SUBJECT: Revising rules against fraud in CHIP and Medicaid

COMMITTEE: Public Health — favorable without amendment

VOTE: 11 ayes — Kolkhorst, Naishtat, Alvarado, Coleman, S. Davis, V. Gonzales, S. King, Laubenberg, Schwertner, Truitt, Zerwas

0 nays

WITNESSES: For — (*Registered, but did not testify:* Brent Connett, Texas Conservative Coalition; Heather Fazio, Texans for Accountable Government; Claudia Smith, Citizens Commission on Human Rights Texas; Marissa Stewart; Jared Wolfe, Texas Association of Health Plans)

Against — None

On — Billy Millwee, Texas Health and Human Services Commission; Douglas Wilson, Health and Human Services Commission - Office of Inspector General; (*Registered, but did not testify:* Rachel Hammon, Texas Association for Home Care and Hospice)

BACKGROUND: Government Code, ch. 531, subch. C outlines the responsibilities of the Health and Human Services Commission (HHSC) in relation to investigating Medicaid fraud and abuse.

A national provider identifier (NPI) is an identification number issued to health care providers by the U.S. Center for Medicare and Medicaid Services.

DIGEST: (*The analysis is of the original version of the bill as modified by a floor amendment the author intends to offer:*)

Rules for providers. HB 1720, as amended, would require a Medicaid or Children's Health Insurance Program (CHIP) provider (including a nurse practitioner or physician assistant) who provided a referral for a health care service to include the names and associated NPIs of the supervised and supervising providers in any claim for reimbursement that would be based on the referral.

A Medicaid provider who ordered home health services would have to evaluate the recipient in person within six months before issuing the order. An authorized health care professional who ordered durable medical equipment for a recipient would have to certify that an in-person evaluation had been conducted within the preceding six-month period.

The bill also would require the HHSC executive commissioner to adopt rules to prohibit a provider from participating in CHIP or Medicaid if the provider failed to repay any overpayments or owned, controlled, managed, or was affiliated with a provider who had been suspended or banned from participating in the programs.

New fraud recovery authority for managed care organizations. If a managed care organization's special investigative unit (SIU) discovered an instance of fraud or abuse by a Medicaid or CHIP provider, the SIU would have to notify HHSC's Office of Inspector General (OIG) immediately and begin payment recovery efforts. If the amount exceeded $100,000, the SIU could begin payment recovery efforts if the OIG did not prohibit it within 10 business days after receiving notification. The managed care organization's SIU could retain any funds recovered through the payment recovery efforts. The managed care organization would be required to submit a quarterly report to the OIG detailing the amount of money recovered.

Payment recovery. HHSC would be authorized to establish a program by contracting with one or more recovery audit organizations to identify underpayments and overpayments in the Medicaid program and attempt to recover overpayments.

If a state agency determined that a federal waiver was necessary to implement the bill's provisions, then the agency would have to request the waiver and could delay implementation until it was granted.

Effective date. The bill would take effect on September 1, 2011, and would apply only to investigations of fraud or abuse that began on or after that date.

SUPPORTERS SAY:

HB1720, as amended, would result in significant cost savings in CHIP and Medicaid and prevent waste, fraud, and abuse by strengthening the coordination efforts between HHSC and managed care providers. Managed care organizations work directly with providers and already have

worked hard to establish education programs to prevent overpayment to providers resulting from poor financial management rather than deliberate efforts to defraud the system. These entities also have invested in technology helping them to manage their payments as efficiently as possible and target irregular claims that could be fraudulent. HB 1720 would expand the scope of these efforts by authorizing managed care organizations to engage in payment recovery efforts and permitting them to retain any funds recouped.

The OIG currently does not have the capacity or resources to investigate and retrieve all fraudulent claims within CHIP and Medicaid. Allowing managed care organizations to assist in these efforts and providing incentives to successfully prevent and manage overpayments could make the entire system fairer and more efficient and allow more eligible people to be served.

Managed care organizations are paid through a capitation rate, which provides a set payment based on the lives covered rather than the fee-for-service model. This payment system gives managed care organizations a financial incentive to prevent, identify, and combat fraud and abuse in Medicaid and CHIP, because overpayments on fraudulent claims could result in a loss of funding. By allowing managed care organizations to keep the regained funds, the total cost of providing care for the enrolled population served could be reduced. As a result, HHSC could reduce the capitation rates paid when the contract was renewed and save state funds.

The bill also would authorize HHSC to be more aggressive in recovering fraudulent claims by contracting with recovery audit contractors to maximize the amount of funds repaid to the state.

HB 1720 would increase transparency and accountability for health care professionals participating in CHIP and Medicaid because they would have to provide the NPI of the supervised and supervising provider when making a referral. It is not uncommon for a nurse practitioner or physician assistant to make referrals for other services. The bill would require these health care professionals to include the NPI in order to leave a record of accountability, and would ensure that a patient had received an in-person evaluation before other services were ordered.

OPPONENTS SAY:

HB 1720 would permit a managed care organization to engage in payment recovery efforts and retain any money repaid. It is unclear how this bill might affect an already low provider participation rate in CHIP and Medicaid. Allowing managed care organizations to engage in the payment recovery effort could create a two-tiered investigative culture. While the bill does contain a provision that addresses due process for providers accused of committing fraud, it is unclear to what extent managed care organizations would be regulated in these efforts and what impact this could have on provider participation.

This provision also could create jurisdiction problems related to whether or not the agency or the managed care provider pursued specific fraud cases and collected reclaimed funds. The bill should include more detailed guidance on the OIG's role in overseeing managed care organization's payment recovery efforts.

NOTES:

The author's floor amendment to HB 1720 would modify the bill by authorizing HHSC to create rules that would establish due process procedures for managed care organizations to follow in payment recovery efforts. The floor amendment would lower the threshold from $200,000 to $100,000 for managed care organizations to begin automatic payment recovery efforts if not prohibited from doing so by the OIG, and would provide that the time window would be 10 business days rather than 10 days. It also would define "affiliated" in relation to a Medicaid or CHIP provider.

According to the fiscal note, the fiscal impact of the bill could not be determined because the amount resulting from any increased collection of overpayments is unknown.