By: Delisi, et al. H.B. No. 1743

A BILL TO BE ENTITLED

AN ACT

relating to prevention of fraud and abuse under the medical assistance program; creating an offense.

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

SECTION 1. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0291 to read as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND 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, the department may impose a 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.

SECTION 2. Section 32.032, Human Resources Code, is amended to read as follows:

Sec. 32.032. PREVENTION AND DETECTION OF FRAUD AND ABUSE.

The department shall adopt reasonable rules for minimizing the opportunity for fraud and abuse, for establishing and maintaining methods for detecting and identifying situations in which a question of fraud or abuse in the program may exist, and for referring cases where fraud or abuse appears to exist to the appropriate law enforcement agencies for prosecution.

SECTION 3. Section 32.0321(a), Human Resources Code, is amended to read as follows:

(a) The department by rule may require each provider of medical assistance in a provider type that has demonstrated significant potential for fraud or abuse to file with the department a surety bond in a reasonable amount. The department by rule shall require a provider of medical assistance to file with the department a surety bond in a reasonable amount if the department identifies a pattern of suspected fraud or abuse involving criminal conduct relating to the provider's services under the medical assistance program that indicates the need for protection against potential future acts of fraud or abuse.

SECTION 4. Section 32.039(a), Human Resources Code, is amended by adding Subdivision (1-a) to read as follows:

(1-a) "Inducement" includes a service, cash in any amount, entertainment, or any item of value.

SECTION 5. Section 32.039, Human Resources Code, is amended by amending Subsections (b), (u), and (v) and adding Subsections (w) and (x) to read as follows:

(b) A person commits a violation if the person:

(1) presents or causes to be presented to the

department a claim that contains a statement or representation the person knows or should know to be false;

(1-a) engages in conduct that violates Section 102.001, Occupations Code;

(1-b) solicits or receives, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind for referring an individual to a person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the medical assistance program, provided that this subdivision does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;

(1-c) solicits or receives, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind for purchasing, leasing, or ordering, or arranging for or recommending the purchasing, leasing, or ordering of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program;

(1-d) offers or pays, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to refer an individual to another person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the medical assistance program, provided

that this subdivision does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;

(1-e) offers or pays, directly or indirectly, overtly or covertly any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to purchase, lease, or order, or arrange for or recommend the purchase, lease, or order of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program;

(1-f) provides or offers an inducement in a manner or for a purpose not otherwise prohibited by this section or Section 102.001, Occupations Code, to an individual, including a recipient, provider, or employee of a provider, for the purpose of influencing a decision regarding selection of a provider or receipt of a good or service under the medical assistance program or for the purpose of otherwise influencing a decision regarding the use of goods or services provided under the medical assistance program; or

(2) is a managed care organization that contracts with the department to provide or arrange to provide health care benefits or services to individuals eligible for medical assistance and:

(A) fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract with the department;

(B) fails to provide to the department information required to be provided by law, department rule, or

contractual provision;

(C) engages in a fraudulent activity in connection with the enrollment in the organization's managed care plan of an individual eligible for medical assistance or in connection with marketing the organization's services to an individual eligible for medical assistance; or

(D) engages in actions that indicate a pattern of:

(i) wrongful denial of payment for a health care benefit or service that the organization is required to provide under the contract with the department; or

(ii) wrongful delay of at least 45 days or a longer period specified in the contract with the department, not to exceed 60 days, in making payment for a health care benefit or service that the organization is required to provide under the contract with the department.

(u) Except as provided by Subsection (w), a [~~A~~] person found liable for a violation under Subsection (c) that resulted in injury to an elderly person, as defined by Section 48.002(a)(1) [~~48.002(1)~~], a disabled person, as defined by Section 48.002(a)(8)(A) [~~48.002(8)(A)~~], or a person younger than 18 years of age may not provide or arrange to provide health care services under the medical assistance program for a period of 10 years. The department by rule may provide for a period of ineligibility longer than 10 years. The period of ineligibility begins on the date on which the determination that the person is liable becomes final. [~~This subsection does not apply to a person who operates a nursing~~

~~facility or an ICF-MR facility.~~]

(v) Except as provided by Subsection (w), a [~~A~~] person found liable for a violation under Subsection (c) that did not result in injury to an elderly person, as defined by Section 48.002(a)(1) [~~48.002(1)~~], a disabled person, as defined by Section 48.002(a)(8)(A) [~~48.002(8)(A)~~], or a person younger than 18 years of age may not provide or arrange to provide health care services under the medical assistance program for a period of three years. The department by rule may provide for a period of ineligibility longer than three years. The period of ineligibility begins on the date on which the determination that the person is liable becomes final[~~. This subsection does not apply to a person who operates a nursing facility or an ICF-MR facility~~].

(w) The department by rule may prescribe criteria under which a person described by Subsection (u) or (v) is not prohibited from providing or arranging to provide health care services under the medical assistance program. The criteria may include consideration of:

(1) the person's knowledge of the violation;

(2) the likelihood that education provided to the person would be sufficient to prevent future violations;

(3) the potential impact on availability of services in the community served by the person; and

(4) any other reasonable factor identified by the department.

(x) Subsections (b)(1-b) through (1-f) do not prohibit a person from engaging in:

(1) generally accepted business practices, as determined by department rule, including:

(A) conducting a marketing campaign;

(B) providing token items of minimal value that advertise the person's trade name; and

(C) providing complimentary refreshments at an informational meeting promoting the person's goods or services;

(2) the provision of a value-added service if the person is a managed care organization; or

(3) other conduct specifically authorized by law.

SECTION 6. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.0391 to read as follows:

Sec. 32.0391. CRIMINAL OFFENSE. (a) A person commits an offense if the person commits a violation under Section 32.039(b)(1-b), (1-c), (1-d), or (1-e).

(b) An offense under this section is a state jail felony.

(c) If conduct constituting an offense under this section also constitutes an offense under another provision of law, including a provision in the Penal Code, the person may be prosecuted under either this section or the other provision.

(d) With the consent of the appropriate local county or district attorney, the attorney general has concurrent jurisdiction with that consenting local prosecutor to prosecute an offense under this section.

SECTION 7. Subchapter B, Chapter 32, Human Resources Code, is amended by adding Section 32.060 to read as follows:

Sec. 32.060. THIRD-PARTY BILLING VENDORS. (a) A

third-party billing vendor may not submit a claim with the department for reimbursement on behalf of a provider of medical services under the medical assistance program unless the vendor has entered into a contract with the department authorizing that activity.

(b) To the extent practical, the contract shall contain provisions comparable to the provisions contained in contracts between the department and providers of medical services, with an emphasis on provisions designed to prevent fraud or abuse under the medical assistance program. At a minimum, the contract must require the third-party billing vendor to:

(1) provide documentation of the vendor's authority to bill on behalf of each provider for whom the vendor submits claims;

(2) submit a claim in a manner that permits the department to identify and verify the vendor, any computer or telephone line used in submitting the claim, any relevant user password used in submitting the claim, and any provider number referenced in the claim; and

(3) subject to any confidentiality requirements imposed by federal law, provide the department, the office of the attorney general, or authorized representatives with:

(A) access to any records maintained by the vendor, including original records and records maintained by the vendor on behalf of a provider, relevant to an audit or investigation of the vendor's services or another function of the department or office of attorney general relating to the vendor; and

(B) if requested, copies of any records described by Paragraph (A) at no charge to the department, the office of the attorney general, or authorized representatives.

(c) On receipt of a claim submitted by a third-party billing vendor, the department shall send a remittance notice directly to the provider referenced in the claim. The notice must:

(1) include detailed information regarding the claim submitted on behalf of the provider; and

(2) require the provider to review the claim for accuracy and notify the department promptly regarding any errors.

(d) The department shall take all action necessary, including any modifications of the department's claims processing system, to enable the department to identify and verify a third-party billing vendor submitting a claim for reimbursement under the medical assistance program, including identification and verification of any computer or telephone line used in submitting the claim, any relevant user password used in submitting the claim, and any provider number referenced in the claim.

SECTION 8. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1011 to read as follows:

Sec. 531.1011. DEFINITIONS. For purposes of this subchapter:

(1) "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.

(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.

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

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

(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.

(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 9. Section 531.102, Government Code, is amended by amending Subsections (a) and (d) and adding Subsections (f) and (g) to read as follows:

(a) The commission, through the commission's office of

investigations and enforcement, is responsible for the investigation of fraud and abuse in the provision of health and human services and the enforcement of state law relating to the provision of those services.

(d) The commission may require employees of health and human services agencies to provide assistance to the commission in connection with the commission's duties relating to the investigation of fraud and abuse in the provision of health and human services.

(f)(1) If the commission receives a complaint of Medicaid fraud or abuse from any source, it must conduct an integrity review to determine whether there is sufficient basis to warrant a full investigation. An integrity review must commence not later than 60 days after the commission receives a complaint or has reason to believe that fraud or abuse has occurred. An integrity review shall be completed not later than 90 days after it has commenced.

(2) If the findings of an integrity review give the commission reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, the commission must take the following action, as appropriate, not later than 30 days after the completion of the integrity review:

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the commission must refer the case to the state's Medicaid fraud control unit, provided that such criminal referral does not preclude the commission 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 commission may conduct a full investigation of the suspected fraud.

(g)(1) In addition to other instances authorized under state or federal law, the commission shall impose without prior notice a hold on payment of claims for reimbursement submitted by a provider to compel production of records or when requested by the state's Medicaid fraud control unit, as applicable. The commission must notify the provider of the hold on payment not later than the fifth working day after the date the payment hold is imposed.

(2) The commission shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which holds on payment or program exclusions:

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

(B) shall automatically be imposed on a provider.

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

SECTION 10. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1021 to read as follows:

Sec. 531.1021. SEIZURE OF ASSETS. (a) The commission,

through the commission's office of investigations and enforcement, may seize assets owned by a person if:

(1) the commission determines through an investigation that there is a substantial likelihood that the person has engaged in conduct that constitutes fraud or abuse under the medical assistance program; and

(2) the seizure of assets is necessary to protect the commission's ability to recover amounts wrongfully obtained by the person and associated damages and penalties to which the commission may otherwise be entitled by law.

(b) The commission shall provide a person whose assets are seized with an opportunity for a hearing at which the person may contest the seizure.

(c) The commission may not dispose of seized assets until:

(1) the person is determined to have engaged in conduct that constitutes fraud or abuse under the medical assistance program; and

(2) the commission's entitlement to the assets is confirmed in accordance with due process.

SECTION 11. Section 531.103(f), Government Code, is amended to read as follows:

(f) A [~~The~~] district attorney, county attorney, city attorney, or private collection agency may collect and retain costs associated with a [~~the~~] case referred to the attorney or agency and 20 percent of the amount of the penalty, restitution, or other reimbursement payment collected.

SECTION 12. Section 531.104, Government Code, is amended by

adding Subsection (c) to read as follows:

(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.

SECTION 13. Section 531.107(b), Government Code, is amended to read as follows:

(b) The task force is composed of a representative of the:

(1) attorney general's office, appointed by the attorney general;

(2) comptroller's office, appointed by the comptroller;

(3) Department of Public Safety, appointed by the public safety director;

(4) state auditor's office, appointed by the state auditor;

(5) commission, appointed by the commissioner of health and human services;

(6) Texas Department of Human Services, appointed by the commissioner of human services; [~~and~~]

(7) Texas Department of Insurance, appointed by the commissioner of insurance; and

(8) Texas Department of Health, appointed by the commissioner of public health.

SECTION 14. Section 31.03, Penal Code, is amended by adding Subsection (j) to read as follows:

(j) With the consent of the appropriate local county or district attorney, the attorney general has concurrent jurisdiction with that consenting local prosecutor to prosecute an offense under this section that involves the state Medicaid program.

SECTION 15. Section 32.45, Penal Code, is amended by adding Subsection (d) to read as follows:

(d) With the consent of the appropriate local county or district attorney, the attorney general has concurrent jurisdiction with that consenting local prosecutor to prosecute an offense under this section that involves the state Medicaid program.

SECTION 16. Section 32.46, Penal Code, is amended by adding Subsection (e) to read as follows:

(e) With the consent of the appropriate local county or district attorney, the attorney general has concurrent jurisdiction with that consenting local prosecutor to prosecute an offense under this section that involves the state Medicaid program.

SECTION 17. Section 37.10, Penal Code, is amended by adding Subsection (i) to read as follows:

(i) With the consent of the appropriate local county or district attorney, the attorney general has concurrent jurisdiction with that consenting local prosecutor to prosecute an offense under this section that involves the state Medicaid program.

SECTION 18. (a) The Medicaid and Public Assistance Fraud

Oversight Task Force, with the participation of the Texas Department of Health's Bureau of Vital Statistics and other agencies designated by the comptroller, shall study procedures and documentation requirements used by the state in confirming a person's identity for purposes of establishing entitlement to Medicaid and other benefits provided through health and human services programs.

(b) Not later than December 1, 2004, the Medicaid and Public Assistance Fraud Oversight Task Force, with assistance from the agencies participating in the study required by Subsection (a) of this section, shall submit a report to the legislature containing recommendations for improvements in the procedures and documentation requirements described by Subsection (a) of this section that would strengthen the state's ability to prevent fraud and abuse in the Medicaid program and other health and human services programs.

SECTION 19. Not later than December 1, 2003, the Office of the Attorney General and the Health and Human Services Commission shall amend the memorandum of understanding required by Section 531.104, Government Code, as necessary to comply with Section 531.104(c), Government Code, as added by this Act.

SECTION 20. The changes in law made by this Act through amending Section 32.039(b), Human Resources Code, and adding Section 32.0391, Human Resources Code, apply only to a violation committed on or after the effective date of this Act. For purposes of this section, a violation is committed on or after the effective date of this Act only if each element of the violation occurs on or

after that date. A violation committed before the effective date of this Act is covered by the law in effect when the violation was committed, and the former law is continued in effect for that purpose.

SECTION 21. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for 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 22. Section 531.103(e), Government Code, is repealed.

SECTION 23. (a) Except as otherwise provided by Subsection (b) of this section, this Act takes effect September 1, 2003.

(b) Section 32.060, Human Resources Code, as added by this Act, takes effect January 1, 2004.