By: Huffman S.B. No. 1803

A BILL TO BE ENTITLED

AN ACT

relating to the office of inspector general of the Health and Human Services Commission.

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 provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in 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 upon fraud hotline complaints, claims mining data, data analysis processes or patterns identified through provider audits, civil false claims cases, and 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) "Physician" includes an individual licensed to practice medicine in this state, a professional association composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code, or a partnership composed solely of physicians.

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

profession.

(9) [~~(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.

(10) [~~(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), and (n) to read as follows:

(f)(1) If the commission receives a complaint of Medicaid fraud or abuse from any source, the office must conduct a preliminary investigation [~~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 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.

(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 upon the determination that a credible allegation of fraud exists [~~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 subsection shall 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 of the hold; and

(B) a description of administrative and judicial due process remedies, including an informal review, 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 for an expedited administrative hearing regarding the hold. The provider must request an expedited 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 the administrative hearing, the state and the subject provider shall each be responsible for one-half of the costs charged by the State Office of Administrative Hearings, for one-half of the costs for transcribing the hearing, and for each

party's own additional costs related to the administrative hearing, including costs associated with discovery, depositions, subpoenas, services of process and witness expenses, preparation for the administrative hearing, investigation costs, travel expenses, investigation expenses, and all other costs, including attorney's fees, associated with the case. The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before a hearing, to advance security for the costs for which the provider is responsible under this subdivision.

(4) Following an 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.

(5) 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 initial 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). 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 from the provider, 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 initial informal resolution 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 from the provider, 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 second informal resolution meeting is to be held. A provider shall 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.

(6) [~~(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 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.

(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 before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(n) To the extent permitted under federal law, the office, acting through the commission, 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.

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. (a) The commission shall maintain a record of all allegations of fraud or abuse against a Medicaid provider containing the date the allegation of fraud or abuse was received or identified and the source of the allegation, if available. This record shall remain confidential under Sections 531.1021(g) and (h).

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

(c) A preliminary investigation shall consist of a review of all allegations, facts, and evidence by the commission's office of inspector general and must result in a preliminary investigation report documenting the allegations, evidence reviewed, if available, procedures utilized to conduct the preliminary investigation, findings of the preliminary investigation, and the office's determination of whether a full investigation is warranted before the allegation proceeds to a full investigation.

(d) If the Medicaid fraud control unit or other law enforcement agency accepts a fraud referral from the office for

investigation, a payment hold based upon a credible allegation of fraud may be continued until such time as that investigation and any associated enforcement proceedings are completed, or until the Medicaid fraud control unit, other law enforcement agency, or other prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(e) If the Medicaid fraud control unit or any other law enforcement agency declines to accept the fraud referral for investigation, a payment hold based upon a credible allegation of fraud must be discontinued unless the commission has alternative federal or state authority by which it may impose a payment hold or unless 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 or other law enforcement agency that any matter accepted 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 office shall post on its publicly available website a description in plain English of, and a video explaining, the processes and procedures that the office uses to determine whether to impose a payment hold on a provider under this subchapter.

Sec. 531.120. INFORMAL RESOLUTION OF PROPOSED OVERPAYMENTS. (a) The commission or the commission's office of inspector general must provide a provider with written notice of

intent to recover any proposed overpayment or debt amount and any related damages or penalties arising out of a fraud or abuse investigation. The notice shall include the specific basis for overpayment, a description of facts and supporting evidence, a representative sample of any documents that form the basis of the overpayment, extrapolation methodology, calculation of the overpayment amount, damages and penalties, if applicable, and a description of administrative and judicial due process remedies, including the provider's right to request informal resolution meetings under this section, a formal administrative appeal hearing, or both.

(b) A provider must request an initial informal resolution meeting under this section not later than the 30th day after the date the provider receives notice under Subsection (a). 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 from the provider, 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 initial informal resolution 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 from the provider, 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 second informal resolution meeting is to be held. A provider shall have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.

Sec. 531.1201. RECOUPMENT OF OVERPAYMENTS OR RECOUPMENT OF DEBT; APPEALS. (a) A provider must request an appeal under this section not later than the 15th day after the date the provider is notified that the commission or the commission's office of inspector general will seek to recover an overpayment or debt from the provider. On receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the Health and Human Services Commission appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office shall file the docketing request under this section not later than 60 days after the provider's request for an administrative hearing or not later than 60 days after the completion of the informal resolution process, if applicable. Unless otherwise determined by the administrative law judge at the administrative hearing under this subsection for good cause, the state and the subject provider shall each be responsible for one-half of the costs charged by the State

Office of Administrative Hearings, for one-half of the costs for transcribing the hearing, and for each party's own additional costs related to the administrative hearing, including costs associated with discovery, depositions, subpoenas, services of process and witness expenses, preparation for the administrative hearing, investigation costs, travel expenses, investigation expenses, and all other costs, including attorney's fees, associated with the case. The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before a hearing, to advance security for the costs for which the provider is responsible under this subsection.

(b) 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.

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)(5) and 531.120(b) 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. Section 32.0291, Human Resources Code, is amended to read as follows:

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

HOLDS. (a) Notwithstanding any other law, the department may:

(1) perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse; and

(2) as necessary to perform that review, withhold payment of the claim for not more than five working days without notice to the person submitting the claim.

(b) Notwithstanding any other law and subject to Section 531.102, Government Code, 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 payment [~~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.~~

[~~(d) The department shall adopt rules that allow a provider subject to a postpayment hold under Subsection (b) to seek an informal resolution of the issues identified by the department in the notice provided under that subsection. A provider must seek an informal resolution under this subsection not later than the deadline prescribed by Subsection (c). A provider's decision to seek an informal resolution under this subsection does not extend the time by which the provider must request an expedited administrative hearing under Subsection (c). However, a hearing initiated under Subsection (c) shall be stayed at the department's request until the informal resolution process is completed~~].

SECTION 5. 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 6. This Act takes effect September 1, 2013.