PRELIMINARY DRAFT

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CHAPTER 544. FRAUD, WASTE, ABUSE, AND OVERCHARGES RELATING TO HEALTH AND HUMAN SERVICES

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SUBCHAPTER A. GENERAL PROVISIONS

Revised Law

Sec. 544.0001. DEFINITIONS. In this chapter:

(1) "Abuse" means:

(A) a practice a provider engages in that is inconsistent with sound fiscal, business, or medical practices and that results in:

(i) an unnecessary cost to Medicaid; or

(ii) reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care; or

(B) a practice a recipient engages in that results in an unnecessary cost to Medicaid.

(2) "Allegation of fraud" means an allegation of Medicaid fraud the commission receives from any source that has not been verified by this state, including an allegation based on:

(A) a fraud hotline complaint;

(B) claims data mining;

(C) data analysis processes; or

(D) a pattern identified through provider audits, civil false claims cases, or law enforcement investigations.

(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by this state. An allegation is considered credible when the commission has:

(A) verified that the allegation has indicia of reliability; and

(B) carefully reviewed all allegations, facts, and evidence and acts judiciously on a case-by-case basis.

(4) "Fraud" means an intentional deception or misrepresentation a person makes with the knowledge that the deception or misrepresentation could result in an unauthorized benefit to that person or another person. The term does not include unintentional technical, clerical, or administrative errors.

(5) "Furnished" refers to the provision of items or services directly by or under the direct supervision of, or the ordering of items or services by:

(A) a practitioner or other individual acting as an employee or in the individual's own capacity;

(B) a provider; or

(C) another supplier of services, excluding services ordered by one party but billed for and provided by or

under the supervision of another.

(6) "Inspector general" means the inspector general the governor appoints under Section 544.0101.

(7) "Office of inspector general" means the commission's office of inspector general.

(8) "Payment hold" means the temporary denial of Medicaid reimbursement for items or services a specified provider furnished.

(9) "Physician" includes:

(A) an individual licensed to practice medicine in this state;

(B) a professional association composed solely of physicians;

(C) a partnership composed solely of physicians;

(D) a single legal entity authorized to practice medicine that is owned by two or more physicians; and

(E) a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code.

(10) "Practitioner" means a physician or other individual licensed under state law to practice the individual's profession.

(11) "Program exclusion" means the suspension of a provider's authorization under Medicaid to request reimbursement for items or services the provider furnished.

(12) Except as otherwise provided by this chapter, "provider" means a person that was or is approved by the commission to:

(A) provide Medicaid services under a contract or provider agreement with the commission; or

(B) provide third-party billing vendor services under a contract or provider agreement with the commission. (Gov. Code, Sec. 531.1011; New.)

Source Law

Sec. 531.1011. DEFINITIONS. For purposes of

this subchapter:

(1) "Abuse" means:

(A) a practice by a provider that is inconsistent with sound fiscal, business, or medical practices and that results in:

(i) an unnecessary cost to Medicaid; or

(ii) the reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care; or

(B) a practice by a recipient that results in an unnecessary cost to Medicaid.

(2) "Allegation of fraud" means an allegation of Medicaid fraud received by the commission from any source that has not been verified by the state, including an allegation based on:

(A) a fraud hotline complaint;

(B) claims data mining;

(C) data analysis processes; or

(D) a pattern identified through provider audits, civil false claims cases, or law enforcement investigations.

(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by the state. An allegation is considered to be credible when the commission has:

(A) verified that the allegation has indicia of reliability; and

(B) reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(4) "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person. The term does not include unintentional technical, clerical, or administrative errors.

(5) "Furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by a practitioner or other individual (either as an employee or in the individual's own capacity), a provider, or other supplier of services, excluding services ordered by one party but billed for and provided by or under the supervision of another.

(6) "Payment hold" means the temporary denial of reimbursement under Medicaid for items or services furnished by a specified provider.

(7) "Physician" includes an individual licensed to practice medicine in this state, a professional association composed solely of physicians, a partnership composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, and a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code.

(8) "Practitioner" means a physician or other individual licensed under state law to practice the individual's profession.

(9) "Program exclusion" means the suspension of a provider from being authorized under Medicaid to request reimbursement of items or services furnished by that specific provider.

(10) "Provider" means a person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the commission to:

(A) provide Medicaid services under a contract or provider agreement with the commission; or

(B) provide third-party billing vendor services under a contract or provider agreement with the commission.

Revisor's Note

(1) Section 531.1011, Government Code, defines terms for purposes of "this subchapter," meaning Subchapter C, Chapter 531, Government Code. Subchapter C is substantially revised in this chapter. The revised law in this chapter also includes the revision of Section 531.0215, Government Code, which is not a provision of Subchapter C, Chapter 531. The revised law substitutes "this chapter" for "this subchapter" and applies the definitions to the entire chapter, including the revised law derived from Section 531.0215, because that section does not use any of the defined terms.

(2) The definitions of "inspector general" and "office of inspector general" are added to the revised law for drafting convenience and to eliminate frequent, unnecessary repetition of the substance of the definitions.

(3) Section 531.1011(10), Government Code, defines "provider" for purposes of Subchapter C, Chapter 531, Government Code, which is substantially revised in this chapter. Section 531.1031(a)(3), Government Code, which is revised in this chapter as Section 544.0151(5), defines "provider" in a different manner for purposes of Sections 531.1031, 531.1032, 531.1033, and 531.1034, Government Code, each of which is included in Subchapter C, Chapter 531, and revised in Subchapter D of this chapter. For clarity and the convenience of the reader, the revised law in this section defines "provider" for purposes of the chapter in the manner specified by Section 531.1011(10),

"[e]xcept as otherwise provided by this chapter," to reflect that a different definition of the term applies in Subchapter D of this chapter.

(4) Section 531.1011(10), Government Code, refers to a person, "firm, partnership, corporation, agency, association, institution, or other entity." The revised law omits the quoted language because Section 311.005(2), Government Code (Code Construction Act), defines "person" to include any legal entity.

Revised Law

Sec. 544.0002. REFERENCE TO OFFICE OF INVESTIGATIONS AND ENFORCEMENT. Notwithstanding any other law, a reference in law or rule to the commission's office of investigations and enforcement means the office of inspector general. (Gov. Code, Sec. 531.102(i).)

Source Law

(i) Notwithstanding any other provision of law, a reference in law or rule to the commission's office of investigations and enforcement means the office of inspector general established under this section.

Revisor's Note

Section 531.102(i), Government Code, refers to the office of inspector general "established under this section." The revised law omits the quoted language as unnecessary because Section 544.0001(7) of this chapter defines "office of inspector general" to mean the Health and Human Services Commission's office of inspector general.

Revised Law

Sec. 544.0003. AUTHORITY OF STATE AGENCY OR GOVERNMENTAL ENTITY NOT LIMITED. Nothing in the following provisions limits the authority of any other state agency or governmental entity:

(1) Section 544.0052;

(2) Section 544.0101;

(3) Section 544.0102;

(4) Section 544.0103;

(5) Section 544.0104;

(6) Section 544.0105;

(7) Section 544.0106;

(8) Section 544.0108;

(9) Sections 544.0109(b) and (d);

(10) Section 544.0110;

(11) Section 544.0113;

(12) Section 544.0114;

(13) Section 544.0251;

(14) Section 544.0252(b);

(15) Section 544.0254;

(16) Section 544.0255;

(17) Section 544.0257;

(18) Section 544.0301;

(19) Section 544.0302;

(20) Section 544.0303; and

(21) Section 544.0304. (Gov. Code, Sec. 531.102(o).)

Source Law

(o) Nothing in this section limits the authority of any other state agency or governmental entity.

Revisor's Note

Section 531.102(o), Government Code, states that nothing in Section 531.102 limits the authority of any other state agency or governmental entity. The relevant provisions of Section 531.102 that could be interpreted as limiting the authority of another state agency or governmental entity are revised in various provisions throughout this chapter, and the revised law references those relevant provisions.

SUBCHAPTER B. HEALTH AND HUMAN SERVICES COMMISSION: ADMINISTRATIVE PROVISIONS

Revised Law

Sec. 544.0051. COORDINATION WITH OFFICE OF ATTORNEY GENERAL; ANNUAL REPORT. (a) The commission, acting through the office of inspector general, and the office of the attorney general shall enter into a memorandum of understanding to develop and implement joint written procedures for processing:

(1) cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law; or

(2) other violations of state or federal law under Medicaid or another program the commission or a health and human services agency administers, including:

(A) the financial assistance program under Chapter 31, Human Resources Code;

(B) the supplemental nutrition assistance program under Chapter 33, Human Resources Code; and

(C) the child health plan program.

(b) The memorandum of understanding must:

(1) require the office of inspector general and the office of the attorney general to:

(A) set priorities and guidelines for referring cases to appropriate state agencies for investigation, prosecution, or other disposition to:

(i) enhance deterrence of fraud, waste, abuse, or other violations of state or federal law under the programs described by Subsection (a)(2), including a violation of Chapter 102, Occupations Code; and

(ii) maximize the imposition of penalties, the recovery of money, and the successful prosecution of cases; and

(B) submit information the comptroller requests about each resolved case for the comptroller's use in improving fraud detection;

(2) require the office of inspector general to:

(A) refer each case of suspected provider fraud, waste, or abuse to the office of the attorney general not later than the 20th business day after the date the office of inspector general determines that the existence of fraud, waste, or abuse is reasonably indicated;

(B) keep detailed records for cases the office of inspector general or the office of the attorney general processes, including information on the total number of cases processed and, for each case:

(i) the agency and division to which the case is referred for investigation;

(ii) the date the case is referred; and

(iii) the nature of the suspected fraud, waste, or abuse; and

(C) notify each appropriate division of the office of the attorney general of each case the office of inspector general refers;

(3) require the office of the attorney general to:

(A) take appropriate action in response to each case referred to the attorney general, which may include:

(i) directly initiating prosecution, with the appropriate local district or county attorney's consent;

(ii) directly initiating civil litigation;

(iii) referring the case to an appropriate United States attorney, a district attorney, or a county attorney; or

(iv) referring the case to a collections agency for initiation of civil litigation or other appropriate action;

(B) ensure that information relating to each case the office of the attorney general investigates is available to each division of the office with responsibility for investigating suspected fraud, waste, or abuse; and

(C) notify the office of inspector general of

each case the attorney general declines to prosecute or prosecutes unsuccessfully;

(4) require representatives of the office of inspector general and of the office of the attorney general to meet not less than quarterly to share case information and determine the appropriate agency and division to investigate each case;

(5) ensure that barriers to direct fraud referrals to the office of the attorney general's Medicaid fraud control unit or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are not imposed; and

(6) include procedures to facilitate the referral of cases directly to the office of the attorney general.

(c) An exchange of information under this section between the office of the attorney general and the commission, the office of inspector general, or a health and human services agency does not affect whether the information is subject to disclosure under Chapter 552.

(d) The commission and the office of the attorney general may not assess or collect investigation and attorney's fees on any state agency's behalf unless the office of the attorney general or another state agency collects a penalty, restitution, or other reimbursement payment to this state.

(e) A district attorney, county attorney, city attorney, or private collection agency may collect and retain:

(1) costs associated with a case referred to the attorney or agency in accordance with procedures adopted under this section; and

(2) 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

(f) The commission and the office of the attorney general shall jointly prepare and submit to the governor, lieutenant governor, and speaker of the house of representatives an annual report concerning the activities of those agencies in detecting and preventing fraud, waste, and abuse under Medicaid or another

program the commission or a health and human services agency administers. The commission and the office of the attorney general may consolidate the report with any other report relating to the same subject matter the commission or the office of the attorney general is required to submit under other law. (Gov. Code, Sec. 531.103.)

Source Law

Sec. 531.103. INTERAGENCY COORDINATION. (a) The commission, acting through the commission's office of inspector general, and the office of the attorney general shall enter into a memorandum of understanding to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law, or other violations of state or federal law under Medicaid or another program administered by the commission or a health and human services agency, including the financial assistance program under Chapter 31, Human Resources Code, the supplemental nutrition assistance program under Chapter 33, Human Resources Code, and the child health plan program. The memorandum of understanding shall require:

(1) the office of inspector general and the office of the attorney general to set priorities and guidelines for referring cases to appropriate state agencies for investigation, prosecution, or other disposition to enhance deterrence of fraud, waste, abuse, or other violations of state or federal law, including a violation of Chapter 102, Occupations Code, in the programs and maximize the imposition of penalties, the recovery of money, and the successful prosecution of cases;

(1-a) the office of inspector general to refer each case of suspected provider fraud, waste, or abuse to the office of the attorney general not later than the 20th business day after the date the office of inspector general determines that the existence of fraud, waste, or abuse is reasonably indicated;

(1-b) the office of the attorney general to take appropriate action in response to each case referred to the attorney general, which action may include direct initiation of prosecution, with the consent of the appropriate local district or county attorney, direct initiation of civil litigation, referral to an appropriate United States attorney, a district attorney, or a county attorney, or referral to a collections agency for initiation of civil litigation or other appropriate action;

(2) the office of inspector general to keep detailed records for cases processed by that office or the office of the attorney general, including information on the total number of cases processed and, for each case:

(A) the agency and division to which the case is referred for investigation;

(B) the date on which the case is referred; and

(C) the nature of the suspected fraud, waste, or abuse;

(3) the office of inspector general to

notify each appropriate division of the office of the attorney general of each case referred by the office of inspector general;

(4) the office of the attorney general to ensure that information relating to each case investigated by that office is available to each division of the office with responsibility for investigating suspected fraud, waste, or abuse;

(5) the office of the attorney general to notify the office of inspector general of each case the attorney general declines to prosecute or prosecutes unsuccessfully;

(6) representatives of the office of inspector general and of the office of the attorney general to meet not less than quarterly to share case information and determine the appropriate agency and division to investigate each case; and

(7) the office of inspector general and the office of the attorney general to submit information requested by the comptroller about each resolved case for the comptroller's use in improving fraud detection.

(b) An exchange of information under this section between the office of the attorney general and the commission, the office of inspector general, or a health and human services agency does not affect whether the information is subject to disclosure under Chapter 552.

(c) The commission and the office of the attorney general shall jointly prepare and submit an annual report to the governor, lieutenant governor, and speaker of the house of representatives concerning the activities of those agencies in detecting and preventing fraud, waste, and abuse under Medicaid or another program administered by the commission or a health and human services agency. The report may be consolidated with any other report relating to the same subject matter the commission or office of the attorney general is required to submit under other law.

(d) The commission and the office of the attorney general may not assess or collect investigation and attorney's fees on behalf of any state agency unless the office of the attorney general or other state agency collects a penalty, restitution, or other reimbursement payment to the state.

(e) In addition to the provisions required by Subsection (a), the memorandum of understanding required by this section must also ensure that no barriers to direct fraud referrals to the office of the attorney general's Medicaid fraud control unit or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are imposed, and must include procedures to facilitate the referral of cases directly to the office of the attorney general.

(f) A district attorney, county attorney, city attorney, or private collection agency may collect and retain costs associated with a case referred to the attorney or agency in accordance with procedures adopted under this section and 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

Revisor's Note

Section 531.103(a), Government Code, directs the

Health and Human Services Commission's office of inspector general and the office of the attorney general to enter into a memorandum of understanding that "shall" include certain requirements. The revised law substitutes "must" for "shall" because under Section 311.016, Government Code (Code Construction Act), applicable to this code, the term "shall" imposes a duty on an actor and the term "must" is more commonly used when no duty is imposed on an actor and the sentence's subject is an inanimate object.

Revised Law

Sec. 544.0052. RULES REGARDING ENFORCEMENT AND PUNITIVE ACTIONS. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt rules establishing criteria for determining enforcement and punitive actions regarding a provider who violated state law, program rules, or the provider's Medicaid provider agreement.

(b) The rules must 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 this state or recipients resulting or potentially resulting from those errors; and

(D) mitigating factors the office of inspector general determines appropriate; and

(2) a specific list of potential penalties, including the amount of the penalties, for fraud and other Medicaid violations. (Gov. Code, Sec. 531.102(x).)

Source Law

(x) 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.

Revised Law

Sec. 544.0053. PROVISION OF INFORMATION TO PHARMACY SUBJECT TO AUDIT; INFORMAL HEARING ON AUDIT FINDINGS. (a) To increase transparency, the 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.

(b) A pharmacy has a right to request an informal hearing before the commission's appeals division to contest the findings of an audit that the office of inspector general or an entity that contracts with the federal government to audit Medicaid providers conducted if the audit findings do not include findings that the pharmacy engaged in Medicaid fraud.

(c) In an informal hearing held under this section, the commission's appeals division staff, assisted by staff responsible for the commission's vendor drug program with expertise in the law governing pharmacies' participation in Medicaid, make the final decision on whether the audit findings are accurate. Office of inspector general staff may not serve on the panel that makes the

decision on the accuracy of an audit. (Gov. Code, Sec. 531.1203.)

Source Law

> 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 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.

Revised Law

Sec. 544.0054. RECORDS OF ALLEGATIONS OF FRAUD OR ABUSE. The commission shall maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential under Section 544.0259(e) and is subject to Section 544.0259(f). (Gov. Code, Sec. 531.118(a).)

Source Law

> Sec. 531.118. PRELIMINARY INVESTIGATIONS OF ALLEGATIONS OF FRAUD OR ABUSE AND FRAUD REFERRALS. (a) The commission shall maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. The record is confidential under Section 531.1021(g) and is subject to Section 531.1021(h).

Revised Law

Sec. 544.0055. RECORD AND CONFIDENTIALITY OF INFORMAL

RESOLUTION MEETINGS. (a) On the written request of a provider who requests an informal resolution meeting held under Section 544.0304 or 544.0506(b), the commission shall, at no expense to the provider, provide for the meeting to be recorded and for the recording to be made available to the provider. The commission may not record an informal resolution meeting unless the commission receives a written request from a provider.

(b) Notwithstanding Section 544.0259(e) and except as provided by this section:

(1) an informal resolution meeting held under Section 544.0304 or 544.0506(b) is confidential; and

(2) any information or materials the office of inspector general, including the office's employees or agents, obtains during or in connection with an informal resolution meeting, including a recording made under Subsection (a), are privileged, confidential, and not subject to disclosure under Chapter 552 or any other means of legal compulsion for release, including disclosure, discovery, or subpoena. (Gov. Code, Sec. 531.1202.)

Source Law

Sec. 531.1202. RECORD AND CONFIDENTIALITY OF INFORMAL RESOLUTION MEETINGS. (a) On the written request of the provider, the commission shall, at no expense to the provider who requested the meeting, provide for an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) to be recorded. The recording of an informal resolution meeting shall be made available to the provider who requested the meeting. The commission may not record an informal resolution meeting unless the commission receives a written request from a provider under this subsection.

(b) Notwithstanding Section 531.1021(g) and except as provided by this section, an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) is confidential, and any information or materials obtained by the commission's office of inspector general, including the office's employees or the office's agents, during or in connection with an informal resolution meeting, including a recording made under Subsection (a), are privileged and confidential and not subject to disclosure under Chapter 552 or any other means of legal compulsion for release, including disclosure, discovery, or subpoena.

Revised Law

Sec. 544.0056. EXPUNCTION OF CHILD'S CHEMICAL DEPENDENCY DIAGNOSIS IN CERTAIN RECORDS. (a) In this section:

(1) "Chemical dependency" has the meaning assigned by Section 461A.002, Health and Safety Code.

(2) "Child" means an individual who is 13 years of age or younger.

(b) After a chemical dependency treatment provider is finally convicted of an offense in which an element of the offense involves submitting a fraudulent claim for reimbursement for services under Medicaid, the commission or other health and human services agency that operates a portion of Medicaid shall expunge or provide for the expunction of a child's diagnosis of chemical dependency that the provider made and that has been entered in any:

(1) appropriate official record of the commission or agency;

(2) applicable medical record that is in the commission's or agency's custody; and

(3) applicable record of a company with which the commission contracts for processing and paying Medicaid claims. (Gov. Code, Sec. 531.112.)

Source Law

Sec. 531.112. EXPUNCTION OF INFORMATION RELATED TO CERTAIN CHEMICAL DEPENDENCY DIAGNOSES IN CERTAIN RECORDS. (a) In this section:

(1) "Chemical dependency" has the meaning assigned by Section 461A.002, Health and Safety Code.

(2) "Child" means a person 13 years of age or younger.

(b) Following the final conviction of a chemical dependency treatment provider for an offense, an element of which involves submitting a fraudulent claim for reimbursement for services under Medicaid, the commission or other health and human services agency that operates a portion of Medicaid shall expunge or provide for the expunction of a diagnosis of chemical dependency in a child that has been made by the treatment provider and entered in any:

(1) appropriate official record of the commission or agency;

(2) applicable medical record that is in the commission's or agency's custody; and

(3) applicable record of a company that the commission contracts with for the processing and payment of claims under Medicaid.

Revisor's Note

Section 531.112(a)(2), Government Code, defines the term "child" to mean a "person" who is 13 years of age or younger. Throughout this chapter, the revised law substitutes "individual" for "person" for clarity and consistency where the context makes clear that the referenced person is an individual and not an entity described by the definition of "person" provided by Section 311.005(2), Government Code (Code Construction Act), applicable to this code.

SUBCHAPTER C. OFFICE OF INSPECTOR GENERAL: GENERAL PROVISIONS

Revised Law

Sec. 544.0101. APPOINTMENT OF INSPECTOR GENERAL; TERM. (a) The governor shall appoint an inspector general to serve as director of the office of inspector general.

(b) The inspector general serves a one-year term that expires February 1. (Gov. Code, Sec. 531.102(a-1).)

Source Law

(a-1) The governor shall appoint an inspector general to serve as director of the office. The inspector general serves a one-year term that expires on February 1.

Revised Law

Sec. 544.0102. COMMISSION POWERS AND DUTIES RELATED TO OFFICE OF INSPECTOR GENERAL. (a) The executive commissioner shall work in consultation with the office of inspector general when the executive commissioner is required by law to adopt a rule or policy necessary to implement a power or duty of the office, including a rule necessary to carry out a responsibility of the office under Section 544.0103(a).

(b) The executive commissioner is responsible for performing all administrative support services functions necessary to operate the office of inspector general in the same manner that the executive commissioner is responsible for providing administrative support services functions for the health and human

services system, including office functions related to:

(1) procurement processes;

(2) contracting policies;

(3) information technology services;

(4) legal services, but only those related to:

(A) open records;

(B) procurement;

(C) contracting;

(D) human resources;

(E) privacy;

(F) litigation support by the attorney general;

(G) bankruptcy; and

(H) other legal services as detailed in the memorandum of understanding or other written agreement required under Section _____ [[[Section 531.00553]]];

(5) budgeting; and

(6) personnel and employment policies.

(c) The commission's internal audit division shall:

(1) regularly audit the office of inspector general as part of the commission's internal audit program; and

(2) include the office in the commission's risk assessments.

(d) The commission's chief counsel is the final authority for all legal interpretations related to statutes, rules, and commission policies on programs the commission administers.

(e) The commission shall:

(1) in consultation with the inspector general, set clear objectives, priorities, and performance standards for the office of inspector general that emphasize:

(A) coordinating investigative efforts to aggressively recover money;

(B) allocating resources to cases that have the strongest supportive evidence and greatest potential to recover money; and

(C) maximizing opportunities for referral of cases to the office of the attorney general in accordance with Section 544.0051; and

(2) train office of inspector general staff to enable the staff to pursue priority Medicaid and other health and human services fraud and abuse cases as necessary.

(f) The commission may require employees of health and human services agencies to provide assistance to the office of inspector general in connection with the office's duties relating to the investigation of fraud and abuse in the provision of health and human services. The office is entitled to access to any information a health and human services agency maintains that is relevant to the office's functions, including internal records.

(g) To the extent permitted by federal law, the executive commissioner, on the office of inspector general's behalf, shall adopt rules establishing:

(1) criteria for:

(A) initiating a full-scale fraud or abuse investigation;

(B) conducting the investigation;

(C) collecting evidence; and

(D) accepting and approving a provider's request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee; and

(2) minimum training requirements for Medicaid provider fraud or abuse investigators.

(h) The executive commissioner, in consultation with the office of inspector general, 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 this state as indicated through:

(i) the provider's volume of billings;

(ii) the provider's history of noncompliance with the law; and

(iii) 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 the allegation that is the subject of the investigation poses; and

(3) to guide field investigators in closing a case that is not worth pursuing through a full investigation. (Gov. Code, Secs. 531.102(a-2), (a-3), (a-4), (a-7), (a-8), (b), (c), (d), (n), (p).)

Source Law

(a-2) The executive commissioner shall work in consultation with the office whenever the executive commissioner is required by law to adopt a rule or policy necessary to implement a power or duty of the office, including a rule necessary to carry out a responsibility of the office 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) subject to Subsection (a-8), 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-7) The chief counsel for the commission is the final authority for all legal interpretations related to statutes, rules, and commission policy on programs administered by the commission.

(a-8) For purposes of Subsection (a-3), "legal services" includes only legal services related to open records, procurement, contracting, human resources,

privacy, litigation support by the attorney general, bankruptcy, and other legal services as detailed in the memorandum of understanding or other written agreement required under Section 531.00553, as added by Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015.

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

(1) coordinating investigative efforts to aggressively recover money;

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

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

(c) The commission shall train office staff to enable the staff to pursue priority Medicaid and other health and human services fraud and abuse cases as necessary.

(d) The commission may require employees of health and human services agencies to provide assistance to the office in connection with the office's duties relating to the investigation of fraud and abuse in the provision of health and human services. The office is entitled to access to any information maintained by a health and human services agency, including internal records, relevant to the functions of the office.

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

(p) The executive commissioner, in consultation with the office, shall adopt rules establishing criteria:

(1) for opening a case;

(2) for prioritizing cases for the efficient management of the office's workload, including rules that direct the office to prioritize:

(A) provider 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.

Revised Law

Sec. 544.0103. OFFICE OF INSPECTOR GENERAL: GENERAL POWERS AND DUTIES. (a) The office of inspector general is responsible for:

(1) preventing, detecting, auditing, inspecting, reviewing, and investigating fraud, waste, and abuse in the provision and delivery of all health and human services in this state, including services provided:

(A) through any state-administered health or human services program that is wholly or partly federally funded; or

(B) by the Department of Family and Protective Services; and

(2) enforcing state law relating to providing those services.

(b) The commission may obtain any information or technology necessary for the office of inspector general to meet the office's responsibilities under this chapter or other law.

(c) The office of inspector general shall closely coordinate with the executive commissioner and relevant staff of health and human services system programs the office oversees in performing functions relating to preventing fraud, waste, and abuse in the delivery of health and human services and enforcing state law relating to the provision of those services, including audits, utilization reviews, provider education, and data analysis.

(d) The office of inspector general shall conduct audits, inspections, and investigations independent of the executive commissioner and the commission but shall rely on the coordination required by Subsection (c) to ensure that the office has a thorough understanding of the health and human services system to knowledgeably and effectively perform the office's duties.

(e) The office of inspector general may:

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

services agency;

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

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

(4) audit the use and effectiveness of state or federal money, including contract and grant money, administered by a person or state agency receiving the money from a health and human services agency;

(5) conduct investigations relating to the money described by Subdivision (4); and

(6) recommend policies to:

(A) promote the economical and efficient administration of the money described by Subdivision (4); and

(B) prevent and detect fraud and abuse in the administration of that money. (Gov. Code, Secs. 531.102(a), (a-5), (a-6), (h).)

Source Law

Sec. 531.102. OFFICE OF INSPECTOR GENERAL. (a) The commission's office of inspector general is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded or services provided by the Department of Family and Protective Services, and the enforcement of state law relating to the provision of those services. The commission may obtain any information or technology necessary to enable the office to meet its responsibilities under this subchapter or other law.

(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 audits, inspections, and 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.

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

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

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

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

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

(5) conduct investigations relating to the funds described by Subdivision (4); and

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

Revisor's Note

(1) Section 531.102(a), Government Code, refers to the responsibilities of the Health and Human Services Commission's office of inspector general under "this subchapter," meaning Subchapter C, Chapter 531, Government Code, "or other law," and Section 531.102(a-6), Government Code, refers to the office's duties under "this section," meaning Section 531.102, Government Code, "and any other law." The provisions of the referenced subchapter and section relating to the responsibilities and duties of the office are revised throughout this chapter. The revised law substitutes "this chapter" for the references to "this subchapter" and "this section" because each provision revised in this chapter that is not derived from the

referenced source law is already included in the source law reference to "other law."

(2) Section 531.102(h), Government Code, permits the Health and Human Services Commission's office of inspector general to engage in certain actions "[i]n addition to performing functions and duties otherwise provided by law." The revised law omits the quoted language as redundant because the authorizations provided by other law to perform those functions and duties apply by their own terms, and an additional statement to that effect is unnecessary.

(3) Sections 531.102(h)(4), (5), and (6), Government Code, refer to state or federal "funds," including contract and grant "funds." Throughout this chapter, the revised law substitutes "money" for "funds" because, in context, the meaning is the same and "money" is the more commonly used term.

Revised Law

Sec. 544.0104. EMPLOYMENT OF MEDICAL DIRECTOR. (a) The office of inspector general shall employ a medical director who:

(1) is a licensed physician under Subtitle B, Title 3, Occupations Code, and the rules the Texas Medical Board adopts under that subtitle; and

(2) preferably has significant knowledge of Medicaid.

(b) The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office of inspector general imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties. (Gov. Code, Sec. 531.102(l).)

Source Law

(l) The office shall employ a medical director who is a licensed physician under Subtitle B, Title 3, Occupations Code, and the rules adopted under that subtitle by the Texas Medical Board, and who preferably has significant knowledge of

Medicaid. The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

Revised Law

Sec. 544.0105. EMPLOYMENT OF DENTAL DIRECTOR. (a) The office of inspector general shall employ a dental director who:

(1) is a licensed dentist under Subtitle D, Title 3, Occupations Code, and the rules the State Board of Dental Examiners adopts under that subtitle; and

(2) preferably has significant knowledge of Medicaid.

(b) The dental director shall ensure that any investigative findings based on the necessity of dental services or the quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office of inspector general imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties. (Gov. Code, Sec. 531.102(m).)

Source Law

(m) The office shall employ a dental director who is a licensed dentist under Subtitle D, Title 3, Occupations Code, and the rules adopted under that subtitle by the State Board of Dental Examiners, and who preferably has significant knowledge of Medicaid. The dental director shall ensure that any investigative findings based on the necessity of dental services or the quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

Revised Law

Sec. 544.0106. CONTRACT FOR REVIEW OF INVESTIGATIVE FINDINGS BY QUALIFIED EXPERT. (a) If the commission does not receive any responsive bids under Chapter 2155 on a competitive solicitation for the services of a qualified expert to review investigative findings under Section 544.0104 or 544.0105 and the number of contracts to be awarded under this subsection is not otherwise limited, the commission may negotiate with and award a contract for the services to a qualified expert on the basis of:

(1) the contractor's agreement to a set fee, either as

a range or lump-sum amount; and

(2) the contractor's affirmation and the office of inspector general's verification that the contractor possesses the necessary occupational licenses and experience.

(b) Notwithstanding Sections 2155.083 and 2261.051, a contract awarded under Subsection (a) is not subject to competitive advertising and proposal evaluation requirements. (Gov. Code, Secs. 531.102(m-1), (m-2).)

Source Law

> (m-1) If the commission does not receive any responsive bids under Chapter 2155 on a competitive solicitation for the services of a qualified expert to review investigative findings under Subsection (l) or (m) and the number of contracts to be awarded under this subsection is not otherwise limited, the commission may negotiate with and award a contract for the services to a qualified expert on the basis of:
>
> (1) the contractor's agreement to a set fee, either as a range or lump-sum amount; and
>
> (2) the contractor's affirmation and the office's verification that the contractor possesses the necessary occupational licenses and experience.
>
> (m-2) Notwithstanding Sections 2155.083 and 2261.051, a contract awarded under Subsection (m-1) is not subject to competitive advertising and proposal evaluation requirements.

Revised Law

Sec. 544.0107. EMPLOYMENT OF PEACE OFFICERS. (a) The office of inspector general shall employ and commission not more than five peace officers at any given time to assist the office in carrying out the office's duties relating to the investigation of Medicaid fraud, waste, and abuse.

(b) A peace officer the office of inspector general employs and commissions is administratively attached to the Department of Public Safety. The commission shall provide administrative support to the department as necessary to support the assignment of the peace officers.

(c) A peace officer the office of inspector general employs and commissions:

(1) is a peace officer for purposes of Article 2.12, Code of Criminal Procedure; and

(2) shall obtain the office of the attorney general's

prior approval before carrying out any duties requiring peace officer status. (Gov. Code, Sec. 531.1022.)

Source Law

> Sec. 531.1022. PEACE OFFICERS. (a) The commission's office of inspector general shall employ and commission not more than five peace officers at any given time for the purpose of assisting the office in carrying out the duties of the office relating to the investigation of fraud, waste, and abuse in Medicaid.
>
> (b) Peace officers employed under this section are administratively attached to the Department of Public Safety. The commission shall provide administrative support to the department necessary to support the assignment of peace officers employed under this section.
>
> (c) 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.
>
> (d) A peace officer employed and commissioned under this section shall obtain prior approval from the office of attorney general before carrying out any duties requiring peace officer status.

Revised Law

Sec. 544.0108. INVESTIGATIVE PROCESS REVIEW. (a) Office of inspector general staff who are not directly involved in investigations the office conducts shall review the office's investigative process, including the office's use of sampling and extrapolation to audit provider records.

(b) The office of inspector general 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 for the office's use in conducting audits. (Gov. Code, Secs. 531.102(r), (s).)

Source Law

> (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 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.

Revised Law

Sec. 544.0109. PERFORMANCE AUDITS AND COORDINATION OF AUDIT ACTIVITIES. (a) Notwithstanding any other law, the 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) the commission's or a health and human services agency's contracting procedures; or

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

(b) The office of inspector general shall coordinate all audit and oversight activities, including those relating to providers and including developing audit plans, risk assessments, and findings, with the commission to minimize duplicative activities. In coordinating the activities, the office shall:

(1) to determine whether to audit a Medicaid managed care organization, annually seek the commission's input and consider previous audits and on-site visits the commission made; and

(2) request the results of an informal audit or on-site visit the commission performed that could inform the office's risk assessment when determining whether to conduct or the scope of an audit of a Medicaid managed care organization.

(c) In addition to the coordination required by Subsection (b), the office of inspector general shall coordinate the office's other audit activities with those of the commission, including developing audit plans, performing risk assessments, and reporting findings, to minimize duplicative audit activities. In coordinating audit activities with the commission under this subsection, the office shall:

(1) to determine whether to conduct a performance audit, seek the commission's input and consider previous audits the

commission conducted; and

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

(d) In accordance with Section ____ [[[Section 533.015(b)]]], the office of inspector general 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 Medicaid managed care organizations that the office and commission conduct. (Gov. Code, Secs. 531.102(q), (v), (w), 531.1025.)

Source Law

[Sec. 531.102]

(q) The office shall coordinate all audit and oversight activities, 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 onsite 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 onsite 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.

(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.

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) 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.

Revisor's Note

Sections 531.102(q), (v), and (w), Government Code, refer to managed care organizations participating in Medicaid. A managed care organization that participates in Medicaid is a Medicaid managed care organization, which is defined by Section _____ [[[Section 531.001]]] as a managed care organization that contracts with the Health and Human Services Commission under Chapter 533, Government Code, which is revised in this subtitle as Chapter __, to provide health care services to Medicaid recipients. That definition applies subtitle-wide, including to the law revised in this chapter. For consistency of terminology, the revised law substitutes references to a "Medicaid managed care organization" for references to a "managed care organization participating in Medicaid."

Revised Law

Sec. 544.0110. REPORTS ON AUDITS, INSPECTIONS, AND INVESTIGATIONS. (a) The office of inspector general shall prepare a final report on each audit, inspection, or investigation conducted under Section 544.0102, 544.0103, 544.0252(b), 544.0254, or 544.0257. The final report must include:

(1) a summary of the activities the office performed in conducting the audit, inspection, or investigation;

(2) a statement on whether the audit, inspection, or investigation resulted in a finding of any wrongdoing; and

(3) a description of any findings of wrongdoing.

(b) A final report on an audit, inspection, or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit, inspection, or investigation remain confidential and not subject to required disclosure in accordance with Section 544.0259(e).

(c) A confidential draft report on an audit, inspection, 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 Services remains confidential and is not subject to disclosure under Chapter 552. (Gov. Code, Secs. 531.102(j), (k).)

Source Law

(j) The office shall prepare a final report on each audit, inspection, or investigation conducted under this section. The final report must include:

(1) a summary of the activities performed by the office in conducting the audit, inspection, or investigation;

(2) a statement regarding whether the audit, inspection, or investigation resulted in a finding of any wrongdoing; and

(3) a description of any findings of wrongdoing.

(k) A final report on an audit, inspection, or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit, inspection, or investigation remain confidential and not subject to required disclosure in accordance with Section 531.1021(g). A confidential draft report on an audit, inspection, 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 Services remains confidential and is not subject to disclosure under Chapter 552.

Revisor's Note

Section 531.102(j), Government Code, refers to a final report on each audit, inspection, or investigation conducted under "this section," meaning Section 531.102, Government Code. The provisions of Section 531.102 that relate to the conduct of an audit, inspection, or investigation are revised in various provisions throughout this chapter, and the revised law references the relevant provisions.

Revised Law

Sec. 544.0111. COMPLIANCE WITH FEDERAL CODING GUIDELINES. (a) In this section, "federal coding guidelines" means the code sets and guidelines the United States Department of Health and Human Services adopts in accordance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).

(b) The office of inspector general, including office staff and any third party with which the office contracts to perform coding services, and the commission's medical and utilization review appeals unit shall comply with federal coding guidelines, including guidelines for diagnosis-related group (DRG) validation and related audits. (Gov. Code, Sec. 531.1023.)

Source Law

Sec. 531.1023. COMPLIANCE WITH FEDERAL CODING GUIDELINES. (a) The commission's office of inspector general, including office staff and any third party with which the office contracts to perform coding services, and the commission's medical and utilization review appeals unit shall comply with federal coding guidelines, including guidelines for diagnosis-related group (DRG) validation and related audits.

(b) In this section, "federal coding guidelines" means the code sets and guidelines adopted by the United States Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Section 1320d et seq.).

Revised Law

Sec. 544.0112. HOSPITAL UTILIZATION REVIEWS AND AUDITS:

PROVIDER EDUCATION PROCESS. The executive commissioner, in consultation with the office of inspector general, shall develop by rule a process for the office, 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. (Gov. Code, Sec. 531.1024.)

Source Law

> 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.

Revised Law

Sec. 544.0113. PROGRAM EXCLUSIONS. The office of inspector general, in consultation with this state's Medicaid fraud control unit, shall establish guidelines under which program exclusions:

(1) may permissively be imposed on a provider; or

(2) shall automatically be imposed on a provider.

(Gov. Code, Sec. 531.102(g)(7).)

Source Law

> (7) The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which program exclusions:
>
> (A) may permissively be imposed on a provider; or
>
> (B) shall automatically be imposed on a provider.

Revised Law

Sec. 544.0114. REPORT. (a) At each quarterly meeting of any advisory council responsible for advising the executive commissioner on the commission's operation, the inspector general shall submit to the executive commissioner, the governor, and the legislature a report on:

(1) the office of inspector general's activities;

(2) the office's performance with respect to performance measures the executive commissioner establishes for the office;

(3) fraud trends the office has identified;

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

(5) the amount of money recovered during the preceding quarter as a result of investigations involving peace officers employed and commissioned by the office for each program for which the office has investigative authority.

(b) The office of inspector general shall publish each report required under this section on the office's Internet website. (Gov. Code, Secs. 531.102(t), (u).)

Source Law

> (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;
>
> (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; and
>
> (5) the amount of money recovered during the preceding quarter as a result of investigations involving peace officers employed and commissioned by the office for each program for which the office has investigative authority.
>
> (u) The office shall publish each report required under Subsection (t) on the office's Internet website.

SUBCHAPTER D. MEDICAID PROVIDER CRIMINAL HISTORY RECORD INFORMATION AND ELIGIBILITY

Revised Law

Sec. 544.0151. DEFINITIONS. In this subchapter:

(1) "Health care professional" means an individual issued a license to engage in a health care profession.

(2) "License" means a license, certificate,

registration, permit, or other authorization that:

(A) a licensing authority issues; and

(B) must be obtained before a person may practice or engage in a particular business, occupation, or profession.

(3) "Licensing authority" means a department, commission, board, office, or other state agency that issues a license.

(4) "Participating agency" means:

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

(B) each licensing authority with authority to issue a license to a health care professional or managed care organization that may participate in Medicaid; and

(C) the office of inspector general.

(5) "Provider" means a person that was or is approved by the commission to provide Medicaid services under a contract or provider agreement with the commission. (Gov. Code, Secs. 531.1011(10) (part), 531.1031(a)(1), (1-a), (1-b), (2), (3).)

Source Law

[Sec. 531.1011.]

(10) "Provider" means a person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the commission to:

(A) provide Medicaid services under a contract or provider agreement with the commission; or

. . . .

Sec. 531.1031. DUTY TO EXCHANGE INFORMATION. (a) In this section and Sections 531.1032, 531.1033, and 531.1034:

(1) "Health care professional" means a person issued a license 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.

(2) "Participating agency" means:

(A) the Medicaid fraud enforcement

divisions of the office of the attorney general;

(B) each licensing authority with authority to issue a license to a health care professional or managed care organization that may participate in Medicaid; and

(C) the office.

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

Revisor's Note

Section 531.1031(a)(1-c), Government Code, defines "office" for purposes of Sections 531.1031, 531.1032, 531.1033, and 531.1034, Government Code, which are revised as this subchapter, as the Health and Human Services Commission's office of inspector general "unless a different meaning is plainly required by the context in which the term appears." Section 544.0001(7) of this chapter defines "office of inspector general" for purposes of this chapter to mean the commission's office of inspector general. The revised law omits the definition of "office" provided by Section 531.1031(a)(1-c) as unnecessary because of the chapter-wide definition provided by Section 544.0001(7), and to the extent a different meaning is required by the context, the revised law throughout this subchapter clarifies that different meaning. The omitted law reads:

> (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.

Revised Law

Sec. 544.0152. EXCHANGE OF CRIMINAL HISTORY RECORD INFORMATION BETWEEN PARTICIPATING AGENCIES. (a) This section applies only to:

(1) criminal history record information a participating agency holds that relates to a health care professional; and

(2) information a participating agency holds that relates to a health care professional or managed care organization

that is the subject of an investigation by a participating agency for alleged Medicaid fraud or abuse.

(b) A participating agency may submit to another participating agency a written request for information to which this section applies. The participating agency that receives the request shall provide the requesting agency with the requested information unless releasing the information:

(1) would jeopardize an ongoing investigation or prosecution by the participating agency that possesses the information; or

(2) is prohibited by other law.

(c) Notwithstanding any other law, a participating agency may enter into a memorandum of understanding or agreement with another participating agency for exchanging criminal history record information relating to a health care professional that both participating agencies are authorized access to under Chapter 411. Confidential criminal history record information in a participating agency's possession that is provided to another participating agency remains confidential while in the possession of the participating agency that receives the information.

(d) A participating agency that discovers information that may indicate fraud or abuse by a health care professional or managed care organization may provide the information to any other participating agency unless the release of the information is prohibited by other law.

(e) If after receiving a request for information under Subsection (b) a participating agency determines that the agency is prohibited from releasing the information, the agency shall, not later than the 30th day after the date the agency received the request, inform the requesting agency of that determination in writing.

(f) Confidential information shared under this section is subject to the same confidentiality requirements and legal restrictions on access to the information that are imposed by law on

the participating agency that originally obtained or collected the information. Sharing information under this section does not affect whether the information is subject to disclosure under Chapter 552.

(g) A participating agency that receives information from another participating agency under this section must obtain written permission from the agency that shared the information before using the information in a licensure or enforcement action.

(h) This section does not affect a participating agency's authority to exchange information under other law. (Gov. Code, Secs. 531.1031(b), (c), (c-1), (d), (e), (f), (g), (h).)

Source Law

> (b) This section applies only to criminal history record information held by a participating agency that relates to a health care professional and information held by a participating agency that relates to a health care professional or managed care organization that is the subject of an investigation by a participating agency for alleged fraud or abuse under Medicaid.
>
> (c) A participating agency may submit to another participating agency a written request for information described by Subsection (b) regarding a health care professional or managed care organization. The participating agency that receives the request shall provide the requesting agency with the information regarding the health care professional or managed care organization unless:
>
> (1) the release of the information would jeopardize an ongoing investigation or prosecution by the participating agency with possession of the information; or
>
> (2) the release of the information is prohibited by other law.
>
> (c-1) Notwithstanding any other law, a participating agency may enter into a memorandum of understanding or agreement with another participating agency for the purpose of exchanging criminal history record information relating to a health care professional that both participating agencies are authorized to access under Chapter 411. Confidential criminal history record information in the possession of a participating agency that is provided to another participating agency in accordance with this subsection remains confidential while in the possession of the participating agency that receives the information.
>
> (d) A participating agency that discovers information that may indicate fraud or abuse by a health care professional or managed care organization may provide that information to any other participating agency unless the release of the information is prohibited by other law.
>
> (e) Not later than the 30th day after the date the agency receives a request for information under

Subsection (c), a participating agency that determines the agency is prohibited from releasing the requested information shall inform the agency requesting the information of that determination in writing.

(f) Confidential information shared under this section remains subject to the same confidentiality requirements and legal restrictions on access to the information that are imposed by law on the participating agency that originally obtained or collected the information. The sharing of information under this section does not affect whether the information is subject to disclosure under Chapter 552.

(g) A participating agency that receives information from another participating agency under this section must obtain written permission from the agency that shared the information before using the information in a licensure or enforcement action.

(h) This section does not affect the participating agencies' authority to exchange information under other law.

Revised Law

Sec. 544.0153. PROVIDER ELIGIBILITY FOR MEDICAID PARTICIPATION: CRIMINAL HISTORY RECORD INFORMATION. (a) The office of inspector general and each licensing authority that requires the submission of fingerprints to conduct a criminal history record information check of a health care professional shall enter into a memorandum of understanding to ensure that only individuals who are licensed and in good standing as health care professionals participate as Medicaid providers. The memorandum under this section may be combined with a memorandum authorized under Section 544.0152(c) and must include a process by which:

(1) to determine a health care professional's eligibility to participate in Medicaid, the office may confirm with a licensing authority that the professional is licensed and in good standing; 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) To determine a health care professional's eligibility to participate as a Medicaid provider, the office of inspector

general may not 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 conducting 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) To determine a provider's eligibility to participate in Medicaid and subject to Subsection (d), the office of inspector general, after seeking public input, shall establish and the executive commissioner by rule shall adopt guidelines for evaluating 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 excluding a person as a Medicaid provider, taking into consideration:

(1) the extent to which the underlying conduct relates to the services provided through 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 Medicaid fraud, waste, or abuse.

(d) The guidelines adopted under Subsection (c) may not impose stricter standards for an individual's eligibility to participate in Medicaid than a licensing authority described by Subsection (a) requires for the individual to engage in a health care profession without restriction in this state.

(e) The office of inspector general and the commission shall use the guidelines the executive commissioner adopts under Subsection (c) to determine whether a Medicaid provider continues to be eligible to participate as a Medicaid provider.

(f) The provider enrollment contractor, if applicable, and a Medicaid managed care organization shall defer to the office of inspector general on whether an individual's criminal history

record information precludes the individual from participating as a Medicaid provider. (Gov. Code, Secs. 531.1032(a), (b), (c), as added Acts 84th Leg., R.S., Ch. 945, (d), (e), (f).)

Source Law

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.

Revisor's Note

(1) Section 531.1032(c), Government Code, as added by Section 2.15(b), Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015, requires the Health and Human Services Commission's office of inspector general, after seeking public input from various geographic areas across this state in person or through teleconferencing centers, to establish guidelines for evaluating certain criminal history record information. Section 531.1032(c), Government Code, as added by Section 5, Chapter 945 (S.B. 207), Acts of the 84th Legislature, Regular Session, 2015, imposes the same duties on the office, except that the office is not required to seek public input from various geographic areas across this state in person or through teleconferencing centers. Because Section 531.1032(c), as added by Chapter 837, is more specific in its requirements than Section 531.1032(c), as added by Chapter 945, the statutes are irreconcilable. Under Section 311.025(a), Government Code (Code Construction Act), if statutes enacted at the same or different sessions of the legislature are irreconcilable, the statute latest in date of enactment prevails. Under Section 311.025(d), Government Code (Code Construction Act), the date of enactment is the date on which the last legislative vote is taken on the bill enacting the statute. The last legislative vote on Chapter 837 was taken May 28, 2015. The last legislative vote on Chapter 945 was

taken May 30, 2015. Accordingly, the revised law omits Section 531.1032(c), as added by Chapter 837, as superseded by Section 531.1032(c), as added by Chapter 945. The omitted law reads:

> (c) For purposes of determining eligibility to participate in Medicaid and subject to Subsection (d), the office, after seeking public input from various geographic areas across this state, either in person or through teleconferencing centers, 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.

(2) Section 531.1032(f), Government Code, refers to a "managed care organization participating in Medicaid." The revised law substitutes "Medicaid managed care organization" for "managed care organization participating in Medicaid" for the reason stated in the revisor's note to Section 544.0109 of this chapter.

Revised Law

Sec. 544.0154. MONITORING OF CERTAIN FEDERAL DATABASES. The office of inspector general shall routinely check appropriate federal databases, including databases referenced in 42 C.F.R. Section 455.436, to ensure that a person excluded by the federal government from participating in Medicaid or Medicare is not participating as a Medicaid provider. (Gov. Code, Sec. 531.1033.)

Source Law

> 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.

Revised Law

Sec. 544.0155. PERIOD FOR DETERMINING PROVIDER ELIGIBILITY FOR MEDICAID. (a) Not later than the 10th day after the date the office of inspector general receives a health care professional's complete application seeking to participate in Medicaid, the office shall inform the commission or the health care professional, as appropriate, of the office's determination of whether the health care professional should be denied participation in Medicaid based on:

(1) information concerning the health care professional's licensing status obtained as described by Section 544.0153(a);

(2) information contained in the criminal history record information check that is evaluated in accordance with guidelines the executive commissioner adopts under Section 544.0153(c);

(3) a review of federal databases under Section 544.0154;

(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 of inspector general shall develop performance metrics to measure the length of time for conducting a determination described by Subsection (a) with respect to:

(1) applications that are complete when submitted; and

(2) all other applications. (Gov. Code, Sec. 531.1034.)

Source Law

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.

SUBCHAPTER E. PREVENTION AND DETECTION OF FRAUD, WASTE, AND ABUSE

Revised Law

Sec. 544.0201. SELECTION AND REVIEW OF MEDICAID CLAIMS TO DETERMINE RESOURCE ALLOCATION. (a) The commission shall annually select and review a random, statistically valid sample of all claims for Medicaid reimbursement, including under the vendor drug program, for potential cases of fraud, waste, or abuse.

(b) In conducting the annual review of claims, the commission may directly contact a recipient by telephone, in person, or both to verify that the services for which a provider submitted a reimbursement claim were actually provided to the recipient.

(c) Based on the results of the annual review of claims, the commission shall determine the types of claims toward which commission resources for fraud and abuse detection should be primarily directed.

(d) Absent an allegation of fraud, waste, or abuse, the

commission may conduct an annual review of claims only after the commission completes the prior year's annual review of claims. (Gov. Code, Sec. 531.109.)

Source Law

> Sec. 531.109. SELECTION AND REVIEW OF CLAIMS. (a) The commission shall annually select and review a random, statistically valid sample of all claims for reimbursement under Medicaid, including under the vendor drug program, for potential cases of fraud, waste, or abuse.
>
> (b) In conducting the annual review of claims under Subsection (a), the commission may directly contact a recipient by telephone or in person, or both, to verify that the services for which a claim for reimbursement was submitted by a provider were actually provided to the recipient.
>
> (c) Based on the results of the annual review of claims, the commission shall determine the types of claims at which commission resources for fraud and abuse detection should be primarily directed.
>
> (d) Absent an allegation of fraud, waste, or abuse, the commission may conduct an annual review of claims under this section only after the commission has completed the prior year's annual review of claims.

Revised Law

Sec. 544.0202. DUTIES RELATED TO FRAUD PREVENTION. (a) The office of inspector general shall compile and disseminate accurate information and statistics relating to:

(1) fraud prevention; and

(2) post-fraud referrals received and accepted or rejected from the commission's or a health and human services agency's case management system.

(b) The commission shall:

(1) aggressively publicize successful fraud prosecutions and fraud-prevention programs through all available means, including the use of statewide press releases; and

(2) ensure that the commission or a health and human services agency maintains and promotes a toll-free telephone hotline for reporting suspected fraud in programs the commission or a health and human services agency administers.

(c) The commission shall develop a cost-effective method to identify applicants for public assistance in counties bordering other states and in metropolitan areas the commission selects who

are already receiving benefits in other states. If economically feasible, the commission may develop a computerized matching system.

(d) The commission shall:

(1) verify automobile information that is used as eligibility criteria; and

(2) establish with the Texas Department of Criminal Justice a computerized matching system to prevent an incarcerated individual from illegally receiving public assistance benefits the commission administers.

(e) Not later than October 1 of each year, the commission shall submit to the governor and Legislative Budget Board a report on the results of computerized matching of commission information with information from neighboring states, if any, and information from the Texas Department of Criminal Justice. The commission may consolidate the report with any other report relating to the same subject matter the commission is required to submit under other law.

(f) The commission and each health and human services agency that administers part of Medicaid shall maintain statistics on the number, type, and disposition of fraudulent benefits claims submitted under the part of the program the agency administers. (Gov. Code, Secs. 531.0215, 531.108.)

Source Law

Sec. 531.0215. COMPILATION OF STATISTICS RELATING TO FRAUD. The commission and each health and human services agency that administers a part of Medicaid shall maintain statistics on the number, type, and disposition of fraudulent claims for benefits submitted under the part of the program the agency administers.

Sec. 531.108. FRAUD PREVENTION. (a) The commission's office of inspector general shall compile and disseminate accurate information and statistics relating to:

(1) fraud prevention; and

(2) post-fraud referrals received and accepted or rejected from the commission's case management system or the case management system of a health and human services agency.

(b) The commission shall:

(1) aggressively publicize successful

fraud prosecutions and fraud-prevention programs through all available means, including the use of statewide press releases; and

(2) ensure that a toll-free hotline for reporting suspected fraud in programs administered by the commission or a health and human services agency is maintained and promoted, either by the commission or by a health and human services agency.

(c) The commission shall develop a cost-effective method of identifying applicants for public assistance in counties bordering other states and in metropolitan areas selected by the commission who are already receiving benefits in other states. If economically feasible, the commission may develop a computerized matching system.

(d) The commission shall:

(1) verify automobile information that is used as criteria for eligibility; and

(2) establish a computerized matching system with the Texas Department of Criminal Justice to prevent an incarcerated individual from illegally receiving public assistance benefits administered by the commission.

(e) Not later than October 1 of each year, the commission shall submit to the governor and Legislative Budget Board an annual report on the results of computerized matching of commission information with information from neighboring states, if any, and information from the Texas Department of Criminal Justice. The report may be consolidated with any other report relating to the same subject matter the commission is required to submit under other law.

Revised Law

Sec. 544.0203. FRAUD, WASTE, AND ABUSE DETECTION TRAINING. (a) The commission shall develop and implement a program to provide annual training on identifying potential cases of Medicaid fraud, waste, or abuse to:

(1) contractors who process Medicaid claims; and

(2) appropriate health and human services agency staff.

(b) The training must include clear criteria that specify:

(1) the circumstances under which a person should refer a potential case to the commission; and

(2) the time by which a referral should be made. (Gov. Code, Sec. 531.105(a).)

Source Law

Sec. 531.105. FRAUD DETECTION TRAINING. (a) The commission shall develop and implement a program to provide annual training to contractors who process Medicaid claims and to appropriate staff of the health and human services agencies in identifying potential cases of fraud, waste, or abuse under Medicaid. The training provided to the contractors and staff must

include clear criteria that specify:

(1) the circumstances under which a person should refer a potential case to the commission; and

(2) the time by which a referral should be made.

Revised Law

Sec. 544.0204. HEALTH AND HUMAN SERVICES AGENCY MEDICAID FRAUD, WASTE, AND ABUSE DETECTION GOAL. (a) The health and human services agencies, in cooperation with the commission, shall periodically set a goal for the number of potential cases of Medicaid fraud, waste, or abuse that each agency will attempt to identify and refer to the commission.

(b) The commission shall include in the report required by Section 544.0051(f) information on the health and human services agencies' goals and the success of each agency in meeting the agency's goal. (Gov. Code, Sec. 531.105(b).)

Source Law

(b) The health and human services agencies, in cooperation with the commission, shall periodically set a goal of the number of potential cases of fraud, waste, or abuse under Medicaid that each agency will attempt to identify and refer to the commission. The commission shall include information on the agencies' goals and the success of each agency in meeting the agency's goal in the report required by Section 531.103(c).

Revised Law

Sec. 544.0205. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE, OR OVERCHARGES. (a) The commission may grant an award to an individual who reports activity that constitutes fraud or abuse of Medicaid money or who reports Medicaid overcharges if the commission determines that the disclosure results in the recovery of an administrative penalty imposed under Section 32.039, Human Resources Code. The commission may not grant an award to an individual in connection with a report if the commission or attorney general had independent knowledge of the activity the individual reported.

(b) The commission shall determine the amount of an award. The award may not exceed five percent of the amount of the administrative penalty imposed under Section 32.039, Human

Resources Code, that resulted from the individual's disclosure. In determining the award amount, the commission:

(1) shall consider how important the disclosure is in ensuring the fiscal integrity of Medicaid; and

(2) may consider whether the individual participated in the fraud, abuse, or overcharge.

(c) An individual who brings an action under Subchapter C, Chapter 36, Human Resources Code, is not eligible for an award under this section. (Gov. Code, Sec. 531.101.)

Source Law

> Sec. 531.101. AWARD FOR REPORTING MEDICAID FRAUD, ABUSE, OR OVERCHARGES. (a) The commission may grant an award to an individual who reports activity that constitutes fraud or abuse of funds in Medicaid or reports overcharges in Medicaid if the commission determines that the disclosure results in the recovery of an administrative penalty imposed under Section 32.039, Human Resources Code. The commission may not grant an award to an individual in connection with a report if the commission or attorney general had independent knowledge of the activity reported by the individual.
>
> (b) The commission shall determine the amount of an award. The award may not exceed five percent of the amount of the administrative penalty imposed under Section 32.039, Human Resources Code, that resulted from the individual's disclosure. In determining the amount of the award, the commission shall consider how important the disclosure is in ensuring the fiscal integrity of Medicaid. The commission may also consider whether the individual participated in the fraud, abuse, or overcharge.
>
> (c) A person who brings an action under Subchapter C, Chapter 36, Human Resources Code, is not eligible for an award under this section.

SUBCHAPTER F. INVESTIGATION OF FRAUD, WASTE, ABUSE, AND OVERCHARGES

Revised Law

Sec. 544.0251. CLAIMS CRITERIA REQUIRING COMMENCEMENT OF INVESTIGATION. The executive commissioner, in consultation with the inspector general, by rule shall set specific claims criteria that, when met, require the office of inspector general to begin an investigation. (Gov. Code, Sec. 531.102(e).)

Source Law

> (e) The executive commissioner, in consultation with the inspector general, by rule shall set specific claims criteria that, when met, require the office to

begin an investigation.

Revised Law

Sec. 544.0252. CIRCUMSTANCES REQUIRING COMMENCEMENT OF PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE. (a) The office of inspector general shall conduct a preliminary investigation of an allegation of fraud or abuse against a provider that the commission receives from any source to determine whether there is a sufficient basis to warrant a full investigation. The office must begin a preliminary investigation not later than the 30th day and complete the investigation not later than the 45th day after the date the commission receives or identifies an allegation of fraud or abuse.

(b) The office of inspector general shall conduct a preliminary investigation as provided by Section 544.0253 of a complaint or allegation of Medicaid fraud or abuse that the commission receives from any source to determine whether there is a sufficient basis to warrant a full investigation. The office must begin a preliminary investigation not later than the 30th day and complete the investigation 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. (Gov. Code, Secs. 531.102(f)(1), 531.118(b).)

Source Law

[Sec. 531.102]

(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.

[Sec. 531.118]

(b) If the commission receives an allegation of fraud or abuse against a provider from any source, the commission's office of inspector general shall conduct a preliminary investigation of the allegation to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day, and be completed not later than the 45th day, after the date the commission receives or identifies an

allegation of fraud or abuse.

Revised Law

Sec. 544.0253. CONDUCT OF PRELIMINARY INVESTIGATION OF ALLEGED FRAUD OR ABUSE. In conducting a preliminary investigation of an allegation of fraud or abuse and before the allegation may proceed to a full investigation, the office of inspector general must:

(1) review the allegation and all facts and evidence relating to the allegation; and

(2) prepare a preliminary investigation report that documents:

(A) the allegation;

(B) the evidence the office reviewed, if available;

(C) the procedures the office used to conduct the preliminary investigation;

(D) the preliminary investigation findings; and

(E) the office's determination of whether a full investigation is warranted. (Gov. Code, Sec. 531.118(c).)

Source Law

> (c) In conducting a preliminary investigation, the office must review the allegations of fraud or abuse and all facts and evidence relating to the allegation and must prepare a preliminary investigation report before the allegation of fraud or abuse may proceed to a full investigation. The preliminary investigation report must document the allegation, the evidence reviewed, if available, the procedures used to conduct the preliminary investigation, the findings of the preliminary investigation, and the office's determination of whether a full investigation is warranted.

Revised Law

Sec. 544.0254. FINDING OF CERTAIN MEDICAID FRAUD OR ABUSE FOLLOWING PRELIMINARY INVESTIGATION: CRIMINAL REFERRAL OR FULL INVESTIGATION. If the findings of a preliminary investigation give the office of inspector general reason to believe that an incident of Medicaid fraud or abuse involving possible criminal conduct has occurred, not later than the 30th day after completing the preliminary investigation, the office, as appropriate:

(1) must refer the case to this state's Medicaid fraud control unit if a provider is suspected of fraud or abuse involving criminal conduct, provided that the criminal referral does not preclude the office from continuing the office's investigation of the provider that may lead to the imposition of appropriate administrative or civil sanctions; or

(2) may conduct a full investigation, subject to Section 544.0253, if there is reason to believe that a recipient has defrauded Medicaid. (Gov. Code, Sec. 531.102(f)(2).)

Source Law

> (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).

Revised Law

Sec. 544.0255. IMMEDIATE CRIMINAL REFERRAL UNDER CERTAIN CIRCUMSTANCES. If the office of inspector general 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 this state's Medicaid fraud control unit. The criminal referral does not preclude the office from continuing the office's investigation of the provider that may lead to the imposition of appropriate administrative or civil sanctions. (Gov. Code, Sec. 531.102(g)(1).)

Source Law

> (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.

Revised Law

Sec. 544.0256. CONTINUATION OF PAYMENT HOLD FOLLOWING REFERRAL TO LAW ENFORCEMENT AGENCY. (a) If this state's Medicaid fraud control unit or another law enforcement agency accepts a fraud referral from the office of inspector general for investigation, a payment hold based on a credible allegation of fraud may be continued until:

(1) the investigation and any associated enforcement proceedings are complete; or

(2) the Medicaid fraud control unit, another law enforcement agency, or another prosecuting authority determines that there is insufficient evidence of fraud by the provider that is the subject of the investigation.

(b) If this state's Medicaid fraud control unit or another law enforcement agency declines to accept a fraud referral from the office of inspector general for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless:

(1) the commission has alternative federal or state authority under which the commission may impose a payment hold; or

(2) the office makes a fraud referral to another law enforcement agency.

(c) On a quarterly basis, the office of inspector general shall request a certification from this state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter the unit or agency accepted on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of a payment hold is warranted. (Gov. Code, Secs. 531.118(d), (e), (f).)

Source Law

(d) If the state's Medicaid fraud control unit or any other law enforcement agency accepts a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud may be

continued until:

(1) that investigation and any associated enforcement proceedings are complete; or

(2) the state's Medicaid fraud control unit, another law enforcement agency, or other prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(e) If the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless the commission has alternative federal or state authority under which it may impose a payment hold or the office makes a fraud referral to another law enforcement agency.

(f) On a quarterly basis, the office must request a certification from the state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter accepted by the unit or agency on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the payment hold is warranted.

Revisor's Note

Section 531.118(f), Government Code, provides that the Health and Human Services Commission's office of inspector general "must" request a certification of certain information. The revised law substitutes "shall" for "must" because under Section 311.016, Government Code (Code Construction Act), applicable to the revised law, the term "shall" imposes a duty on an actor, and it is clear that requesting the certification is a duty imposed on the office of inspector general.

Revised Law

Sec. 544.0257. COMPLETION OF FULL INVESTIGATION OF ALLEGED MEDICAID FRAUD OR ABUSE. (a) The office of inspector general 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.

(b) Except as otherwise provided by this subsection, if the office of inspector general determines that more time is needed to complete a full 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. (Gov. Code, Sec. 531.102(f-1).)

Source Law

> (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.

Revised Law

Sec. 544.0258. MEMORANDUM OF UNDERSTANDING FOR ASSISTING ATTORNEY GENERAL INVESTIGATIONS RELATED TO MEDICAID. (a) The commission and the attorney general shall enter into a memorandum of understanding under which the commission shall:

(1) provide investigative support to the attorney general as required in connection with cases under Subchapter B, Chapter 36, Human Resources Code; and

(2) assist in performing preliminary investigations and ongoing investigations for actions the attorney general prosecutes under Subchapter C, Chapter 36, Human Resources Code.

(b) The memorandum of understanding must specify the type, scope, and format of the investigative support the commission provides to the attorney general.

(c) The memorandum of understanding must ensure that barriers to direct fraud referrals to this state's Medicaid fraud control unit by Medicaid agencies or unreasonable impediments to communication between Medicaid agency employees and the Medicaid fraud control unit are not imposed. (Gov. Code, Sec. 531.104.)

Source Law

Sec. 531.104. ASSISTING INVESTIGATIONS BY ATTORNEY GENERAL. (a) The commission and the attorney general shall execute a memorandum of understanding under which the commission shall provide investigative support as required to the attorney general in connection with cases under Subchapter B, Chapter 36, Human Resources Code. Under the memorandum of understanding, the commission shall assist in performing preliminary investigations and ongoing investigations for actions prosecuted by the attorney general under Subchapter C, Chapter 36, Human Resources Code.

(b) The memorandum of understanding must specify the type, scope, and format of the investigative support provided to the attorney general under this section.

(c) The memorandum of understanding must ensure that no barriers to direct fraud referrals to the state's Medicaid fraud control unit by Medicaid agencies or unreasonable impediments to communication between Medicaid agency employees and the state's Medicaid fraud control unit will be imposed.

Revised Law

Sec. 544.0259. SUBPOENAS. (a) The office of inspector general may issue a subpoena in connection with an investigation the office conducts. The subpoena may be:

(1) issued to compel the attendance of a relevant witness or the production, for inspection or copying, of relevant evidence in this state; and

(2) served personally or by certified mail.

(b) The office of inspector general, acting through the attorney general, may file suit in a district court in this state to enforce a subpoena with which a person fails to comply. On finding that good cause exists for issuing the subpoena, the court shall order the person to comply with the subpoena. The court may punish a person who fails to obey the court order.

(c) Reimbursement of the expenses of a witness whose attendance is compelled under this section is governed by Section 2001.103.

(d) The office of inspector general shall pay a reasonable fee for subpoenaed photocopies. The fee may not exceed the amount the office may charge for copies of the office's records.

(e) Except for the disclosure of information to the state

auditor's office, law enforcement agencies, and other entities as permitted by other law, all information and materials subpoenaed or compiled by the office of inspector general in connection with an audit, inspection, or investigation or by the office of the attorney general in connection with a Medicaid fraud investigation are:

(1) confidential and not subject to disclosure under Chapter 552; and

(2) not subject to disclosure, discovery, subpoena, or other means of legal compulsion for release to anyone other than the office of inspector general, the attorney general, or the office's or attorney general's employees or agents involved in the audit, inspection, or investigation.

(f) A person who receives information under Subsection (e) may disclose the information only in accordance with Subsection (e) and in a manner that is consistent with the authorized purpose for which the person first received the information. (Gov. Code, Sec. 531.1021.)

Source Law

Sec. 531.1021. SUBPOENAS. (a) The office of inspector general may issue a subpoena in connection with an investigation conducted by the office. A subpoena may be issued under this section to compel the attendance of a relevant witness or the production, for inspection or copying, of relevant evidence that is in this state.

(b) A subpoena may be served personally or by certified mail.

(c) If a person fails to comply with a subpoena, the office, acting through the attorney general, may file suit to enforce the subpoena in a district court in this state.

(d) On finding that good cause exists for issuing the subpoena, the court shall order the person to comply with the subpoena. The court may punish a person who fails to obey the court order.

(e) The office shall pay a reasonable fee for photocopies subpoenaed under this section in an amount not to exceed the amount the office may charge for copies of its records.

(f) The reimbursement of the expenses of a witness whose attendance is compelled under this section is governed by Section 2001.103.

(g) All information and materials subpoenaed or compiled by the office in connection with an audit, inspection, or investigation or by the office of the attorney general in connection with a Medicaid fraud investigation are confidential and not subject to

disclosure under Chapter 552, and not subject to disclosure, discovery, subpoena, or other means of legal compulsion for their release to anyone other than the office or the attorney general or their employees or agents involved in the audit, inspection, or investigation conducted by the office or the attorney general, except that this information may be disclosed to the state auditor's office, law enforcement agencies, and other entities as permitted by other law.

(h) A person who receives information under Subsection (g) may disclose the information only in accordance with Subsection (g) and in a manner that is consistent with the authorized purpose for which the person first received the information.

SUBCHAPTER G. PAYMENT HOLDS

Revised Law

Sec. 544.0301. IMPOSITION OF PAYMENT HOLD. (a) As authorized by state and federal law and except as provided by Subsections (d) and (e), the office of inspector general shall impose, as a serious enforcement tool to mitigate ongoing financial risk to this state, a payment hold on claims for reimbursement submitted by a provider only:

(1) to compel production of records;

(2) when requested by this state's Medicaid fraud control unit; or

(3) on the determination that a credible allegation of fraud exists, subject to Sections 544.0104(b) and 544.0105(b), as applicable.

(b) The office of inspector general shall impose a payment hold under this section without prior notice, and the payment hold takes effect immediately.

(c) The office of inspector general shall, in consultation with this state's Medicaid fraud control unit, establish guidelines regarding the imposition of payment holds authorized under this section.

(d) On the determination that a credible allegation of fraud exists and in accordance with 42 C.F.R. Sections 455.23(e) and (f), the office of inspector general may find that good cause exists to not impose a payment hold, to not continue a payment hold, to impose a payment hold only in part, or to convert a payment hold imposed in

whole to one imposed only in part if:

(1) law enforcement officials specifically requested that a payment hold not be imposed because a payment hold would compromise or jeopardize an investigation;

(2) available remedies implemented by this state other than a payment hold would more effectively or quickly protect Medicaid money;

(3) 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;

(4) 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:

(A) is the sole community physician or the sole source of essential specialized services in a community; or

(B) serves a large number of Medicaid recipients within a designated medically underserved area;

(5) the attorney general declines to certify that a matter continues to be under investigation; or

(6) the office determines that a full or partial payment hold is not in the best interests of Medicaid.

(e) Unless the office of inspector general has evidence that a provider materially misrepresented documentation relating to medically necessary services, the office may not impose a payment hold on claims for reimbursement the provider submits for those services if the provider obtained prior authorization from the commission or a commission contractor. (Gov. Code, Secs. 531.102(g)(2) (part), (7-a), (8), (9).)

Source Law

(2) As authorized under state and 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. . . .

(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 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.

Revised Law

Sec. 544.0302. NOTICE. (a) The office of inspector general shall notify a provider of a payment hold imposed under Section 544.0301(a) 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.

(b) In addition to the requirements of 42 C.F.R. Section 455.23(b), the payment hold notice must also include:

(1) the specific basis for the hold, including:

(A) the claims supporting the allegation at that point in the investigation;

(B) a representative sample of any documents that form the basis for the hold; and

(C) a detailed summary of the office of inspector general's evidence relating to the allegation;

(2) a description of administrative and judicial due process rights and remedies, including:

(A) the provider's option to seek informal resolution;

(B) the provider's right to seek a formal administrative appeal hearing; or

(C) the provider's ability to seek both an informal resolution and a formal administrative appeal hearing; and

(3) a detailed timeline for the provider to pursue the rights and remedies described in Subdivision (2). (Gov. Code, Sec. 531.102(g)(2) (part).)

Source Law

> (2) . . . 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, 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;
>
> (B) a description of administrative and judicial due process rights and remedies, including the provider's option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both; and
>
> (C) a detailed timeline for the provider to pursue the rights and remedies described in Paragraph (B).

Revisor's Note

Section 531.102(g)(2), Government Code, specifies that the Health and Human Services

Commission's office of inspector general "must" notify a provider of a payment hold. The revised law substitutes "shall" for "must" for the reason stated in the revisor's note to Section 544.0256 of this chapter.

Revised Law

Sec. 544.0303. EXPEDITED ADMINISTRATIVE HEARING. (a) A provider subject to a payment hold imposed under Section 544.0301(a), other than a hold this state's Medicaid fraud control unit requested, must request an expedited administrative hearing not later than the 10th day after the date the provider receives notice of the hold from the office of inspector general under Section 544.0302.

(b) On a provider's timely written request, the office of inspector general shall, not later than the third day after the date the office receives the request, file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the payment hold for which the provider submitted the request.

(c) Not later than the 45th day after the date the State Office of Administrative Hearings receives a request from the office of inspector general for an expedited administrative hearing, the State Office of Administrative Hearings shall hold the hearing.

(d) In an expedited administrative hearing held under this section:

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

(2) the provider and the office are each entitled to two continuances under reasonable circumstances; and

(3) the office is required to show probable cause that:

(A) the credible allegation of fraud that is the

basis of the imposed payment hold has an indicia of reliability; and

(B) continuing to pay the provider presents an ongoing significant financial risk to this state and a threat to the integrity of Medicaid.

(e) The office of inspector general is responsible for the costs of the expedited administrative hearing, but a provider is responsible for the provider's own costs incurred in preparing for the hearing.

(f) In the expedited administrative hearing, the administrative law judge shall decide whether the payment hold should continue but may not adjust the amount or percent of the payment hold.

(g) Notwithstanding any other law, including Section 2001.058(e), the administrative law judge's decision in the expedited administrative hearing is final and may not be appealed. (Gov. Code, Secs. 531.102(g)(3), (4), (5).)

Source Law

> (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 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:
>
> (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;
>
> (B) the provider and the office are each entitled to two continuances under reasonable circumstances; 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.
>
> (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.

(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.

Revisor's Note

(1) Section 531.102(g)(3), Government Code, refers to the imposition of a payment hold under Subdivision (2), meaning Section 531.102(g)(2), Government Code. The provision of Section 531.102(g)(2) related to imposing a payment hold is revised in this chapter as Section 544.030(a), and the revised law is drafted accordingly.

(2) Section 531.102(g)(3), Government Code, refers to a provider's receipt of notice under Subdivision (2), meaning Section 531.102(g)(2), Government Code. The provision of Section 531.102(g)(2) related to a provider's receipt of notice is revised in this chapter as Section 544.0302, and the revised law is drafted accordingly.

Revised Law

Sec. 544.0304. INFORMAL RESOLUTION. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt rules that allow a provider subject to a payment hold imposed under Section 544.0301(a), other than a hold this state's Medicaid fraud control unit requested, to seek an informal resolution of the issues the office identifies in the notice provided under Section 544.0302.

(b) A provider must request an initial informal resolution meeting under this section not later than the deadline prescribed by Section 544.0303(a) for requesting an expedited administrative hearing.

(c) On receipt of a timely request, the office of inspector general shall:

(1) decide whether to grant the provider's request for

an initial informal resolution meeting; and

(2) if the office decides to grant the request, schedule the initial informal resolution meeting and give notice to the provider of the time and place of the meeting.

(d) A provider may request a second informal resolution meeting after the date of an initial informal resolution meeting. On receipt of a timely request, the office of inspector general shall:

(1) decide whether to grant the provider's request for a second informal resolution meeting; and

(2) if the office decides to grant the request, schedule the second informal resolution meeting and give notice to the provider of the time and place of the second meeting.

(e) Before a second informal resolution meeting is held, a provider must have an opportunity to provide additional information for the office of inspector general to consider.

(f) A provider's decision to seek an informal resolution under this section does not extend the time by which the provider must request an expedited administrative hearing under Section 544.0303(a). The informal resolution process shall run concurrently with the administrative hearing process, and the informal resolution process shall be discontinued when the State Office of Administrative Hearings issues a final determination on the payment hold. (Gov. Code, Sec. 531.102(g)(6).)

Source Law

> (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 initial informal resolution meeting. The office shall give notice to the provider of the time and place of the

initial informal resolution meeting. A provider may request a second informal resolution meeting 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 second informal resolution meeting. The office shall give notice to the provider of the time and place of the second informal resolution meeting. 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.

Revisor's Note

(1) Section 531.102(g)(6), Government Code, refers to the imposition of a payment hold under Subdivision (2), meaning Section 531.102(g)(2), Government Code. The provision of Section 531.102(g)(2) related to imposing a payment hold is revised in this chapter as Section 544.030(a), and the revised law is drafted accordingly.

(2) Section 531.102(g)(6), Government Code, refers to a payment hold notice provided under "that subdivision," meaning Section 531.102(g)(2), Government Code. The provision of Section 531.102(g)(2) related to a payment hold notice is revised in this chapter as Section 544.0302, and the revised law is drafted accordingly.

(3) Section 531.102(g)(6), Government Code, refers to the deadline for requesting an expedited administrative hearing prescribed by Subdivision (3), meaning Section 531.102(g)(3), Government Code. The provision of Section 531.102(g)(3) prescribing the deadline for requesting an expedited administrative hearing is revised in this chapter as Section 544.0303(a), and the revised law is drafted

accordingly.

Revised Law

Sec. 544.0305. WEBSITE POSTING. The office of inspector general shall post on the office's publicly available Internet website a description in plain English of, and a video explaining, the processes and procedures the office uses to determine whether to impose a payment hold on a provider under this subchapter. (Gov. Code, Sec. 531.119.)

Source Law

> Sec. 531.119. WEBSITE POSTING. The commission's office of inspector general shall post on its publicly available website a description in plain English of, and a video explaining, the processes and procedures the office uses to determine whether to impose a payment hold on a provider under this subchapter.

Revisor's Note

Section 531.119, Government Code, refers to the processes and procedures the Health and Human Services Commission's office of inspector general uses in determining whether to impose a payment hold on a provider under "this subchapter," meaning Subchapter C, Chapter 531, Government Code. The provisions of Subchapter C, Chapter 531, relating to imposing a payment hold are revised as this subchapter, and the revised law is drafted accordingly.

SUBCHAPTER H. MANAGED CARE ORGANIZATION PREVENTION AND INVESTIGATION OF FRAUD AND ABUSE

Revised Law

Sec. 544.0351. APPLICABILITY OF SUBCHAPTER. This subchapter applies only to a managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program, including Medicaid and the child health plan program. (Gov. Code, Sec. 531.113(a) (part).)

Source Law

> Sec. 531.113. MANAGED CARE ORGANIZATIONS:

SPECIAL INVESTIGATIVE UNITS OR CONTRACTS. (a) Each managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program, including Medicaid and the child health plan program, . . .

Revised Law

Sec. 544.0352. SPECIAL INVESTIGATIVE UNIT OR CONTRACTED ENTITY TO INVESTIGATE FRAUD AND ABUSE. (a) A managed care organization to which this subchapter applies shall:

(1) establish and maintain a special investigative unit within the organization to investigate fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers; or

(2) contract with another entity to investigate fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers.

(b) A managed care organization that contracts for the investigation of fraudulent claims and other types of program abuse by recipients or enrollees, as applicable, and service providers under Subsection (a)(2) shall file with the office of inspector general:

(1) a copy of the written contract;

(2) the names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the organization contracts; and

(3) a description of the qualifications of the principals of the entity with which the organization contracts. (Gov. Code, Secs. 531.113(a) (part), (c).)

Source Law

(a) [Each managed care organization that provides or arranges for the provision of health care services to an individual under a government-funded program] . . . shall:

(1) establish and maintain a special investigative unit within the managed care organization to investigate fraudulent claims and other types of program abuse by recipients and service providers; or

(2) contract with another entity for the investigation of fraudulent claims and other types of program abuse by recipients and service providers.

(c) If a managed care organization contracts for the investigation of fraudulent claims and other types of program abuse by recipients and service providers under Subsection (a)(2), the managed care organization shall file with the commission's office of inspector general:

(1) a copy of the written contract;

(2) the names, addresses, telephone numbers, and fax numbers of the principals of the entity with which the managed care organization has contracted; and

(3) a description of the qualifications of the principals of the entity with which the managed care organization has contracted.

Revisor's Note

Sections 531.113(a) and (c), Government Code, refer to "recipients" under government-funded health care programs, including Medicaid and the child health plan program. A person who receives benefits under Medicaid is generally referred to as a "recipient" and a person who receives benefits under the child health plan program is generally referred to as an "enrollee." The revised law substitutes a reference to "recipients or enrollees, as applicable" for "recipients" for accuracy and consistency throughout Subtitle I, Title 4, Government Code, which includes this chapter.

Revised Law

Sec. 544.0353. FRAUD AND ABUSE PREVENTION PLAN. (a) A managed care organization to which this subchapter applies shall:

(1) adopt a plan to prevent and reduce fraud and abuse; and

(2) annually file the plan with the office of inspector general for approval.

(b) The plan must include:

(1) a description of the organization's procedures for:

(A) detecting and investigating possible acts of fraud or abuse;

(B) mandatory reporting of possible acts of fraud or abuse to the office of inspector general; and

(C) educating and training personnel to prevent fraud and abuse;

(2) the name, address, telephone number, and fax number of the individual responsible for carrying out the plan;

(3) a description or chart outlining the organizational arrangement of the organization's personnel responsible for investigating and reporting possible acts of fraud or abuse;

(4) a detailed description of the results of fraud and abuse investigations the organization's special investigative unit or the entity with which the organization contracts under Section 544.0352(a)(2) conducts; and

(5) provisions for maintaining the confidentiality of any patient information relevant to a fraud or abuse investigation. (Gov. Code, Sec. 531.113(b).)

Source Law

> (b) Each managed care organization subject to this section shall adopt a plan to prevent and reduce fraud and abuse and annually file that plan with the commission's office of inspector general for approval. The plan must include:
>
> (1) a description of the managed care organization's procedures for detecting and investigating possible acts of fraud or abuse;
>
> (2) a description of the managed care organization's procedures for the mandatory reporting of possible acts of fraud or abuse to the commission's office of inspector general;
>
> (3) a description of the managed care organization's procedures for educating and training personnel to prevent fraud and abuse;
>
> (4) the name, address, telephone number, and fax number of the individual responsible for carrying out the plan;
>
> (5) a description or chart outlining the organizational arrangement of the managed care organization's personnel responsible for investigating and reporting possible acts of fraud or abuse;
>
> (6) a detailed description of the results of investigations of fraud and abuse conducted by the managed care organization's special investigative unit or the entity with which the managed care organization contracts under Subsection (a)(2); and
>
> (7) provisions for maintaining the confidentiality of any patient information relevant to an investigation of fraud or abuse.

Revised Law

Sec. 544.0354. ASSISTANCE AND OVERSIGHT BY OFFICE OF

INSPECTOR GENERAL. (a) The office of inspector general may review the records of a managed care organization to which this subchapter applies to determine compliance with this subchapter.

(b) The 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 to which this subchapter applies;

(2) establish requirements for providing training to and regular oversight of special investigative units established by organizations under Section 544.0352(a)(1) and entities with which organizations contract under Section 544.0352(a)(2);

(3) establish requirements for approving plans to prevent and reduce fraud and abuse organizations adopt under Section 544.0353;

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

(5) as needed, assist organizations in discovering or investigating fraud, waste, and abuse; 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, recipients, and enrollees. (Gov. Code, Secs. 531.113(d), (d-1).)

Source Law

> (d) The commission's office of inspector general may review the records of a managed care organization to determine compliance with this section.
>
> (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;

(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.

Revisor's Note

Section 531.113(d-1)(6), Government Code, refers to fraud, waste, and abuse in a "managed care setting," including fraud, waste, and abuse by "recipients." It is clear from Section 531.113(a), Government Code, which is revised in relevant part as Section 544.0351 of this chapter, that the "managed care setting" to which Section 531.113(d-1)(6) refers includes managed care provided under Medicaid and the child health plan program. The revised law refers to both "recipients" and "enrollees" for the reason stated in the revisor's note to Section 544.0352 of this chapter.

Revised Law

Sec. 544.0355. RULES. (a) The executive commissioner, in consultation with the office of inspector general, shall adopt rules as necessary to accomplish the purposes of this subchapter, including rules defining the investigative role of the office with respect to the investigative role of special investigative units established by managed care organizations under Section 544.0352(a)(1) and entities with which managed care organizations contract under Section 544.0352(a)(2).

(b) The rules must specify the office of inspector general'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. (Gov. Code, Sec. 531.113(e).)

Source Law

(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.

SUBCHAPTER I. FINANCIAL ASSISTANCE FRAUD

Revised Law

Sec. 544.0401. DEFINITION. In this subchapter, "financial assistance" means assistance provided under the financial assistance program under Chapter 31, Human Resources Code. (Gov. Code, Sec. 531.114(a) (part).)

Source Law

(a) . . . financial assistance under Chapter 31, Human Resources Code, or . . . .

Revised Law

Sec. 544.0402. FALSE OR MISLEADING INFORMATION RELATED TO FINANCIAL ASSISTANCE ELIGIBILITY. To establish or maintain the eligibility of an individual and the individual's family for financial assistance or to increase or prevent a reduction in the amount of that assistance, an individual may not intentionally:

(1) make a statement that the individual knows is false or misleading;

(2) misrepresent, conceal, or withhold a fact; or

(3) knowingly misrepresent a statement as being true. (Gov. Code, Sec. 531.114(a) (part).)

Source Law

Sec. 531.114. FINANCIAL ASSISTANCE FRAUD. (a) For purposes of establishing or maintaining the eligibility of a person and the person's family for financial assistance . . . for purposes of increasing or preventing a reduction in the amount of that assistance, a person may not intentionally:

(1) make a statement that the person knows is false or misleading;

(2) misrepresent, conceal, or withhold a fact; or

(3) knowingly misrepresent a statement as being true.

Revised Law

Sec. 544.0403. COMMISSION ACTION FOLLOWING DETERMINATION OF VIOLATION. If after an investigation the commission determines that an individual violated Section 544.0402, the commission shall:

(1) notify the individual of the alleged violation not later than the 30th day after the date the commission completes the investigation and provide the individual with an opportunity for a hearing on the matter; or

(2) refer the matter to the appropriate prosecuting attorney for prosecution. (Gov. Code, Sec. 531.114(b).)

Source Law

(b) If after an investigation the commission determines that a person violated Subsection (a), the commission shall:

(1) notify the person of the alleged violation not later than the 30th day after the date the commission completes the investigation and provide the person with an opportunity for a hearing on the matter; or

(2) refer the matter to the appropriate prosecuting attorney for prosecution.

Revised Law

Sec. 544.0404. INELIGIBILITY FOR FINANCIAL ASSISTANCE FOLLOWING VIOLATION; RIGHT TO APPEAL. (a) An individual is not eligible to receive financial assistance as provided by Subsection (b) if the individual waives the right to a hearing or a hearing officer at an administrative hearing held under this subchapter determines that the individual violated Section 544.0402. An individual who a hearing officer determines violated Section 544.0402 may appeal that determination by filing a petition in the district court in the county in which the violation occurred not

later than the 30th day after the date the hearing officer makes the determination.

(b) An individual determined under Subsection (a) to have violated Section 544.0402 is not eligible for financial assistance:

(1) before the first anniversary of the date of that determination if the individual has no previous violations; and

(2) permanently if the individual was previously determined to have committed a violation.

(c) An individual who is convicted of a state or federal offense for conduct described by Section 544.0402 or who is granted deferred adjudication or placed on community supervision for that conduct is permanently disqualified from receiving financial assistance. (Gov. Code, Secs. 531.114(c), (d), (e).)

Source Law

> (c) If a person waives the right to a hearing or if a hearing officer at an administrative hearing held under this section determines that a person violated Subsection (a), the person is ineligible to receive financial assistance as provided by Subsection (d). A person who a hearing officer determines violated Subsection (a) may appeal that determination by filing a petition in the district court in the county in which the violation occurred not later than the 30th day after the date the hearing officer made the determination.
>
> (d) A person determined under Subsection (c) to have violated Subsection (a) is not eligible for financial assistance:
>
> (1) before the first anniversary of the date of that determination, if the person has no previous violations; and
>
> (2) permanently, if the person was previously determined to have committed a violation.
>
> (e) If a person is convicted of a state or federal offense for conduct described by Subsection (a), or if the person is granted deferred adjudication or placed on community supervision for that conduct, the person is permanently disqualified from receiving financial assistance.

Revised Law

Sec. 544.0405. HOUSEHOLD ELIGIBILITY FOR FINANCIAL ASSISTANCE NOT AFFECTED. This subchapter does not affect the eligibility for financial assistance of any other member of the household of an individual who is ineligible as a result of Section 544.0404(b) or (c). (Gov. Code, Sec. 531.114(f).)

Source Law

(f) This section does not affect the eligibility for financial assistance of any other member of the household of a person ineligible as a result of Subsection (d) or (e).

Revised Law

Sec. 544.0406. RULES. The executive commissioner shall adopt rules as necessary to implement this subchapter. (Gov. Code, Sec. 531.114(g).)

Source Law

(g) The executive commissioner shall adopt rules as necessary to implement this section.

SUBCHAPTER J. USE OF TECHNOLOGY TO DETECT, INVESTIGATE, AND PREVENT FRAUD, ABUSE, AND OVERCHARGES

Revised Law

Sec. 544.0451. LEARNING, NEURAL NETWORK, OR OTHER TECHNOLOGY RELATING TO MEDICAID. (a) The commission shall:

(1) use learning, neural network, or other technology to identify and deter Medicaid fraud throughout this state; and

(2) require each health and human services agency that performs any part of Medicaid to participate in implementing and using the technology.

(b) The commission shall contract with a private or public entity to develop and implement the technology. The commission may require the contracted entity to install and operate the technology at locations the commission specifies, including commission offices.

(c) The commission shall maintain all information necessary to apply the technology to claims data covering a period of at least two years. The data used for data processing shall be maintained as an independent subset for security purposes.

(d) The commission shall refer cases the technology identifies to the office of inspector general or the office of the attorney general, as appropriate.

(e) Each month, the technology must match vital statistics unit death records with Medicaid claims filed by a provider. If the

commission determines that a provider filed a claim for services provided to an individual after the individual's date of death, as determined by the vital statistics unit death records, the commission shall refer the case to the office of inspector general for investigation. (Gov. Code, Sec. 531.106.)

Source Law

> Sec. 531.106. LEARNING, NEURAL NETWORK, OR OTHER TECHNOLOGY. (a) The commission shall use learning, neural network, or other technology to identify and deter fraud in Medicaid throughout this state.
>
> (b) The commission shall contract with a private or public entity to develop and implement the technology. The commission may require the entity it contracts with to install and operate the technology at locations specified by the commission, including commission offices.
>
> (c) The data used for data processing shall be maintained as an independent subset for security purposes.
>
> (d) The commission shall require each health and human services agency that performs any aspect of Medicaid to participate in the implementation and use of the technology.
>
> (e) The commission shall maintain all information necessary to apply the technology to claims data covering a period of at least two years.
>
> (f) The commission shall refer cases identified by the technology to the commission's office of inspector general or the office of the attorney general, as appropriate.
>
> (g) Each month, the technology implemented under this section must match vital statistics unit death records with Medicaid claims filed by a provider. If the commission determines that a provider has filed a claim for services provided to a person after the person's date of death, as determined by the vital statistics unit death records, the commission shall refer the case for investigation to the commission's office of inspector general.

Revised Law

Sec. 544.0452. MEDICAID FRAUD INVESTIGATION TRACKING SYSTEM. (a) The commission shall use an automated fraud investigation tracking system through the office of inspector general to monitor the progress of an investigation of suspected fraud, abuse, or insufficient quality of care in Medicaid.

(b) For each case of suspected fraud, abuse, or insufficient quality of care the technology required under Section 544.0451 identifies, the automated fraud investigation tracking system must:

(1) receive from the technology electronically transferred records relating to the case;

(2) record the details and monitor the status of an investigation of the case, including maintaining a record of the beginning and completion dates for each phase of the case investigation;

(3) generate documents and reports related to the status of the case investigation; and

(4) generate standard letters to a provider regarding the status or outcome of an investigation.

(c) The commission shall require each health and human services agency that performs any part of Medicaid to participate in implementing and using the automated fraud investigation tracking system. (Gov. Code, Sec. 531.1061.)

Source Law

> Sec. 531.1061. FRAUD INVESTIGATION TRACKING SYSTEM. (a) The commission shall use an automated fraud investigation tracking system through the commission's office of inspector general to monitor the progress of an investigation of suspected fraud, abuse, or insufficient quality of care under Medicaid.
>
> (b) For each case of suspected fraud, abuse, or insufficient quality of care identified by the technology required under Section 531.106, the automated fraud investigation tracking system must:
>
> (1) receive electronically transferred records relating to the identified case from the technology;
>
> (2) record the details and monitor the status of an investigation of the identified case, including maintaining a record of the beginning and completion dates for each phase of the case investigation;
>
> (3) generate documents and reports related to the status of the case investigation; and
>
> (4) generate standard letters to a provider regarding the status or outcome of an investigation.
>
> (c) The commission shall require each health and human services agency that performs any aspect of Medicaid to participate in the implementation and use of the automated fraud investigation tracking system.

Revised Law

Sec. 544.0453. MEDICAID FRAUD DETECTION TECHNOLOGY. The commission may contract with a contractor who specializes in developing technology capable of identifying fraud patterns exhibited by Medicaid recipients to:

(1) develop and implement the fraud detection technology; and

(2) determine whether a fraud pattern by Medicaid recipients is present in the recipients' eligibility files the commission maintains. (Gov. Code, Sec. 531.111.)

Source Law

> Sec. 531.111. FRAUD DETECTION TECHNOLOGY. The commission may contract with a contractor who specializes in developing technology capable of identifying patterns of fraud exhibited by Medicaid recipients to:
>
> (1) develop and implement the fraud detection technology; and
>
> (2) determine if a pattern of fraud by Medicaid recipients is present in the recipients' eligibility files maintained by the commission.

Revised Law

Sec. 544.0454. DATA MATCHING AGAINST FEDERAL FELON LIST. The commission shall develop and implement a system to cross-reference the list of fugitive felons the federal government maintains with data collected for the following programs:

(1) the child health plan program;

(2) the financial assistance program under Chapter 31, Human Resources Code;

(3) Medicaid;

(4) nutritional assistance programs under Chapter 33, Human Resources Code;

(5) long-term care services, as defined by Section 22.0011, Human Resources Code;

(6) community-based support services identified or provided in accordance with Section _____ [[[Section 531.02481]]]; and

(7) other health and human services programs, as appropriate. (Gov. Code, Sec. 531.115.)

Source Law

> Sec. 531.115. FEDERAL FELONY MATCH. The commission shall develop and implement a system to cross-reference data collected for the programs listed under Section 531.008(c) with the list of fugitive felons maintained by the federal government.

Revisor's Note

Section 531.115, Government Code, refers to "the programs listed under Section 531.008(c)," Government Code. Before the enactment of Chapter 837 (S.B. 200), Acts of the 84th Legislature, Regular Session, 2015, Section 531.008(c) required the establishment within the Health and Human Services Commission of a division to make eligibility determinations for listed health and human services programs. Section 1.09 of Chapter 837 amended Section 531.008(c) and repealed that list of programs. Because the remaining reference to "the programs listed under Section 531.008(c)" in Section 531.115 is an oversight, the revised law substitutes for the quoted language the health and human services programs that were listed in Section 531.008(c) before the subsection was amended.

Revised Law

Sec. 544.0455. ELECTRONIC DATA MATCHING. (a) In this section, "public assistance program" includes:

(1) Medicaid;

(2) the financial assistance program under Chapter 31, Human Resources Code; and

(3) a nutritional assistance program under Chapter 33, Human Resources Code, including the supplemental nutrition assistance program under that chapter.

(b) At least quarterly, the commission shall conduct electronic data matches for a recipient of public assistance program benefits to verify the identity, income, employment status, and other factors that affect the recipient's eligibility. To verify a recipient's eligibility, the electronic data matching must match information the recipient provided with information contained in databases appropriate federal and state agencies maintain.

(c) Health and human services agencies shall cooperate with

the commission by providing data or any other assistance necessary to conduct the electronic data matches required by this section.

(d) The commission shall enter into a memorandum of understanding with each state agency from which data is required to conduct electronic data matches under this section and Section 544.0456.

(e) The commission may contract with a public or private entity to conduct the electronic data matches required by this section.

(f) The executive commissioner shall establish procedures by which the commission or a health and human services agency the commission designates verifies the electronic data matches the commission conducts under this section. Not later than the 20th day after the date an electronic data match is verified, the commission shall remove from eligibility a recipient who is determined to be ineligible for a public assistance program. (Gov. Code, Sec. 531.110.)

Source Law

Sec. 531.110. ELECTRONIC DATA MATCHING PROGRAM. (a) In this section, "public assistance program" includes:

(1) Medicaid;

(2) the financial assistance program under Chapter 31, Human Resources Code; and

(3) a nutritional assistance program under Chapter 33, Human Resources Code, including the supplemental nutrition assistance program under that chapter.

(a-1) The commission shall conduct electronic data matches for a recipient of benefits under a public assistance program at least quarterly to verify the identity, income, employment status, and other factors that affect the eligibility of the recipient.

(b) To verify eligibility of a recipient of public assistance program benefits, the electronic data matching must match information provided by the recipient with information contained in databases maintained by appropriate federal and state agencies.

(c) The health and human services agencies shall cooperate with the commission by providing data or any other assistance necessary to conduct the electronic data matches required by this section.

(c-1) The commission shall enter into a memorandum of understanding with each state agency from which data is required to conduct electronic data matches under this section and Section 531.1081.

(d) The commission may contract with a public or private entity to conduct the electronic data matches required by this section.

(e) The executive commissioner shall establish procedures by which the commission, or a health and human services agency designated by the commission, verifies the electronic data matches conducted by the commission under this section. Not later than the 20th day after the date the electronic data match is verified, the commission shall remove from eligibility a recipient who is determined to be ineligible for a public assistance program.

Revised Law

Sec. 544.0456. METHODS TO REDUCE FRAUD, WASTE, AND ABUSE IN CERTAIN PUBLIC ASSISTANCE PROGRAMS. (a) In this section:

(1) "Financial assistance benefits" means monetary payments under:

(A) the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code; or

(B) this state's temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Supplemental nutrition assistance benefits" means monetary payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code.

(b) To the extent not otherwise provided by this subtitle or Title 2, Human Resources Code, and in accordance with this section, the commission shall develop and implement methods for reducing fraud, waste, and abuse in public assistance programs.

(c) On a monthly basis, the commission shall:

(1) conduct electronic data matches with the Texas Lottery Commission to determine whether a recipient of supplemental nutrition assistance benefits or a recipient's household member received reportable lottery winnings;

(2) use the database system developed under Section _____ [[[Section 531.0214]]] to:

(A) match vital statistics unit death records with a list of individuals eligible for financial assistance or supplemental nutrition assistance benefits; and

(B) ensure that any individual receiving

assistance under either program who is discovered to be deceased has the individual's eligibility for assistance promptly terminated; and

(3) review the out-of-state electronic benefit transfer card transactions a recipient of supplemental nutrition assistance benefits made to determine whether those transactions indicate a possible change in the recipient's residence.

(d) The commission shall immediately review a recipient's eligibility for public assistance benefits if the commission discovers information under this section that affects the recipient's eligibility.

(e) A recipient presumptively commits a program violation if the recipient fails to disclose lottery winnings that are required to be reported to the commission under a public assistance program.

(f) The executive commissioner shall adopt rules necessary to implement this section. (Gov. Code, Sec. 531.1081.)

Source Law

Sec. 531.1081. INTEGRITY OF CERTAIN PUBLIC ASSISTANCE PROGRAMS. (a) In this section:

(1) "Financial assistance benefits" means money payments under the federal Temporary Assistance for Needy Families program operated under Chapter 31, Human Resources Code, or under the state temporary assistance and support services program operated under Chapter 34, Human Resources Code.

(2) "Supplemental nutrition assistance benefits" means money payments under the supplemental nutrition assistance program operated under Chapter 33, Human Resources Code.

(b) To the extent not otherwise provided by this subtitle or Title 2, Human Resources Code, the commission shall develop and implement, in accordance with this section, methods for reducing abuse, fraud, and waste in public assistance programs.

(c) On a monthly basis, the commission shall:

(1) conduct electronic data matches with the Texas Lottery Commission to determine if a recipient of supplemental nutrition assistance benefits or a recipient's household member received reportable lottery winnings;

(2) use the database system developed under Section 531.0214 to match vital statistics unit death records with a list of individuals eligible for financial assistance or supplemental nutrition assistance benefits, and ensure that any individual receiving assistance under either program who is discovered deceased has their eligibility for assistance promptly terminated; and

(3) review the out-of-state electronic benefit transfer card transactions made by a recipient of supplemental nutrition assistance benefits to determine whether those transactions indicate a possible change in the recipient's residence.

(d) The commission shall immediately review the eligibility of a recipient of public assistance benefits if the commission discovers information under this section that affects the recipient's eligibility.

(e) A recipient who fails to disclose lottery winnings that are required to be reported to the commission under a public assistance program presumptively commits a program violation.

(f) The executive commissioner shall adopt rules necessary to implement this section.

Revisor's Note
(End of Subchapter)

Section 531.1112, Government Code, requires the Health and Human Services Commission and the commission's office of inspector general to study the feasibility of increasing the use of technology to strengthen the detection and deterrence of Medicaid fraud and to implement any methods the commission and office determine are effective. Section 6(b), Chapter 268 (S.B. 10), Acts of the 80th Legislature, Regular Session, 2007, requires the commission to submit to the legislature not later than December 1, 2008, a report detailing the findings of the study, which must include a description of any method described by Section 531.1112(b) that the commission has implemented or intends to implement. The commission conducted the study and, in December 2008, submitted the required report to the legislature. Therefore, the revised law omits the provision as executed. The omitted law reads:

> Sec. 531.1112. STUDY CONCERNING INCREASED USE OF TECHNOLOGY TO STRENGTHEN FRAUD DETECTION AND DETERRENCE; IMPLEMENTATION. (a) The commission and the commission's office of inspector general shall jointly study the feasibility of increasing the use of technology to strengthen the detection and deterrence of fraud in Medicaid. The study must include the determination of the feasibility of using technology to verify a person's citizenship and eligibility for coverage.
>
> (b) The commission shall implement

any methods the commission and the commission's office of inspector general determine are effective at strengthening fraud detection and deterrence.

SUBCHAPTER K. RECOVERY AND RECOUPMENT IN CASES OF FRAUD, ABUSE, AND OVERCHARGES

Revised Law

Sec. 544.0501. RECOVERY MONITORING SYSTEM. (a) The commission shall use an automated recovery monitoring system to monitor the collections process for a settled case of fraud, abuse, or insufficient quality of care in Medicaid.

(b) The recovery monitoring system must:

(1) monitor the collection of money resulting from settled cases, including by recording:

(A) monetary payments received from a provider who agreed to a monetary payment plan; and

(B) deductions taken through the recoupment program from subsequent Medicaid claims the provider filed; and

(2) provide immediate notice of a provider who:

(A) agreed to a monetary payment plan or to deductions through the recoupment program from subsequent Medicaid claims; and

(B) fails to comply with the settlement agreement, including by providing notice of a provider who:

(i) does not make a scheduled payment; or

(ii) pays less than a scheduled amount. (Gov. Code, Sec. 531.1062.)

Source Law

Sec. 531.1062. RECOVERY MONITORING SYSTEM. (a) The commission shall use an automated recovery monitoring system to monitor the collections process for a settled case of fraud, abuse, or insufficient quality of care under Medicaid.

(b) The recovery monitoring system must:

(1) monitor the collection of funds resulting from settled cases, including:

(A) recording monetary payments received from a provider who has agreed to a monetary payment plan; and

(B) recording deductions taken through the recoupment program from subsequent Medicaid claims filed by the provider; and

(2) provide immediate notice of a provider

who has agreed to a monetary payment plan or to deductions through the recoupment program from subsequent Medicaid claims who fails to comply with the settlement agreement, including providing notice of a provider who does not make a scheduled payment or who pays less than the scheduled amount.

Revised Law

Sec. 544.0502. PAYMENT RECOVERY EFFORTS BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a) In this section, "contracted entity" means an entity with which a managed care organization contracts under Section 544.0352(a)(2).

(b) A managed care organization or the organization's contracted entity that discovers Medicaid or child health plan program fraud or abuse shall:

(1) immediately submit written notice to the office of inspector general and the office of the attorney general that:

(A) is in the form and manner the office of inspector general prescribes; and

(B) contains a detailed description of:

(i) the fraud or abuse; and

(ii) each payment made to a provider as a result of the fraud or abuse;

(2) subject to Subsection (c), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with rules the executive commissioner adopts.

(c) A managed care organization or the organization's contracted entity may not engage in payment recovery efforts if:

(1) the amount sought to be recovered under Subsection (b)(2) exceeds $100,000; and

(2) not later than the 10th business day after the date the organization or entity notifies the office of inspector general and the office of the attorney general under Subsection (b)(1), the organization or entity receives a notice from either office indicating that the organization or entity is not authorized to proceed with recovery efforts.

(d) A managed care organization may retain one-half of any money the organization or the organization's contracted entity recovers under Subsection (b)(2). The organization shall remit the remaining amount of recovered money to the office of inspector general for deposit to the credit of the general revenue fund.

(e) If the office of inspector general notifies a managed care organization in accordance with Subsection (c), proceeds with recovery efforts, and recovers all or part of the payments the organization identified as required by Subsection (b)(1), the organization is entitled to one-half of the amount recovered for each payment the organization identified after any federal share is deducted. The organization may not receive more than one-half of the total amount recovered after any federal share is deducted.

(f) Notwithstanding this section, if the office of inspector general discovers Medicaid or child health plan program fraud, waste, or abuse in performing the office's duties, the office may recover payments made to a provider as a result of the fraud, waste, or abuse as otherwise provided by this chapter. The office shall deposit all payments the office recovers under this subsection to the credit of the general revenue fund.

(g) The office of inspector general shall coordinate with appropriate managed care organizations to ensure that the office and an organization or an organization's contracted entity do not both begin payment recovery efforts under this section for the same case of fraud, waste, or abuse.

(h) A managed care organization shall submit a quarterly report to the office of inspector general detailing the amount of money the organization recovered under Subsection (b)(2).

(i) The executive commissioner shall adopt rules necessary to implement this section, including rules establishing due process procedures that a managed care organization must follow when engaging in payment recovery efforts as provided by this section. In adopting the rules establishing due process procedures, the executive commissioner shall require that a managed care

organization or an organization's contracted entity that engages in payment recovery efforts as provided by this section and Section 544.0503 provide to a provider required to use electronic visit verification:

(1) written notice of the organization's intent to recoup overpayments in accordance with Section 544.0503; and

(2) at least 60 days to cure any defect in a claim before the organization may begin efforts to collect overpayments. (Gov. Code, Sec. 531.1131.)

Source Law

Sec. 531.1131. FRAUD AND ABUSE RECOVERY BY CERTAIN PERSONS; RETENTION OF RECOVERED AMOUNTS. (a) If a managed care organization or an entity with which the managed care organization contracts under Section 531.113(a)(2) discovers fraud or abuse in Medicaid or the child health plan program, the organization or entity shall:

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

(2) subject to Subsection (b), begin payment recovery efforts; and

(3) ensure that any payment recovery efforts in which the organization engages are in accordance with applicable rules adopted by the executive commissioner.

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

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

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

after any applicable federal share is deducted. The organization may not receive more than one-half of the total amount of money recovered after any applicable federal share is deducted.

(c-2) Notwithstanding any provision of this section, if the commission's office of inspector general discovers fraud, waste, or abuse in Medicaid or the child health plan program in the performance of its duties, the office may recover payments made to a provider as a result of the fraud, waste, or abuse as otherwise provided by this subchapter. All payments recovered by the office under this subsection shall be deposited to the credit of the general revenue fund.

(c-3) The commission's office of inspector general shall coordinate with appropriate managed care organizations to ensure that the office and an organization or an entity with which an organization contracts under Section 531.113(a)(2) do not both begin payment recovery efforts under this section for the same case of fraud, waste, or abuse.

(d) A managed care organization shall submit a quarterly report to the commission's office of inspector general detailing the amount of money recovered under Subsection (a)(2).

(e) The executive commissioner shall adopt rules necessary to implement this section, including rules establishing due process procedures that must be followed by managed care organizations when engaging in payment recovery efforts as provided by this section.

(f) In adopting rules establishing due process procedures under Subsection (e), the executive commissioner shall require that a managed care organization or an entity with which the managed care organization contracts under Section 531.113(a)(2) that engages in payment recovery efforts in accordance with this section and Section 531.1135 provide:

(1) written notice to a provider required to use electronic visit verification of the organization's intent to recoup overpayments in accordance with Section 531.1135; and

(2) a provider described by Subdivision (1) at least 60 days to cure any defect in a claim before the organization may begin any efforts to collect overpayments.

Revisor's Note

Section 531.1131(c-2), Government Code, authorizes the Health and Human Services Commission's office of inspector general to recover payments made to a provider as a result of fraud, waste, or abuse as otherwise provided by this "subchapter," meaning Subchapter C, Chapter 531, Government Code. Although the law revised in this chapter includes provisions not included in Subchapter C, Chapter 531, the revised law substitutes "chapter" for "subchapter" because the law revised in this chapter is substantially derived

from Subchapter C, Chapter 531, and the inclusion of provisions not derived from Subchapter C does not expand the scope of the office's authority to recover payments.

Revised Law

Sec. 544.0503. PROCESS FOR MANAGED CARE ORGANIZATIONS TO RECOUP OVERPAYMENTS RELATED TO ELECTRONIC VISIT VERIFICATION TRANSACTIONS. (a) The executive commissioner shall adopt rules that standardize the process by which a managed care organization collects alleged overpayments that are made to a health care provider and discovered through an audit or investigation the organization conducts secondary to missing electronic visit verification information. The rules must require that the organization:

(1) provide written notice to a provider:

(A) of the organization's intent to recoup overpayments not later than the 30th day after the date an audit is complete;

(B) of the specific claims and electronic visit verification transactions that are the basis of the overpayment;

(C) of the process the provider should use to communicate with the organization to provide information about the electronic visit verification transactions;

(D) of the provider's option to seek an informal resolution of the alleged overpayment;

(E) of the process to appeal the determination that an overpayment was made; and

(F) if the provider intends to respond to the notice, that the provider must respond not later than the 30th day after the date the provider receives the notice; and

(2) limit the duration of audits to 24 months.

(b) Notwithstanding any other law, a managed care organization may not attempt to recover an overpayment described by Subsection (a) until the provider exhausts all rights to an appeal.

(Gov. Code, Sec. 531.1135.)

Source Law

Sec. 531.1135. MANAGED CARE ORGANIZATIONS: PROCESS TO RECOUP CERTAIN OVERPAYMENTS. (a) The executive commissioner shall adopt rules that standardize the process by which a managed care organization collects alleged overpayments that are made to a health care provider and discovered through an audit or investigation conducted by the organization secondary to missing electronic visit verification information. In adopting rules under this section, the executive commissioner shall require that the managed care organization:

(1) provide written notice of the organization's intent to recoup overpayments not later than the 30th day after the date an audit is complete; and

(2) limit the duration of audits to 24 months.

(b) The executive commissioner shall require that the notice required under this section inform the provider:

(1) of the specific claims and electronic visit verification transactions that are the basis of the overpayment;

(2) of the process the provider should use to communicate with the managed care organization to provide information about the electronic visit verification transactions;

(3) of the provider's option to seek an informal resolution of the alleged overpayment;

(4) of the process to appeal the determination that an overpayment was made; and

(5) if the provider intends to respond to the notice, that the provider must respond not later than the 30th day after the date the provider receives the notice.

(c) Notwithstanding any other law, a managed care organization may not attempt to recover an overpayment described by Subsection (a) until the provider has exhausted all rights to an appeal.

Revised Law

Sec. 544.0504. RECOVERY AUDIT CONTRACTORS. To the extent required under Section 1902(a)(42), Social Security Act (42 U.S.C. Section 1396a(a)(42)), the commission shall establish a program under which the commission contracts with one or more recovery audit contractors to identify Medicaid underpayments and overpayments and recover the overpayments. (Gov. Code, Sec. 531.117.)

Source Law

Sec. 531.117. RECOVERY AUDIT CONTRACTORS. To the extent required under Section 1902(a)(42), Social Security Act (42 U.S.C. Section 1396a(a)(42)), the commission shall establish a program under which the commission contracts with one or more recovery audit

contractors for purposes of identifying underpayments and overpayments under Medicaid and recovering the overpayments.

Revised Law

Sec. 544.0505. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES. Not later than December 1 of each year, the commission shall prepare and submit to the legislature a report on the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts made under Subchapter H and Section 544.0502 by special investigative units or entities with which a managed care organization contracts under Section 544.0352(a)(2). The report must specify the amount of money each managed care organization retained under Section 544.0502(d). (Gov. Code, Sec. 531.1132.)

Source Law

Sec. 531.1132. ANNUAL REPORT ON CERTAIN FRAUD AND ABUSE RECOVERIES. Not later than December 1 of each year, the commission shall prepare and submit a report to the legislature relating to the amount of money recovered during the preceding 12-month period as a result of investigations and recovery efforts made under Sections 531.113 and 531.1131 by special investigative units or entities with which a managed care organization contracts under Section 531.113(a)(2). The report must specify the amount of money retained by each managed care organization under Section 531.1131(c).

Revised Law

Sec. 544.0506. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) The commission or the 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;

(5) 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;

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

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

(8) a description of administrative and judicial due process remedies, including the provider's option to seek informal resolution, the provider's right to seek a formal administrative appeal hearing, or that the provider may seek both.

(b) A provider may request an informal resolution meeting. On receipt of the request, the office of inspector general shall schedule the meeting and give notice to the provider of the time and place of the meeting. 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.

(c) The commission shall provide the notice required by Subsection (a) to a provider that is a hospital not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid. (Gov. Code, Sec. 531.120.)

Source Law

> 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 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 request an informal resolution meeting under this section, and on receipt of the request, the office shall schedule the informal resolution meeting. The office shall give notice to the provider of the time and place of the informal resolution meeting. 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.

(c) The commission shall provide the notice required by Subsection (a) to a provider that is a hospital not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid.

Revised Law

Sec. 544.0507. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) A provider must request an appeal under this section not later than the 30th day after the date the provider is notified that the commission or the office of inspector general will seek to recover an overpayment or debt from the provider.

(b) On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or 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 commission's appeals division, as the provider requests, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office shall file the docketing request not later than the 60th day after the date of the provider's request or not later than the 60th day after completing the informal resolution process, if applicable.

(c) The office of inspector general is responsible for the costs of an administrative hearing, but a provider is responsible for the provider's own costs incurred in preparing for the hearing.

(d) A provider who is the subject of a recoupment of

overpayment or debt arising out of a fraud or abuse investigation may appeal a final administrative order issued after an administrative hearing by filing a petition for judicial review in a district court in Travis County. (Gov. Code, Sec. 531.1201.)

Source Law

> Sec. 531.1201. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) A provider must request an appeal under this section not later than the 30th 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 for the provider's own costs incurred in preparing for the hearing.
>
> (d) Following an administrative hearing under Subsection (a), a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.