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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 an irregularity 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;

(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 made be made, in whole or in part, under the medical assistance program;

(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; or

(2) 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.

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. 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) Notwithstanding any other law, for purposes of obtaining information relevant to the office's duties from a law enforcement agency, prosecutor, or governmental entity, the office is considered to be a law enforcement agency and may obtain the information in the same manner as another law enforcement agency. Information obtained by the office under this subsection that deals with the detection, investigation, or prosecution of crime is excepted from the requirements of Section 552.021 in the manner provided by Section 552.108.

(g) In connection with the investigation of fraud and abuse in the provision of health and human services, the office may issue

a subpoena throughout this state to compel the attendance and testimony of a witness or production of records. The subpoena may compel attendance or production at the office or at another place designated in the subpoena.

SECTION 9. 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 10. Section 531.103, Government Code, is amended by

adding Subsections (c-1) and (e-1) and amending Subsection (e) to read as follows:

(c-1) In addition to the report required by Subsection (c), the office of the attorney general, not later than November 1 of each year, shall prepare and submit to the governor, the legislature, and the comptroller a report that specifically addresses the activities of the attorney general's Medicaid fraud control unit and civil Medicaid fraud section. The attorney general shall consult with the comptroller regarding the format of the report and make reasonable efforts to provide the report in the format requested by the comptroller. The report must specify, for the Medicaid fraud control unit and the civil Medicaid fraud section, respectively, the following information:

(1) total agency expenditures;

(2) caseloads;

(3) the length of time required to complete each case through each phase of activity;

(4) recoveries and penalties arising from each case;

(5) difficulties in operations; and

(6) any other information considered relevant by the attorney general to an analysis of the effectiveness of the unit and section.

(e) The commission shall refer a case of suspected fraud, waste, or abuse under the state Medicaid program to the appropriate United States attorney, district attorney, county attorney, city attorney, or private collection agency if the attorney general fails to act within 30 days of referral of the case to the office of

the attorney general. A failure by the attorney general to act within 30 days constitutes approval by the attorney general under Section 2107.003.

(e-1) In addition to the provisions required by Subsection (a), the memorandum of understanding required by this section must identify circumstances under which the commission may refer a case of suspected fraud, waste, or abuse under the state Medicaid program directly to the appropriate United States attorney, district attorney, county attorney, city attorney, or private collection agency. A case referred in accordance with this subsection is considered approved by the attorney general under Section 2107.003.

SECTION 11. 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 12. (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 13. 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 531.103, Government Code, as necessary to comply with Section 531.103(e-1), Government Code, as added by this Act.

SECTION 14. 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 15. 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 16. (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.