;
- the provider and OIG are each entitled to two continuances for reasonable circumstances;
- OIG is required to show probable cause that the credible allegation of fraud that is the basis of the 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.

C.S.S.B 207 removes the requirement in current law that unless otherwise determined by the administrative law judge for good cause, the state and the provider is to pay one-half of the SOAH and transcription costs for the payment hold hearing and removes language requiring the provider to advance security for the provider's costs. The bill also deletes other language specifying that each party is responsible for its own cost related to the hearing and other costs, including attorney's fees. The bill makes OIG responsible for the costs of the hearing, but specifies that providers are responsible for their own costs in preparing for the hearing, unless otherwise determined by the administrative law judge for good cause.

C.S.S.B 207 provides that a SOAH judge shall decide if a payment hold should continue, but not adjust the amount or percent of the hold. The bill provides that notwithstanding provisions in the Administrative Procedure Act allowing a state agency to change, vacate, or modify an order issued by an administrative law judge under certain circumstances, that the judge's decision is final and may not be appealed.

C.S.S.B 207 removes the statutory right for a provider subject to a payment hold to have two informal resolution meetings and also removes associated timelines for these meetings. The bill instead gives OIG discretion whether to grant the provider's request for an initial and a second informal resolution meeting. The bill deletes language providing that a hearing be stayed until the informal resolution process is completed. Instead, the bill requires that the informal resolution process run concurrently with the administrative hearing process and that the informal resolution process be discontinued upon SOAH's final determination on the payment hold.

Payment Hold Guidelines

C.S.S.B 207 removes a reference to payment holds relating to guidelines under which they are permissively and automatically imposed. Instead, the bill requires OIG, in consultation with the Medicaid Fraud Control Unit, to establish guidelines for imposing payment holds only for circumstances authorized by in law.

Provides exceptions to full payment holds

C.S.S.B 207 provides a list of good cause exceptions, on a finding that a credible allegation of fraud exists, to not place 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 only in part, in accordance with federal law. These include:

- law enforcement officials have specifically requested that a payment hold not be imposed because it would compromise or jeopardize an investigation;
- other available remedies would more effectively or quickly protect Medicaid funds;
- OIG determines, based on written evidence submitted by the provider, the hold should be removed;
- the hold jeopardizes Medicaid recipients' access to services because the provider meets certain factors;
- the attorney general declines to certify that a matter continues to be under investigation; or
- OIG determines that the hold is not in the best interest of the Medicaid program.

C.S.S.B 207 prohibits OIG from placing a payment hold based on claims for medically necessary services for which the provider obtained a prior authorization from HHSC, unless OIG has evidence that the provider materially misrepresented documentation relating to those services.

Allows sharing of draft reports with affected agencies

C.S.S.B 207 allows OIG to share confidential drafts of audits or investigations that concern the death of a child with the Department of Family and Protective Services. The bill provides that the draft remains confidential and is not subject to disclosure under open record requirements.

Requires criteria for carrying out core functions

The bill requires the executive commissioner to adopt rules, in consultation with OIG, establishing criteria:

- for opening a case;
- for prioritizing provider, recipient, and internal affairs cases according to specific factors for each case type; and
- to guide field investigators in closing cases that are not worth pursuing through a full investigation.

C.S.S.B 207 also requires the executive commissioner, in consultation with OIG, to adopt rules establishing criteria for determining enforcement and punitive actions for a provider who has violated state law, program rules, or the provider's Medicaid provider agreement. The rules must include direction for categorizing provider violations and scaling resulting enforcement actions, taking into account certain listed factors and must include a specific list of potential penalties, including the amount of the penalties, for fraud and other Medicaid violations.

Requires internal and external review of processes

C.S.S.B 207 requires OIG to have staff not directly involved in investigations review its investigative processes, including OIG's use of sampling and extrapolation methods to audit provider records.

C.S.S.B 207 also requires OIG to arrange for a peer review, by the Association of Inspectors General or a similar third party, of OIG's sampling and extrapolation techniques. The bill requires the executive commissioner, in consultation with OIG, to adopt by rule sampling and extrapolation standards to be used in conducting audits. These standards must be based on the peer review and generally accepted practices among other offices of inspector general.

Requires regular reporting

C.S.S.B 207 requires OIG to report quarterly to any advisory council responsible for advising the executive commissioner on HHSC's operations, the executive commissioner, the governor, and

the legislature on:

- OIG's activities;
- OIG's performance with respect to performance measures established by the executive commissioner;
- fraud trends identified by OIG; and
- any recommendations for changes in policy to prevent or address fraud, waste, and abuse.

C.S.S.B 207 requires these reports to be published on OIG's website.

Requires audit coordination

C.S.S.B 207 requires OIG to consult with the executive commissioner regarding the adoption of rules defining OIG's role, jurisdiction, and frequency of audits of managed care organizations conducted by OIG and HHSC. The bill requires OIG to coordinate all audit and oversight activities related to providers with HHSC to minimize duplication. The bill requires OIG to annually seek input from HHSC and consider previous audits and onsite visits made by HHSC to determine whether to audit a managed care organization, and to request the results of any informal audit or onsite 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.

C.S.S.B 207 also requires HHSC to consult with OIG before defining, by rule, HHSC and OIG's role, jurisdiction, and frequency of audits of managed care organizations participating in Medicaid.

C.S.S.B 207 requires HHSC to share with OIG at OIG's request, results of any informal audit or onsite visit that could inform OIG's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization. The bill requires the executive commissioner to adopt required rules by September 1, 2016.

Alters subpoena authority

C.S.S.B 207 removes language for OIG to request that the executive commissioner or designee approve of OIG's issuance of subpoenas and instead provides for OIG to issue subpoenas.

Authorizes peace officers for federal investigations

C.S.S.B 207 requires OIG, pursuant to federal law, to employ and commission peace officers to assist OIG in carrying out its duties of investigating fraud, waste, and abuse, in the supplemental nutritional assistance program and temporary assistance for needy families, in coordination and conjunction with appropriate federal entities. Peace officers employed and commissioned by OIG are considered peace officers under other provisions of law and are required to be supervised by OIG.

Changes process for provider enrollment background checks

C.S.S.B 207 adds definitions of "license," "licensing authority," "office," and "provider" and amends the definition of "participating agency." The bill requires OIG and each licensing authority that requires the submission of fingerprints for a criminal history record information check of a health care professional enter into a memorandum of understanding to ensure that only persons licensed and in good standing as health care professionals participate as Medicaid providers. The bill allows the memorandum of understanding to be combined with another memorandum of understanding and requires it to include a process by which 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 that the licensing authority immediately notify OIG if a provider's license has been revoked or suspended or the licensing

authority has taken disciplinary action against a health care professional. The bill prohibits OIG from conducting a criminal history record information check for the purpose of determining Medicaid eligibility for a health care professional who the office has confirmed is licensed and in good standing. The bill does not prohibit OIG from conducting a criminal history check that is required or appropriate for other reasons.

C.S.S.B 207 requires OIG, after seeking public input, to establish and the executive commissioner by rule to adopt criminal history guidelines for the evaluation of criminal history information for providers or potential providers for purposes of determining eligibility to participate in Medicaid. The bill requires the guidelines to outline conduct, by provider type, that may be in the criminal history information that will result in exclusion of a person from Medicaid, taking into consideration the extent to which the underlying conduct relates to the services provided under the program, the degree to which the person would interact with Medicaid recipients as a provider, and any previous evidence that he person engaged in fraud, waste, or abuse under Medicaid. The bill provides that OIG may not impose stricter standards for eligibility to participate in Medicaid than a licensing authority that conducts fingerprint-based criminal history checks requires for a person to engage in their healthcare profession without restriction. The bill requires OIG and HHSC to use the guidelines to determine whether a provider may continue participating in Medicaid.

C.S.S.B 207 requires the provider enrollment contractor, if applicable, and a managed care organization to defer to OIG regarding whether a person's criminal history record information precludes the person from participating as a Medicaid provider. The bill also requires OIG to routinely check appropriate federal databases to ensure a person excluded from participating in Medicaid or Medicare is not participating as a provider in Medicaid.

C.S.S.B 207 requires OIG to inform HHSC or the health care professional not later than the 10th day after receiving a complete application whether a person seeking to participate as a Medicaid provider should be denied participation in the program based on a list of factors. The bill provides that completion of an on-site visit of a healthcare professional is not required within the 10-day timeframe. The bill requires OIG to develop metrics to measure the length of time for conducting a determination of a person's eligibility to participate in the Medicaid program for applications that are complete when submitted and for all other applications. The bill requires the executive commissioner to adopt guidelines by September 1, 2016.

Provides for stronger role in managed care

C.S.S.B 207 requires OIG, in consultation with HHSC, to:

- investigate fraud, waste, and abuse by managed care organizations;
- establish requirements for providing training and oversight of special investigative units or other contracted entities for investigating fraud and other program abuse;
- establish requirements for approving plans to prevent and reduce fraud and abuse adopted by managed care organizations;
- evaluate and communicate statewide fraud, waste, and abuse trends to special investigative units and contracted entities to determine the prevalence of those trends;
- assist managed care units in discovering or investigating fraud, waste, and abuse as needed; and
- provide ongoing, regular training to appropriate commission 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.

C.S.S.B 207 also adds to existing language requiring the executive commissioner to adopt rules, in consultation with OIG, to include rules defining OIG's role with respect to the investigative role of the special investigative units and other contracted entities. The rules must specify OIG's role in:

- reviewing the findings of special investigative units;
- investigating managed care overpayment cases of more than $100,000; and
- investigating providers enrolled in more than one managed care organizations.

Simplifies overpayment appeal process

C.S.S.B 207 requires that notice of an overpayment sent to a provider by OIG must include information relating to the extrapolation methodology used in the overpayment investigation, and the methods to determine the overpayment. The information provided must be in sufficient detail so that the extrapolation results may be demonstrated to be statistically valid and fully reproducible. The bill also specifies that the description of rights and remedies included in this notice include the option, instead of the right, to informal resolution in addition to the right to a formal hearing.

C.S.S.B 207 removes the statutory right to a second informal resolution meeting for a provider subject to recoupment of an overpayment and removes from statute corresponding timeframes for the initial and second informal resolution meeting. The bill requires that the informal resolution process on the overpayment run concurrently with the payment hold hearing process and that it may not delay the hearing on the overpayment. The bill extends the time in which a provider may request an appeal for an overpayment from 15 days to 30 days.

C.S.S.B 207 removes requirements for the state and the provider to pay for one-half the SOAH and transcription costs for the overpayment hearing and deletes other language regarding each party's own costs related to the hearing and other costs, including attorney's fees. The bill also repeals the provision in law for the provider to advance security for the provider's costs. The bill requires OIG to pay the costs of the hearing, but specifies that providers are responsible for their own costs in preparing for the hearing. The bill provides that changes to the overpayment process apply only to providers notified of a proposed recoupment on or after the effective date of the bill.

Provides confidentiality for informal resolution meetings

C.S.S.B 207 provides that on written request of a provider, HHSC may record informal resolution meetings, and that HHSC may not record these meetings unless it receives a written request from a provider. The bill also provides that, notwithstanding other provisions in law, these informal resolution meetings are confidential and information or materials obtained by OIG during or in connection with an informal resolution meeting are privileged and confidential and not subject to disclosure under open record requirements or other means of legal compulsion for release, including disclosure, discovery, or subpoena.

Requires compliance with federal coding guidelines

C.S.S.B 207 requires OIG and any third party contracted to perform coding services to comply with federal coding guidelines, including for diagnosis-related group validation and related audits. The bill also requires the executive commissioner to develop by rule a process for OIG or any third party contracted to perform coding services to communicate with and educate providers on diagnosis-related group validation criteria used in hospital utilization reviews and audits. The bill requires the executive commissioner to adopt rules, in consultation with the inspector general of OIG, establishing the process for communicating with and educating providers about diagnosis-related validation criteria as soon as practicable after the effective date of the act.

Authorizes performance audits

C.S.S.B 207 authorizes OIG to conduct a performance audit of any program, project, or agreement administered or entered into by HHSC or a health and human services agency,

including an audit related to contracting procedures and the performance of HHSC or a health and human services agency. The bill also requires OIG to coordinate audit activities with HHSC to minimize duplication of audit activities. The bill requires OIG to seek input from HHSC and consider previous audits for determining whether to conduct a performance audit, and to request the results of an audit conducted by HHSC if the results could inform OIG's risk assessment when determining whether to conduct, or the scope of, a performance audit.

Provides appeal rights for pharmacy audits

C.S.S.B 207 gives a pharmacy audited by OIG or a federal contractor the right to request an informal hearing before HHSC's appeals division to contest the findings of such an audit if the findings do not include that the pharmacy engaged in Medicaid fraud. The bill provides that staff from HHSC's appeals division, assisted by vendor drug program staff, make the final decision on the audit's accuracy. The bill prohibits OIG staff from serving on the panel that makes decisions on the audit's accuracy. The bill also requires OIG to provide pharmacies subject to such an audit information relating to the extrapolation methodology used in the audit, and methods to determine the overpayment if OIG has access to the information. The information provided must be in sufficient detail so that the audit results may be demonstrated to be statistically valid and fully reproducible. The bill requires the executive commissioner, in consultation with the inspector general of OIG, to adopt rules to implement this provision not later than March 1, 2016. The bill provides that this informal appeal process applies to the findings of an audit made on or after the effective date, or an audit, the results of which are the subject of a dispute pending on the effective date.

Repeals prohibition on client participation in managed care and HIPP

C.S.S.B 207 repeals a provision in law prohibiting on an individual enrolled in the Health Insurance Premium Payment reimbursement program from participating in a Medicaid managed care program.

Requires special Sunset review

C.S.S.B 207 requires the Sunset Advisory Commission to conduct a special-purpose review of the overall performance of OIG as part of its review of agencies for the 87th Legislature. The bill requires Sunset to focus on OIG's investigations and the effectiveness and efficiency of OIG's processes, and provides that OIG is not subject to abolishment as part of the review.

Repealers

C.S.S.B 207 repeals the following provisions:

- Section 531.1201(c), Government Code
- Section 32.0422(k), Human Resources Code

EFFECTIVE DATE

September 1, 2015.

COMPARISON OF SENATE ENGROSSED AND SUBSTITUTE

While C.S.S.B. 207 may differ from the engrossed in minor or nonsubstantive ways, the following comparison is organized and formatted in a manner that indicates the substantial differences between the engrossed and committee substitute versions of the bill.

SENATE ENGROSSED	HOUSE COMMITTEE SUBSTITUTE

SECTION 1. Section 531.1011(4), Government Code, is amended.

SECTION 2. Section 531.102, Government Code, is amended by amending Subsections (g) and (k), amending Subsection (f) as amended by S.B. 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), and (t) to read as follows:

(a-2) The executive commissioner shall work in consultation with the office whenever the law requires the commissioner to adopt a rule or policy necessary to implement a power or duty of the office, including rules necessary to carry out a responsibility under Subsection (a).

(a-3) The executive commissioner is responsible for performing all administrative support services functions necessary to operate the office 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 the office related to the following:

(1) procurement processes;

(2) contracting policies;

(3) information technology services;

(4) legal services;

(5) budgeting; and

(6) personnel and employment policies.

(a-4) The commission's internal audit division shall regularly audit the office as part of the commission's internal audit program and shall include the office in the commission's risk assessments.

(a-5) The office shall closely coordinate with the executive commissioner and the relevant staff of health and human services system programs that the office 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) The office shall conduct investigations independent of the executive commissioner and the commission but shall rely on the coordination required by Subsection (a-5) to ensure that the office has a thorough understanding of the health and

SECTION 1. Same as engrossed version.

SECTION 2. Section 531.102, Government Code, is amended 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) to read as follows:

(a-2) Pursuant to federal law, the office shall work in consultation with the executive commissioner to adopt rules necessary to implement a power or duty of the office related to the operations of the office. Rules adopted under this section may not affect Medicaid policies.

(a-3) The executive commissioner is responsible for performing all administrative support services functions necessary to operate the office 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 the office related to the following:

(1) procurement processes;

(2) contracting policies;

(3) information technology services;

(4) legal services;

(5) budgeting; and

(6) personnel and employment policies.

(a-4) The commission's internal audit division shall regularly audit the office as part of the commission's internal audit program and shall include the office in the commission's risk assessments.

(a-5) The office shall closely coordinate with the executive commissioner and the relevant staff of health and human services system programs that the office 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) The office shall conduct investigations independent of the executive commissioner and the commission but shall rely on the coordination required by Subsection (a-5) to ensure that the office has a thorough understanding of the health and

human services system for purposes of knowledgeably and effectively performing the office's duties under this section and any other law.

(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 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 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 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 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

human services system for purposes of knowledgeably and effectively performing the office's duties under this section and any other law.

(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 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 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 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 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 effect immediately. 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;

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 effect immediately. 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 Medicaid [~~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~~].

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~~];

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[~~(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. Notwithstanding any other law, including Section 2001.058(e), 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, in consultation with the office, 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~~

(4) Unless otherwise determined by the administrative law judge for good cause, 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 [~~The 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. Notwithstanding any other law, including Section 2001.058(e), 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, in consultation with the office, 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.

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

(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

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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 Medicaid.

(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

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Services remains confidential and is not subject to disclosure under Chapter 552.

(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 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, in consultation with 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 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

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

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performed by staff who are not directly involved in investigations conducted by the office.	performed by staff who are not directly involved in investigations conducted by the office.
	(s) The office shall arrange for the Association of Inspectors General or a similar third party to conduct a peer review of the office's sampling and extrapolation techniques. Based on the review and generally accepted practices among other offices of inspectors general, the executive commissioner, in consultation with the office, shall by rule adopt sampling and extrapolation standards to be used by the office in conducting audits.
(s) At each quarterly meeting of any advisory council responsible for advising the executive commissioner on the operation of the commission, the inspector general shall submit a report to the executive commissioner, the governor, and the legislature on: (1) the office's activities; (2) the office's performance with respect to performance measures established by the executive commissioner for the office; (3) fraud trends identified by the office; 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.	(t) At each quarterly meeting of any advisory council responsible for advising the executive commissioner on the operation of the commission, the inspector general shall submit a report to the executive commissioner, the governor, and the legislature on: (1) the office's activities; (2) the office's performance with respect to performance measures established by the executive commissioner for the office; (3) fraud trends identified by the office; 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.
(t) The office shall publish each report required under Subsection (s) on the office's Internet website.	(u) The office shall publish each report required under Subsection (t) on the office's Internet website.
	(v) In accordance with Section 533.015(b), the office shall consult with the executive commissioner regarding the adoption of rules defining the office's role in and jurisdiction over, and the frequency of, audits of managed care organizations participating in Medicaid that are conducted by the office and the commission.
	(w) The office shall coordinate all audit and oversight activities relating to providers, including the development of audit plans, risk assessments, and findings, with the commission to minimize the duplication of activities. In coordinating activities under this subsection, the office shall: (1) on an annual basis, seek input from the commission and consider previous audits and on-site visits made by the commission 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 the commission that could inform the office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.
SECTION 3. Section 531.1021(a), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended.	SECTION 3. Same as engrossed version.
No equivalent provision.	SECTION 4. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.10225 to read as follows: Sec. 531.10225. ADDITIONAL PEACE OFFICERS. (a) Pursuant to federal law, the commission's office of inspector general shall employ and commission peace officers for the purpose of assisting the office in carrying out, in coordination and conjunction with the appropriate federal entities, the duties of the office relating to the investigation of fraud, waste, and abuse in the supplemental nutrition assistance program under Chapter 33, Human Resources Code, and the temporary assistance for needy families program under Chapter 31, Human Resources Code. (b) A peace officer employed and commissioned by the office under this section is a peace officer for purposes of Article 2.12, Code of Criminal Procedure. (c) The office shall supervise a peace officer employed and commissioned under this section.
No equivalent provision.	SECTION 5. Section 531.1031(a), Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows: (a) In this section and Sections 531.1032, 531.1033, and 531.1034: (1) "Health care professional" means a person issued a license[~~, registration, or certification~~] to engage in a health care profession. (1-a) "License" means a license, certificate, registration, permit, or other authorization that: (A) is issued by a licensing authority; and (B) must be obtained before a person may practice or engage in a particular business,

occupation, or profession.

(1-b) "Licensing authority" means a department, commission, board, office, or other agency of the state that issues a license.

(1-c) "Office" means the commission's office of inspector general unless a different meaning is plainly required by the context in which the term appears.

(2) "Participating agency" means:

(A) the Medicaid fraud enforcement divisions of the office of the attorney general;

(B) each licensing authority [~~board or agency~~] with authority to issue a license to[~~, register, regulate, or certify~~] a health care professional or managed care organization that may participate in Medicaid; and

(C) the [~~commission's~~] office [~~of inspector general~~].

(3) "Provider" has the meaning assigned by Section 531.1011(10)(A).

No equivalent provision.

SECTION 6. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.1032, 531.1033, and 531.1034 to read as follows:

Sec. 531.1032. OFFICE OF INSPECTOR GENERAL: CRIMINAL HISTORY RECORD INFORMATION CHECK. (a) The office 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 shall 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. The memorandum under this section may be combined with a memorandum authorized under Section 531.1031(c-1) and must include a process by which:

(1) the office 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 the office if:

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

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

(b) The office may not, for purposes of

determining a health care professional's eligibility to participate in Medicaid as a provider, conduct a criminal history record information check of a health care professional who the office has confirmed under Subsection (a) is licensed and in good standing. This subsection does not prohibit the office 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) For purposes of determining eligibility to participate in Medicaid and subject to Subsection (d), the office, after seeking public input, shall establish and the executive commissioner by rule shall adopt guidelines for the evaluation of criminal history record information of providers and potential providers. The guidelines must 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) The guidelines adopted under Subsection (c) may not impose 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) The office and the commission shall 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) The provider enrollment contractor, if applicable, and a managed care organization participating in Medicaid shall defer to the office 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. The office shall 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) Not later than the 10th day after the date the office receives the complete application of a health care professional seeking to participate in Medicaid, the office shall inform the commission or the health care professional, as appropriate, of the office'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 the office; or

(5) any other reason the office determines appropriate.

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

(c) The office shall 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 4. Section 531.113, Government Code, is amended by adding Subsection (d-1) and amending Subsection (e) as amended by S.B. 219, Acts of the 84th Legislature, Regular Session, 2015, to read as follows:

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

(1) investigate, including by means of

SECTION 7. Section 531.113, Government Code, is amended by adding Subsection (d-1) and amending Subsection (e) as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, to read as follows:

(d-1) The commission's office of inspector general, in consultation with the commission, 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 Medicaid 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, in consultation with the office, 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.

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 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 commission and office 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) The executive commissioner, in consultation with the office, 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 in which 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 8. Same as engrossed version.

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

SECTION 9. Section 531.120, Government Code, is amended to read as follows:

Sec. 531.120. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The commission or the commission's office of inspector general shall provide a provider with written 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. The notice must include:

(1) the specific basis for the overpayment or debt;

(2) a description of facts and supporting evidence;

(3) a representative sample of any documents that form the basis for the overpayment or debt;

(4) the extrapolation methodology;

(4-a) 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;

(5) the calculation of the overpayment or debt amount;

(6) the amount of damages and penalties, if applicable; and

(7) a description of administrative and judicial due process 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.

(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. Sections 531.1201(a) and (b), Government Code, are amended to read as follows:

(a) A provider must request an appeal under this section not later than the 30th [~~15th~~] day after the date the provider is notified that the commission or the commission's office of inspector general will seek to recover an overpayment or debt from the provider. On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the Health and Human Services Commission appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office shall file the docketing request under this section not later than the 60th day after the date of the provider's request for an administrative hearing or not later than the 60th day after the completion of the informal resolution process, if applicable.

(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

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 10. Sections 531.1201(a) and (b), Government Code, are amended to read as follows:

(a) A provider must request an appeal under this section not later than the 30th [~~15th~~] day after the date the provider is notified that the commission or the commission's office of inspector general will seek to recover an overpayment or debt from the provider. On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the Health and Human Services Commission appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office shall file the docketing request under this section not later than the 60th day after the date of the provider's request for an administrative hearing or not later than the 60th day after the completion of the informal resolution process, if applicable.

(b) Unless otherwise determined by the administrative law judge for good cause, the commission's office of inspector general is responsible for the costs of an

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. Section 531.1202, Government Code, is amended.

SECTION 9. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.1023, 531.1024, 531.1027, and 531.1203 to read as follows:

Sec. 531.1023. COMPLIANCE WITH FEDERAL CODING GUIDELINES. The commission's office of inspector general, including office staff and any third party with which the office contracts to perform coding services, shall 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. The executive commissioner shall by rule develop a process for the commission's office of inspector general, including office staff and any third party with which the office contracts to perform coding services, to communicate with and educate providers about the diagnosis-related group (DRG) validation criteria that the office uses in conducting hospital utilization reviews and audits.

Sec. 531.1027. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES. (a) Notwithstanding any other law, the commission's office of

administrative hearing held under Subsection (a), but a provider is responsible for the provider's own costs incurred in preparing for the hearing [~~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 11. Substantially the same as engrossed version.

SECTION 12. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.1023, 531.1024, 531.1025, and 531.1203 to read as follows:

Sec. 531.1023. COMPLIANCE WITH FEDERAL CODING GUIDELINES. The commission's office of inspector general, including office staff and any third party with which the office contracts to perform coding services, shall 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. The executive commissioner, in consultation with the office, shall by rule develop a process for the commission's office of inspector general, including office staff and any third party with which the office contracts to perform coding services, to communicate with and educate providers about the diagnosis-related group (DRG) validation criteria that the office uses in conducting hospital utilization reviews and audits.

Sec. 531.1025. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES. (a) Notwithstanding any other law, the commission's office of

inspector general may conduct a performance audit of any program or project administered or agreement entered into by the commission or a health and human services agency, including an audit related to:

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

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

(b) The office shall coordinate the office's audit activities with those of the commission, including the development of audit plans, the performance of risk assessments, and the reporting of findings, to minimize the duplication of audit activities. In coordinating audit activities with the commission under this subsection, the office shall:

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

(2) request the results of an audit conducted by the commission if those results could inform the office'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) 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 findings 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 Medicaid, 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

inspector general may conduct a performance audit of any program or project administered or agreement entered into by the commission or a health and human services agency, including an audit related to:

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

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

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

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

(2) request the results of an audit conducted by the commission if those results could inform the office'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) 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 findings 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 Medicaid, 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 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.

No equivalent provision.

SECTION 10. The following provisions are repealed:
(1) Section 531.1201(c), Government Code; and
(2) Section 32.0422(k), Human Resources Code, as amended by S.B. 219, Acts of the 84th Legislature, Regular Session, 2015.

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 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 13. Section 533.015, Government Code, as amended by S.B. No. 219, Acts of the 84th Legislature, Regular Session, 2015, is amended to read as follows:
Sec. 533.015. COORDINATION OF EXTERNAL OVERSIGHT ACTIVITIES. (a) To the extent possible, the commission shall coordinate all external oversight activities to minimize duplication of oversight of managed care plans under Medicaid and disruption of operations under those plans.
(b) The executive commissioner, after consulting with the commission's office of inspector general, shall by rule define the commission's and office's roles in and jurisdiction over, and frequency of, audits of managed care organizations participating in Medicaid that are conducted by the commission and the commission's office of inspector general.
(c) In accordance with Section 531.102(w), the commission shall share with the commission's office of inspector general, at the request of the office, the results of any informal audit or on-site visit that could inform that office's risk assessment when determining whether to conduct, or the scope of, an audit of a managed care organization participating in Medicaid.

SECTION 14. Same as engrossed version.

SECTION 11. 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 15. Same as engrossed version.
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 16. Same as engrossed version.
SECTION 13. Not later than March 1, 2016, the executive commissioner of the Health and Human Services Commission in consultation with the inspector general of the office of inspector general 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 17. Not later than March 1, 2016, the executive commissioner of the Health and Human Services Commission, in consultation with the inspector general of the commission's office of inspector general, 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. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission shall 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. As soon as practicable after the effective date of this Act, the executive commissioner of the Health and Human Services Commission, in consultation with the inspector general of the commission's office of inspector general, shall 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.

No equivalent provision.	SECTION 19. Not later than September 1, 2016, the executive commissioner of the Health and Human Services Commission shall adopt the guidelines required under Section 531.1032(c), Government Code, as added by this Act.
SECTION 15. 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 20. Same as engrossed version.
SECTION 16. Not later than March 1, 2016, the executive commissioner of the Health and Human Services Commission in consultation with the inspector general of the office of inspector general shall adopt rules necessary to implement Section 531.1203, Government Code, as added by this Act.	SECTION 21. (a) Not later than March 1, 2016, the executive commissioner of the Health and Human Services Commission, in consultation with the inspector general of the commission's office of inspector general, shall adopt rules necessary to implement Section 531.1203, Government Code, as added by this Act. (b) Section 531.1203, Government Code, as added by this Act, applies to: (1) the findings of an audit that are made on or after the effective date of this Act; or (2) an audit the results of which are the subject of a dispute pending on the effective date of this Act.
No equivalent provision.	SECTION 22. Not later than September 1, 2016, the executive commissioner of the Health and Human Services Commission shall adopt rules required by Section 533.015(b), Government Code, as added by this Act.
SECTION 17. 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 23. Same as engrossed version.
SECTION 18. This Act takes effect September 1, 2015.	SECTION 24. Same as engrossed version.