SUBJECT: Modifying the HHSC Office of Inspector General

COMMITTEE: Human Services — committee substitute recommended

VOTE: 9 ayes — Raymond, Rose, Keough, S. King, Klick, Naishtat, Peña, Price, Spitzer

0 nays

SENATE VOTE: On final passage, April 21 — 30-0

WITNESSES: For — (*Registered, but did not testify*: Mary Nava, Bexar County Medical Society; Mark Vane, Gardere Wynne Sewell LLP; Fred Shannon, Hewlett Packard; Mariah Ramon, Teaching Hospitals of Texas; Marina Hench, Texas Association for Home Care and Hospice; Scot Kibbe, Texas Health Care Association; Michelle Romero, Texas Medical Association; David Reynolds, Texas Osteopathic Medical Association)

Against — None

On — (*Registered, but did not testify*: Kyle Janek and Karen Ray, Health and Human Services Commission; Sarah Kirkle and Danielle Nasr, Sunset Advisory Commission)

BACKGROUND: The Texas Legislature created the Office of Inspector General in 2003 as part of its reorganization of the health and human services system. The office is subject to Sunset review but not abolishment.

**Office structure.** The office is a division of the Health and Human Services Commission, but the office largely operates independently, separate from the commission. The office's inspector general is appointed by the governor to serve a one-year term.

**Office function.** The office is charged with preventing, detecting, and investigating fraud, waste, and abuse throughout the health and human services system. The office has a wide variety of functions and performed more than 100,000 investigations, reviews, and audits in fiscal 2013. The

Office of Inspector General includes five divisions: operations, compliance, internal affairs, enforcement, and chief counsel. The office also directs the operation of the Health Insurance Premium Payment (HIPP) program, which reimburses a Medicaid-eligible person or family for the cost of commercial insurance premiums when those costs are less than the cost of Medicaid services.

**Funding.** In fiscal 2014, the Office of Inspector General had 774 people on staff and a $48.9 million budget, which has increased by nearly 30 percent since 2011.

DIGEST:

CSSB 207 would modify rulemaking, duties and operations of the Office of Inspector General (OIG) for the Health and Human Services Commission (HHSC).

**Role of the executive commissioner, OIG, and governor.** The bill would require OIG to work in consultation with the executive commissioner of HHSC to adopt rules necessary to implement a power or duty related to the operations of OIG. These rules could not affect Medicaid policies.

The HHSC executive commissioner would be responsible for performing all administrative support services necessary to operate OIG, including functions of OIG related to:

- procurement processes;
- contracting policies;
- information technology services;
- legal services;
- budgeting; and
- personnel and employment policies.

HHSC's internal audit division would regularly audit OIG as part of the commission's internal audit program and would include the office in the commission's risk assessments.

OIG would closely coordinate with the executive commissioner and the

staff of programs under OIG's purview when performing functions related to the prevention of fraud, waste, and abuse in the health and human services system and the enforcement of state law related to the provision of those services, including audit utilization reviews, provider education, and data analysis.

OIG would conduct investigations independent of the executive commissioner and HHSC. OIG would rely on coordination between the office, program staff and the executive commissioner in ensuring that the office had a thorough understanding of the health and human services system for purposes of knowledgeably and effectively performing the office's duties.

**Definition of fraud.** The bill would change the definition of "fraud" in Government Code, sec. 531.1011(4) to specify that the term did not include unintentional technical, clerical, or administrative errors.

**Criminal history background checks.** OIG would enter into a memorandum of understanding with each state licensing authority that required a fingerprinted background check of a health care professional to ensure that only individuals who were licensed and in good standing as health care professionals would be Medicaid providers. The memorandum of understanding would have to include a process for OIG to confirm that a health care professional was licensed and in good standing. The licensing authority would immediately notify OIG if a provider's license had been revoked or suspended or if there had been disciplinary action against the provider. The bill would require OIG to routinely check federal databases to ensure that a provider who was excluded from the Medicaid program was not continuing to participate as a Medicaid provider.

The bill would specify other guidelines for the criminal background check, which OIG and HHSC could use to determine whether a provider would be eligible to continue to participate in Medicaid. The guidelines could not impose stricter standards for a person's eligibility to participate in Medicaid than those that a licensing authority would require for a health professional to provide services in the state. The provider

enrollment contractor, if applicable, and a Medicaid managed care organization would defer to OIG regarding whether a person's criminal history record would preclude the person from being a Medicaid provider. HHSC would adopt Medicaid eligibility guidelines by September 1, 2016.

The bill would set a timeline of 10 days for OIG to inform the HHSC or the health care professional whether the professional was denied participation in Medicaid, according to certain criteria specified in the bill.

**Investigations.** The bill would authorize OIG to issue a subpoena in connection with an investigation conducted by the office. The subpoena could be issued to compel the attendance of a relevant witness or the production of relevant evidence that was in the state.

The bill would require OIG to complete preliminary investigations of Medicaid fraud and abuse by the 45th day after the date the commission received a complaint or allegation or had reason to believe that fraud or abuse had occurred. It would require OIG to complete a full investigation by the 180th day after the date the full investigation began unless the office determined that more time was needed. Under the bill, if OIG determined that it needed more time, the office would have to notify the provider subject to the investigation of the delay and would have to specify why the office was unable to complete the investigation within the 180-day period.

These changes would apply only to a complaint or allegation received on or after September 1, 2015. The bill would not require the office to give notice to a provider if notice would jeopardize the investigation.

**Peace officers.** OIG could, according to federal law, employ and commission peace officers to assist the office in carrying out the duties of the office related to the investigation of fraud, waste, and abuse in the Supplemental Nutritional Assistance Program and the Temporary Assistance for Needy Families program.

**Payment holds and provider notice.** The bill would specify that a payment hold is a serious enforcement tool that the office imposes to

mitigate ongoing financial risk to the state and that a payment hold would take effect immediately. The bill would require OIG to consult with the state's Medicaid fraud control unit in establishing guidelines regarding the imposition of certain payment holds.

The bill would require OIG to notify a provider affected by the payment hold within five days of imposing the payment hold. The bill would require that the notice given to the provider include a detailed summary of OIG's evidence relating to the allegation and a description of administrative and judicial due process rights and remedies. These remedies would include providers' "option," rather than "right," to seek informal resolution, their right to seek a formal administrative appeal hearing, or both. The notice would have to include a detailed timeline for the provider to pursue these rights and remedies.

The bill would specify under which circumstances OIG could impose a payment hold or could find that good cause existed not to impose a payment hold, not to continue a payment hold, to impose a partial payment hold, or to convert a full payment hold to a partial payment hold. OIG could not impose a payment hold on claims for reimbursement that a provider had submitted for medically necessary services and for which the provider had obtained prior authorization unless the office had evidence that the provider had materially misrepresented documentation of the provided services.

The bill would specify that OIG could impose a payment hold without notice to a provider only if a payment hold was needed to compel the provider to give records to OIG, when requested by the state's Medicaid fraud control unit, or on the determination that a credible allegation of fraud existed.

These changes would apply only to a complaint or allegation received on or after September 1, 2015. The executive commissioner of HHSC, in consultation with the inspector general of OIG, would adopt rules necessary to implement provisions related to payment holds by March 1, 2016.

**Continuation of payment holds.** Under the bill, a SOAH judge would have to decide in an expedited administrative hearing if a payment hold should continue but could not adjust the amount or percent of the payment hold. The judge's decision would be final and could not be appealed. The bill would remove the ability of a provider subject to a payment hold to appeal a final administrative order. These changes would apply only to a complaint or allegation received on or after September 1, 2015.

**Administrative hearings.** The bill would require OIG to file a request with the State Office of Administrative Hearings (SOAH) for an expedited administrative hearing regarding a payment hold within three days after the date the office received a provider's request for such a hearing. The bill also would require a provider to request an expedited administrative hearing within 10 days after receiving notice from OIG regarding a payment hold. Under the bill, SOAH would have to hold the expedited administrative hearing within 45 days after receiving a hearing request.

During expedited administrative hearings, the bill would:

- require the provider and the office each to limit testimony to four hours;
- entitle the provider and the office each to two continuances under reasonable circumstances; and
- require the office to show probable cause that the credible allegation of fraud that was the basis of the payment hold had an indication of reliability and that continuing to pay the provider would be an ongoing significant financial risk to the state and a threat to the integrity of the Medicaid program.

These changes would apply only to a complaint or allegation received on or after September 1, 2015.

**SOAH hearing costs.** The bill would remove the requirement in existing law that OIG and the provider share costs of an expedited administrative hearing. Instead, unless otherwise determined by the administrative law judge for good cause, the bill would make OIG responsible for the costs of the hearing and make the provider responsible for the provider's own

costs incurred in preparing for the hearing. The bill also would remove the requirement in law that a provider advance a security payment for the costs of the hearing. These changes would apply only to a complaint or allegation received on or after September 1, 2015.

**Informal resolution process.** The bill would allow OIG to decide whether to grant a provider's request for a first or second informal resolution meeting. Informal resolution meetings would be confidential and any information or materials obtained by OIG would be privileged and confidential and not subject to disclosure under any means of legal compulsion for release, nor under Government Code, ch. 552 related to public information.

The bill would remove existing time requirements for when OIG would have to schedule the meeting or when the office would have to give notice of the meeting. The bill would require the informal resolution process to run concurrently with the administrative hearing process and would discontinue the informal resolution process once SOAH issued a final determination on the payment hold. These changes would apply only to a complaint or allegation received on or after September 1, 2015.

The executive commissioner would consult with OIG when adopting rules to allow a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution.

The bill would require HHSC to have an informal resolution meeting recorded and to provide the recording to the provider at no cost, if the provider requested it in writing. HHSC could not record an informal resolution meeting unless it received a written request from a provider.

**Recoupment of overpayment or debt**. The bill would require HHSC or OIG to give a provider written notice of any proposed recoupment of an overpayment or debt related to Medicaid services and any damages or penalties related to a fraud or abuse investigation. The notice would have to include the specific basis and calculation of the overpayment or debt, facts and supporting evidence, a representative sample of the documents used as a basis for the overpayment or debt, the extrapolation

methodology and related information, the amount of damages and penalties, and a description of due process remedies, including informal resolution.

The bill would require a provider to request an appeal of a recoupment or overpayment of debt within 30 days of the date the provider was notified. Unless otherwise determined by the administrative law judge for good cause, OIG would be responsible for the costs of an administrative hearing.

**Rules on OIG operation and duties.** The executive commissioner of HHSC would set rules for opening and prioritizing cases. In addition, the executive commissioner, in consultation with OIG, would have to adopt rules detailing OIG investigation procedures and criteria for enforcement and punitive actions. These rules would include direction for categorizing provider violations according to the nature of the violation and for scaling resulting enforcement actions, taking into consideration the seriousness of the violation, the prevalence of the provider's errors, financial harm, and mitigating factors. The rules also would have to include a specific list of potential penalties.

The bill would specify that OIG would consult with HHSC regarding:

- investigations of possible fraud, waste, and abuse by certain managed care organizations;
- training and oversight of special investigative units established by managed care organizations;
- requirements for approving managed care organizations' plans to prevent and reduce fraud and abuse;
- evaluation of statewide fraud, waste, and abuse trends in the Medicaid program; and
- assistance to managed care organizations in discovering or investigating fraud, waste, and abuse;
- providing ongoing, regular training to appropriate HHSC and OIG staff concerning fraud, waste, and abuse in a managed care setting, including training related to service providers and recipients.

**Extrapolation review.** The bill would require OIG to review its investigative process, including its use of sampling and extrapolation to audit provider records. The bill would require the review to be performed by staff who were not directly involved in OIG investigations.

The bill also would require OIG to 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 states' offices of inspector general, the executive commissioner of HHSC, in consultation with OIG, would rule to adopt sampling and extrapolation standards to be used by OIG in conducting audits.

The OIG inspector general would submit a report to the executive commissioner of HHSC, the governor, and the Legislature at each quarterly meeting of any advisory council responsible for advising the executive commissioner on the operation of the commission. The report would be published on OIG's website and would include information on the office's activities, performance measures, fraud trends, and recommendations for policy changes to prevent or address fraud, waste, and abuse in the health and human services system.

OIG would consult with the executive commissioner regarding the adoption of rules defining OIG's role in and jurisdiction over audits of Medicaid managed care organizations and the frequency of those audits. OIG would consult with HHSC in investigating fraud, waste, and abuse by Medicaid managed care organizations. After consulting with OIG, HHSC would rule by September 1, 2016, to define the roles of HHSC and OIG and their jurisdiction over audits of Medicaid managed care organizations. HHSC also would determine the frequency of those audits.

OIG also would coordinate all audit and oversight activities related to providers, including external oversight activities, to minimize the duplication of activities, including those of Medicaid managed care plans. The bill would specify that OIG would seek input from the commission and consider previous audits and on-site visits made from the commission in coordinating these activities. HHSC would be required to share with

OIG 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 an audit of a Medicaid managed care organization and the scope of that audit.

**Pharmacies subject to audits.** The bill would specify that a pharmacy would have a right to request an informal hearing before the HHSC's appeals division to contest an audit that did not find that the pharmacy engaged in Medicaid fraud. The bill would require staff of the HHSC's appeals division, assisted by vendor drug program staff, to make the final decision on whether an audit's findings were accurate. It would disallow OIG staff from serving on the panel that made a decision regarding the accuracy of the audit.

OIG would have to provide pharmacies under audit with detailed information, if OIG had access to it, relating to the extrapolation methodology used as part of the audit and the methods used to determine whether the Medicaid program overpaid the pharmacy. The information would have to be in sufficient detail so that the audit results could be demonstrated to be statistically valid and fully reproducible.

By March 1, 2016, the executive commissioner of HHSC, in consultation with OIG, would have to adopt the necessary rules to implement these changes. Provisions related to pharmacies would apply to the findings of an audit made on or after September 1, 2015, or an audit that was the subject of a dispute pending on that date.

**Federal medical coding guidelines for hospital reviews.** OIG, including office staff and any third party would comply with federal medical coding guidelines, including guidelines for diagnosis-related group validation and related audits. The HHSC executive commissioner, in consultation with OIG, would rule to develop a process for OIG, its staff, and any third party to communicate with and educate providers about the diagnosis-related group validation criteria that OIG would use to conduct hospital utilization reviews and audits. HHSC would adopt these rules as soon as practicable after September 1, 2015.

**Performance audits and audit coordination.** The bill would authorize OIG to conduct a performance audit of any program or project administered or agreement entered into by HHSC or a health and human services agency, including an audit related to contracting procedures or the performance of the HHSC or a health and human services agency. In coordinating audits with HHSC, OIG would be required to seek input from the commission and to consider previous audits for purposes of determining whether to conduct a performance audit and to request the results of an audit conducted by HHSC if those results could inform OIG's risk assessment when determining whether to conduct a performance audit or its scope.

**Participation in HIPP and managed care.** The bill would repeal the prohibition on an individual's participation in both the Health Insurance Premium Payment Program (HIPP) and Medicaid managed care.

**Reports on the death of a child.** The bill would allow a confidential draft report on an audit or investigation that concerned the death of a child to be shared with the Department of Family and Protective Services, but the draft report would remain confidential.

**Federal waivers.** The bill would direct a state agency needing a waiver or authorization from a federal agency to implement a provision of the bill to request that waiver or authorization. The affected state agency could delay implementation of affected provisions in the bill until the agency received the waiver or authority.

**Future Sunset review.** The Sunset Advisory Commission would conduct a special-purpose review of the overall performance of OIG as part of its review of agencies for the 87th Legislature in 2021. OIG would not be abolished solely because it was not explicitly continued following the review.

The bill would take effect September 1, 2015.

SUPPORTERS SAY:

CSSB 207 would help address management and due process concerns found during the Sunset review of the Health and Human Services

Commission (HHSC). The bill also would provide needed structure, guidelines, and performance measures to OIG's investigative processes to reduce overzealous investigation of Medicaid providers and to ensure consistent and fair results.

**Appointment of inspector general.** The bill would retain appointment of the inspector general with the governor to allow an arm's-length relationship with the HHSC executive commissioner. By retaining this arrangement, the bill would ensure accountability and independence in the inspector general position while still allowing HHSC to have input into rulemaking at OIG.

**Executive commissioner.** The HHSC executive commissioner would be responsible for performing all administrative support services necessary to operate OIG, which would hold the executive commissioner accountable for OIG's performance. This practice is common in other state offices of inspector general.

**Sunset review.** Given the lack of data to fully evaluate OIG's performance, especially related to investigations, the bill would require OIG to undergo special review by the Sunset Advisory Commission in six years. Within that period, OIG should have a case management system and the ability to track data to better illustrate its overall performance and the effectiveness and efficiency of its processes. Because OIG does not have its own Sunset date, it is subject to review, but not abolishment. Any concerns that may emerge in the six years before the next review could be addressed at the will of the Legislature and would not depend on this timeline.

**Definition of fraud.** By making the definition of "fraud" less broad and specifying that the definition does not include unintentional technical, clerical, or administrative errors, the bill would focus OIG's fraud investigations on those actually committing fraud and would help prevent resources from being wasted on providers who commit clerical errors. Previously, OIG cast too wide a net and spent time and money on investigating providers who made clerical mistakes but were not committing fraud. Overzealous investigations based on a broad definition

of fraud also caused communities with limited health resources to unnecessarily lose access to Medicaid providers.

**Participation in HIPP and managed care.** The bill appropriately would remove an outdated prohibition on the participation of an individual in both HIPP and Medicaid managed care to allow Medicaid clients in the HIPP program to access long-term care services and supports through Medicaid managed care.

**Payment holds and provider notice.** The bill would streamline the payment hold process to more quickly mitigate state financial risks and reduce any undue burden on providers. The timelines in the bill would increase efficiency in the payment hold and appeal processes. The bill would ensure that providers were not subject to payment holds any longer than necessary. The bill also would clarify the intended serious nature of payment holds and would specify that payment holds should be reserved for significant events such as fraud and to compel the production of records. It would respond to concerns that OIG had used payment holds as a bargaining chip to encourage providers to settle their cases, even in cases that did not pose a significant financial risk to the state.

**Rules on OIG operation and duties.** The bill would require rules for opening cases, prioritizing cases, prioritizing investigations, and scaling penalties to the nature of the violation, which would increase workload efficiency and investigation transparency, consistency, and fairness at OIG. The rules also would ensure that Medicaid providers were not overly penalized for less serious violations. The state needs a robust network of Medicaid providers, and scaling penalties to the severity of violations would ensure that Medicaid providers' practices were not subjected to a payment hold for an unnecessarily long period of time.

**Time limits on investigations.** The bill would require OIG to complete preliminary investigations within 45 days of receiving a complaint or referral, which would provide time for OIG to determine whether to refer the matter to the Medicaid fraud control unit for criminal prosecution and ensure that investigations were completed in a timely manner. Requiring a 180-day time limit on full-scale investigations and requiring OIG to notify

the provider if an investigation took longer than 180 days would increase transparency for providers about the investigative process while ensuring the timely completion of investigations.

**Informal resolution process.** Turning informal resolution meetings before a payment hold hearing into an option rather than a statutory right would aid in streamlining the hearing process and making it more efficient. It also would bring the process more in line with comparable processes before Medical Board and Board of Nursing hearings. A provider still would have a right to two informal resolution meetings before proceeding to the hearing.

**Extrapolation review.** By requiring OIG to review its extrapolation methodology and provide its methodology to pharmacies subject to audits, the bill would help ensure the integrity of the sampling and extrapolation methodology the office uses in its reviews. The bill also would respond to concerns over the improper use of the office's methodology by requiring a third party to conduct a peer review of the office's sampling and extrapolation techniques

**SOAH hearing costs.** OIG should cover costs of expedited administrative hearings to reduce the burden to providers in accessing due process. The bill still would require providers to cover their own costs in preparing for the hearing. The bill would align payment hold hearings with the standard state practice of requiring the agency to pay for SOAH hearings.

**Pharmacies subject to audits.** The bill would make clear that pharmacies have the right to request a hearing to contest an OIG audit and would increase transparency by allowing pharmacies to review the methodology OIG used as part of the audit.

**Hospital utilization review.** The bill would increase consistency and accountability at OIG by requiring the office to use federal medical billing codes and to develop a process for using diagnosis-related group validation criteria in hospital utilization reviews.

OPPONENTS

**Appointment of OIG.** Current law requiring the governor to appoint the

SAY: inspector general fosters confusion about whether the inspector general answers to the governor or the HHSC executive commissioner. Problems with this structure and its lack of clear accountability were illustrated by the inability of the HHSC executive commissioner to properly hold the inspector general accountable for overzealous Medicaid investigations and excessive spending on badges and other items.

**Sunset review.** Given the important work done by OIG and the management and other concerns uncovered in the Sunset review, it would be more appropriate for OIG to undergo special review in three years rather than six. This would permit enough time for changes to be made without allowing any problems to get out of hand. The Legislature would have enough information to evaluate changes made by the bill and make any necessary adjustments.

**Definition of fraud.** The Medicaid program has had significant problems in the past with providers who were actually committing fraud, waste, or abuse and endangering the health of children. Limiting the definition of fraud might impair OIG's ability to investigate providers and find those who had legitimately committed fraud. OIG does not order payment holds with enough frequency to significantly limit access to Medicaid providers or indicate that the definition of fraud is too broad.

**Informal resolution process.** The bill should not allow OIG to determine whether a provider should be granted an informal resolution meeting and should not remove timelines that were just recently added to code. These changes would make the informal resolution process less transparent and slower.

**SOAH hearing costs.** The bill would remove recently added requirements in code for providers and OIG to share costs and provide for expedited administrative hearings. Providers agreed to share these costs and provide a security deposit for the cost of the hearing. Cost sharing would not pose an undue burden for providers.

**Payment holds.** The timeline proposed in the bill for how soon a provider would have to respond to notice of a payment hold to request an expedited

administrative hearing is too short. Providers need more than 10 days to get billing sheets from the billing company in order to respond.

NOTES:

The companion bill, HB 3279 by Gonzales, was recommitted to the House General Investigating and Ethics committee on April 29.

The House committee substitute for CSSB 207 differs from the engrossed Senate version of the bill by:

- requiring OIG and HHSC to coordinate audit and oversight activities of Medicaid managed care organizations;
- prohibiting OIG from performing duplicative criminal history checks of providers who received fingerprint-based checks and were in good standing with a licensing agency;
- requiring OIG to adopt guidelines on evaluating criminal history information;
- requiring OIG to make a determination on provider eligibility within 10 days;
- requiring OIG to consult with HHSC in its duties related to Medicaid managed care organizations and to provide training to OIG and HHSC staff;
- requiring OIG to request a peer review of extrapolation and sampling methodologies from a third party;
- requiring OIG to provide detailed information regarding its extrapolation methodology with a provider notice for overpayment;
- giving OIG authority to adopt rules necessary to implement its powers or duties in consultation with the HHSC executive commissioner;
- requiring OIG to employ peace officers for the purpose of investigating fraud, waste, and abuse in SNAP and TANF; and
- providing that the appeal process for pharmacy audits would apply retroactively to audits subject to a pending audit dispute on September 1, 2015.