BILL ANALYSIS

S.B. 1542
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Public Health
Committee Report (Unamended)

BACKGROUND AND PURPOSE

State and federal law allows the Texas Health and Human Services Commission office of inspector general to conduct random prepayment reviews of Medicaid claims submitted by physicians or health care providers suspected of fraud, waste, and abuse. The prepayment review mechanisms are considered by program integrity officials to be a useful tool in deterring and detecting wasteful or fraudulent claims. Yet, the law does not specify what types of events trigger the reviews nor does the agency have rules that articulate how and when a prepayment review is conducted.

The prepayment review process is costly and burdensome to physicians and providers. When placed on review, the physician or provider is required to drop all claims to paper and submit copies of the medical record associated with each claim. Physicians and providers often do not know why the prepayment review is being conducted, do not know what steps need to be taken to ameliorate the billing problems that triggered the review, and are unable to request an appeal if a claim is denied while on prepayment review.

The Medicaid billing system is complicated and replete with rules not necessarily consistent with those of Medicare or commercial insurance carriers. As such, billing mistakes will certainly be made, most of which are unintended errors rather than intentional fraud. When mistakes are made, physicians and providers should be required to correct them and make restitution. At the same time, if the Medicaid program is to retain and attract a sufficient network of providers, those providers must trust that when billing errors are made they will be informed in timely way of those errors, allowed to correct them, and afforded due process to appeal a decision by the agency that may have been made in error.

S.B. 1542 requires the executive commissioner of the Health and Human Services Commission to adopt rules governing the use of prepayment reviews and strengthens due process and notice provisions associated with payment holds. S.B. 1542 also requires the office of inspector general and the office of attorney general to develop and implement joint written procedures regarding the chain of custody for medical records taken in fraud or abuse investigations. The bill also ensures due process for physicians and providers accused of Medicaid fraud or abuse, aiding the state's efforts to recruit more physicians and providers to participate in the program.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to executive commissioner of the Health and Human Services Commission in SECTIONS 1, 3, and 4 of this bill.

ANALYSIS

Section 531.0055, Government Code, as amended by Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, expressly grants to the executive commissioner of the Health and Human Services Commission (HHSC) all rulemaking authority for the operation of and

provision of services by the health and human services agencies. Similarly, Sections 1.16-1.29, Chapter 198 (H.B. 2292), Acts of the 78th Legislature, Regular Session, 2003, provide for the transfer of a power, duty, function, program, or activity from a health and human services agency abolished by that act to the corresponding legacy agency. To the extent practicable, this bill analysis is written to reflect any transfer of rulemaking authority and to update references as necessary to an agency's authority with respect to a particular health and human services program.

S.B. 1542 amends the Government Code to require the claims criteria adopted by the executive commissioner for cases of suspected fraud, abuse, or overcharges in the provision of health and human services to be consistent with the criteria adopted under provisions regarding prepayment reviews and postpayment holds. The bill requires a notice from HHSC's office of inspector general of a hold on payment of the claims reimbursement of a provider to include prescribed information regarding the payment hold. The bill requires that a provider subject to a hold on payment who submits a timely request for an expedited administrative hearing regarding the hold be given notice of the date, time, and location of the hearing and a list of the provider's rights not later than the 30th day before the date the hearing is scheduled.

S.B. 1542 provides for the automatic termination of a hold on the 60th day after the date of a timely hearing request if a hearing is not scheduled on or before the 60th day after the date of the request, and authorizes the hold to be reinstated only if prima facie evidence of fraud, waste, or abuse is presented subsequently at the hearing. The bill authorizes a hold to continue after a hearing, if the hearing is held on or before the 60th day after the date of a timely request, only if the hearing officer determines that such prima facie evidence was presented. The bill excludes the period in which a hearing is stayed in conjunction with a request for an informal resolution from computing whether a hearing was scheduled or held not later than the 60th day after the hearing request. The bill provides for the automatic termination of a hold on the 60th day after the date of a timely informal resolution request if the resolution is not completed on or before the 60th day after the date of the request, and authorizes the hold to be reinstated only if prima facie evidence of fraud, waste, or abuse is presented subsequently at the hearing. The bill authorizes a hold to continue after the completion of an informal resolution, if the resolution is completed on or before the 60th day after the date of a timely request, only if the office determines that such prima facie evidence was presented during the resolution process.

S.B. 1542 requires the executive commissioner to adopt rules for the office of inspector general, rather than requiring the office to establish guidelines, under which holds on payment or program exclusions may permissively or shall automatically be imposed on a provider. The bill requires the office, if a payment hold is terminated, either automatically or after a hearing or informal review, in accordance with provisions of the bill, to inform all affected claims payors, including Medicaid managed care organizations, of the termination not later than the fifth day after the date of the termination. The bill entitles a provider in a case in which a payment hold was imposed, who ultimately prevails in a hearing or, if the case is appealed, on appeal, or with respect to whom the office determines that prima facie evidence of fraud, waste, or abuse was not presented during an informal resolution process, to prompt payment of all payments held and interest on those payments at a rate equal to the prime rate, as published in the Wall Street Journal on the first day of each calendar year that is not a Saturday, Sunday, or legal holiday, plus one percent.

S.B. 1542 includes in the requirements of the memorandum of understanding between HHSC and the office of the attorney general that HHSC's office of inspector general and the office of the attorney general develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, which must include procedures for maintaining a chain of custody for any records obtained during an investigation and for maintaining the confidentiality of the records; a procedure by which a provider who is the subject of an investigation may make copies of any records taken from the provider during the course of the investigation before the records are taken or, in lieu of the opportunity to make copies, a requirement that the office of

inspector general or the office of the attorney general, as applicable, make copies of the records taken and provide those copies not later than the 10th day after the date the records are taken; and a procedure for returning any original records obtained from a provider who is the subject of a case of suspected fraud, waste, or abuse not later than the 15th day after the final resolution of the case, including all hearings and appeals. The bill provides that an exchange of information between the office of the attorney general and HHSC for these purposes does not affect the confidentiality of the information.

S.B. 1542 amends the Human Resources Code to require the executive commissioner to adopt rules, not later than November 1, 2009, governing the conduct of a prepayment review of a claim for reimbursement from a Medicaid provider and establishes certain requirements for the rules. The bill prohibits HHSC from performing a random prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse. The bill authorizes HHSC to only perform a prepayment review of the claims of a provider who meets the criteria adopted by the executive commissioner for imposition of a prepayment review. The bill removes provisions regarding the requirements and procedures relating to expedited administrative hearings and informal resolutions concerning a postpayment hold.

S.B. 1542 requires a state agency that is affected by a provision of the bill to request a federal waiver or authorization if the agency determines that a waiver or authorization is necessary for the implementation of the provision, and authorizes the agency to delay implementation until the federal waiver or authorization is granted.

EFFECTIVE DATE

September 1, 2009.