By: Huffman (Kolkhorst, Raymond) S.B. No. 1803

Substitute the following for S.B. No. 1803:

By: Raymond C.S.S.B. No. 1803

A BILL TO BE ENTITLED

AN ACT

relating to investigations of and payment holds relating to allegations of fraud or abuse and investigations of and hearings on overpayments and other amounts owed by providers in connection with the Medicaid program or other health and human services programs.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 531.1011, Government Code, is amended to read as follows:

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 the Medicaid program; 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 the Medicaid program.

(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, including any act that constitutes fraud under applicable federal or state law.

(5) [~~(2)~~] "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" [~~(3) "Hold on payment"~~] means the temporary denial of reimbursement under the Medicaid program for items or services furnished by a specified provider.

(7) [~~(4)~~] "Practitioner" means a physician or other individual licensed under state law to practice the individual's profession.

(8) [~~(5)~~] "Program exclusion" means the suspension of a provider from being authorized under the Medicaid program to request reimbursement of items or services furnished by that specific provider.

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

(A) provide medical assistance under contract or provider agreement with the commission; or

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

SECTION 2. Section 531.102, Government Code, is amended by amending Subsections (f) and (g) and adding Subsections (l), (m), (n), (o), and (p) to read as follows:

(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) [~~an integrity review~~] to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation [~~An integrity review~~] must begin not later than the 30th day after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. A preliminary investigation [~~An integrity review~~] shall be completed not later than the 90th day after it began.

(2) If the findings of a preliminary investigation [~~an integrity review~~] give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, the office must take the following action, as appropriate, not later than the 30th day after the completion of the preliminary investigation [~~integrity review~~]:

(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 the Medicaid program, the office may conduct a full investigation of the suspected fraud, subject to Section 531.118(c).

(g)(1) Whenever the office learns or has reason to suspect that a provider's records are being withheld, concealed, destroyed, fabricated, or in any way falsified, the office shall immediately refer the case to the state's Medicaid fraud control unit. However, such criminal referral does not preclude the office from continuing its investigation of the provider, which investigation may lead to the imposition of appropriate administrative or civil sanctions.

(2) In addition to other instances authorized under state or federal law, the office shall impose without prior notice a payment hold on [~~payment of~~] claims for reimbursement submitted by

a provider 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, and the criteria adopted under Subsection (n)(3) [~~on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or wilful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23, as applicable~~]. The office must notify the provider of the payment hold [~~on payment~~] in accordance with 42 C.F.R. Section 455.23(b). In addition to the requirements of 42 C.F.R. Section 455.23(b), the notice of payment hold provided under this subdivision must also include:

(A) the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation and a representative sample of any documents that form the basis for the hold; and

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

(3) On timely written request by a provider subject to a payment hold [~~on payment~~] 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 or the appeals division of the commission, as requested by the provider, for an expedited administrative hearing regarding the hold. The provider must request an expedited administrative

hearing under this subdivision not later than the 30th [~~10th~~] day after the date the provider receives notice from the office under Subdivision (2). Unless otherwise determined by the administrative law judge for good cause at an expedited administrative hearing before the State Office of Administrative Hearings under this subdivision, the state and the provider shall each be responsible for:

(A) one-half of the costs charged by the State Office of Administrative Hearings;

(B) one-half of the costs for transcribing the hearing;

(C) the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, depositions, and subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and

(D) all other costs associated with the hearing that are incurred by the party, including attorney's fees.

(4) The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before an expedited administrative hearing before the State Office of Administrative Hearings under Subdivision (3), to advance security for the costs for which the provider is responsible under that subdivision.

(5) Following an expedited administrative hearing under Subdivision (3), a provider subject to a payment hold, other than a hold requested by the state's Medicaid fraud control unit, may appeal a final administrative order by filing a petition for

judicial review in a district court in Travis County.

(6) The executive commissioner [~~commission~~] shall adopt rules that allow a provider subject to a [~~hold on~~] 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 [~~seek~~] 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 schedule an initial informal resolution meeting not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the meeting is to be held. A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held. A provider must have an opportunity to provide

additional information before the second informal resolution meeting for consideration by the office. 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). However, a hearing initiated under Subdivision (3) shall be stayed [~~at the office's request~~] until the informal resolution process is completed.

(7) [~~(5)~~] The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds [~~on payment~~] or program exclusions:

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

(B) shall automatically be imposed on a provider.

(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 the Medicaid program. 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 who preferably has knowledge of Medicaid program rules and requirements before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(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 the Medicaid program. 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 who preferably has knowledge of Medicaid program rules and requirements before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(n) The executive commissioner shall, in conjunction with the office and in consultation with the state's Medicaid fraud control unit, adopt rules for the office that establish:

(1) criteria for initiating a full fraud or abuse investigation, conducting the investigation, and collecting evidence;

(2) training requirements for Medicaid provider fraud or abuse investigators; and

(3) criteria for determining, in accordance with state and federal law, when good cause exists to:

(A) not impose a payment hold on a provider;

(B) discontinue a payment hold imposed on a provider;

(C) partially discontinue a payment hold imposed on a provider; and

(D) convert a full payment hold imposed on a provider to a partial payment hold.

(o) In determining what constitutes good cause for purposes of Subsection (n)(3), the executive commissioner shall consider:

(1) a specific request by a law enforcement agency that the office not impose a payment hold on a provider or

discontinue a payment hold imposed on a provider;

(2) a determination by the office that other available remedies implemented by the office or commission could more effectively or quickly protect Medicaid funds than imposing or continuing a payment hold;

(3) evidence submitted by a provider that convinces the office that a payment hold should be discontinued or partially imposed;

(4) a determination by the office that a Medicaid recipient's access to items or services will be jeopardized by the imposition of a payment hold;

(5) a determination by the office that a payment hold should be discontinued because the state's Medicaid fraud control unit or a law enforcement agency declines to cooperate in certifying that the unit or agency is continuing to investigate the credible allegation of fraud that is the basis of the payment hold;

(6) a determination by the office that imposing a full or partial payment hold is not in the best interest of the Medicaid program; and

(7) a determination by the office that a partial payment hold will ensure that potentially fraudulent claims under the Medicaid program will not be continued to be paid.

(p) An employee of the office may bring a whistleblower suit in accordance with Chapter 554.

SECTION 3. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.118, 531.119, 531.120, 531.1201, and 531.1202 to read as follows:

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).

(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 as provided by Section 531.102(f)(1).

(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.

(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.

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.

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;

(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 right to seek informal resolution, a formal administrative appeal hearing, or both.

(b) The executive commissioner shall adopt rules that allow a provider who is the subject of a proposed recoupment of an overpayment or debt to seek informal resolution of the issues identified in the notice provided under Subsection (a).

(c) The rules adopted under Subsection (b) must require a provider who seeks informal resolution of the issues identified in the notice provided under Subsection (a) to request an initial informal resolution meeting not later than the 30th day after the date the provider receives the notice. On receipt of a timely request, the office shall schedule the initial informal resolution meeting not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall give notice to the provider of the time and place of the initial informal resolution meeting not later than

the 30th day before the date the meeting is to be held.

(d) The rules adopted under Subsection (b) must allow a provider to request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.

(e) Not later than the 60th day after the date of the initial informal resolution meeting or, if a second informal resolution meeting is requested by the provider, after the second informal resolution meeting, or on a later date at the request of a provider, the commission or the office shall provide the provider with written notice of the commission's or office's final determination of whether the commission or office will seek to recoup an overpayment or debt from the provider.

(f) If a provider does not request an informal resolution meeting under this section, not later than the 60th day after the date the provider receives the notice under Subsection (a), the commission or the office shall provide the provider with written notice of the commission's or office's final determination of

whether the commission or office will seek to recoup an overpayment or debt from the provider.

(g) Nothing in this section shall be construed to require a provider to request an informal resolution meeting under this section before requesting an appeal under Section 531.1201 of the commission's or office's final determination to recoup an overpayment or debt from the provider.

Sec. 531.1201. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) If, after a final determination, the commission or the commission's office of inspector general seeks to recoup from a provider an overpayment or debt arising out of a fraud or abuse investigation in an amount that is less than $1 million, the provider may appeal the determination not later than the 15th day after the date the provider receives the notice under Section 531.120(e) or (f), as applicable, by requesting in writing that the commission or office set an administrative hearing on the determination. On receipt of a timely written request for an administrative hearing from the provider under this section, the commission or the office shall file a docketing request with the State Office of Administrative Hearings or the appeals division of the commission, as requested by the provider, for an administrative hearing on the final determination to recoup the overpayment or debt and any associated damages and penalties.

(b) If, after a final determination, the commission or the commission's office of inspector general seeks to recoup an overpayment or debt arising out of a fraud or abuse investigation in an amount of $1 million or more from a provider, the provider may

appeal the determination not later than the 15th day after the date the provider receives the notice under Section 531.120(e) or (f), as applicable, by:

(1) requesting in writing that the commission or office file a docketing request with the State Office of Administrative Hearings for an administrative hearing on the final determination to recoup an overpayment or debt and any associated damages and penalties; or

(2) filing a petition to appeal the final determination to recoup an overpayment or debt and any associated damages and penalties in a district court in Travis County.

(c) If a provider requests that the commission or office set an administrative hearing under Subsection (b)(1), the provider may not appeal any administrative order issued by an administrative law judge relating to the commission's or office's final determination to recoup an overpayment or debt and any associated damages and penalties from the provider in a district court.

(d) Unless otherwise determined by the administrative law judge for good cause, at any administrative hearing under this section before the State Office of Administrative Hearings, the state and the provider shall each be responsible for:

(1) one-half of the costs charged by the State Office of Administrative Hearings;

(2) one-half of the costs for transcribing the hearing;

(3) the party's own costs related to the hearing, including the costs associated with preparation for the hearing,

discovery, depositions, and subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and

(4) all other costs associated with the hearing that are incurred by the party, including attorney's fees.

(e) The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before an administrative hearing under this section before the State Office of Administrative Hearings, to advance security for the costs for which the provider is responsible under Subsection (d).

Sec. 531.1202. PRESENCE OF NEUTRAL THIRD PARTY AT INFORMAL RESOLUTION MEETINGS. The commission shall employ a person whose salary is paid by the commission and who is independent of the commission's office of inspector general to attend the informal resolution meetings held under Sections 531.102(g)(6) and 531.120(c) and (d) as a neutral third-party observer. The person shall report to the executive commissioner on the proceedings and outcome of each informal resolution meeting.

SECTION 4. The heading to Section 32.0291, Human Resources Code, is amended to read as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND PAYMENT [~~POSTPAYMENT~~] HOLDS.

SECTION 5. Sections 32.0291(b) and (c), Human Resources Code, are amended to read as follows:

(b) Subject to Section 531.102, Government Code, and notwithstanding [~~Notwithstanding~~] any other law, the department may impose a payment [~~postpayment~~] hold on [~~payment of~~] future

claims submitted by a provider [~~if the department has reliable evidence that the provider has committed fraud or wilful misrepresentation regarding a claim for reimbursement under the medical assistance program. The department must notify the provider of the postpayment hold not later than the fifth working day after the date the hold is imposed~~].

(c) A payment hold authorized by this section is governed by the requirements and procedures specified for a payment hold under Section 531.102, Government Code, including the notice requirements under Subsection (g) of that section. [~~On timely written request by a provider subject to a postpayment hold under Subsection (b), the department shall file a request with the State Office of Administrative Hearings for an expedited administrative hearing regarding the hold. The provider must request an expedited hearing under this subsection not later than the 10th day after the date the provider receives notice from the department under Subsection (b). The department shall discontinue the hold unless the department makes a prima facie showing at the hearing that the evidence relied on by the department in imposing the hold is relevant, credible, and material to the issue of fraud or wilful misrepresentation.~~]

SECTION 6. Section 32.0291(d), Human Resources Code, is repealed.

SECTION 7. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for the implementation of that provision, the agency affected by the provision shall request the

waiver or authorization and may delay implementing that provision until the waiver or authorization is granted.

SECTION 8. This Act takes effect September 1, 2013.