

By: Truitt

H.B. No. 2938

A BILL TO BE ENTITLED

AN ACT

1
2 relating to the conduct of investigations, prepayment reviews, and
3 payment holds in cases of suspected fraud, waste, or abuse in the
4 provision of health and human services.

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

6 SECTION 1. Sections 531.102(e) and (g), Government Code,
7 are amended to read as follows:

8 (e) The executive commissioner [~~commissioner~~], in
9 consultation with the inspector general, by rule shall set specific
10 claims criteria that, when met, require the office to begin an
11 investigation. The claims criteria adopted under this subsection
12 must be consistent with the criteria adopted under Section
13 32.0291(a-1), Human Resources Code.

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

21 (2) In addition to other instances authorized under
22 state or federal law, the office shall impose without prior notice a
23 hold on payment of claims for reimbursement submitted by a provider
24 to compel production of records or when requested by the state's

1 Medicaid fraud control unit, as applicable. The office must notify
2 the provider of the hold on payment not later than the fifth working
3 day after the date the payment hold is imposed. The notice to the
4 provider must include:

5 (A) an information statement indicating the
6 nature of a payment hold;

7 (B) a statement of the reason the payment hold is
8 being imposed, the provider's suspected violation, and the evidence
9 to support that suspicion; and

10 (C) a statement that the provider is entitled to
11 request a hearing regarding the payment hold or an informal
12 resolution of the identified issues, the time within which the
13 request must be made, and the procedures and requirements for
14 making the request, including that a request for a hearing must be
15 in writing.

16 (3) On timely written request by a provider subject to
17 a hold on payment under Subdivision (2), other than a hold requested
18 by the state's Medicaid fraud control unit, the office shall file a
19 request with the State Office of Administrative Hearings for an
20 expedited administrative hearing regarding the hold. The provider
21 must request an expedited hearing under this subdivision not later
22 than the 10th day after the date the provider receives notice from
23 the office under Subdivision (2). A provider who submits a timely
24 request for a hearing under this subdivision must be given notice of
25 the following not later than the 30th day before the date the
26 hearing is scheduled:

27 (A) the date, time, and location of the hearing;

1 and

2 (B) a list of the provider's rights at the
3 hearing, including the right to present witnesses and other
4 evidence.

5 (3-a) With respect to a provider who timely requests a
6 hearing under Subdivision (3):

7 (A) if the hearing is not scheduled on or before
8 the 60th day after the date of the request, the payment hold is
9 automatically terminated on the 60th day after the date of the
10 request and may be reinstated only if prima facie evidence of fraud,
11 waste, or abuse is presented subsequently at the hearing; and

12 (B) if the hearing is held on or before the 60th
13 day after the date of the request, the payment hold may be continued
14 after the hearing only if the hearing officer determines that prima
15 facie evidence of fraud, waste, or abuse was presented at the
16 hearing.

17 (4) The commission shall adopt rules that allow a
18 provider subject to a hold on payment under Subdivision (2), other
19 than a hold requested by the state's Medicaid fraud control unit, to
20 seek an informal resolution of the issues identified by the office
21 in the notice provided under that subdivision. A provider must seek
22 an informal resolution under this subdivision not later than the
23 deadline prescribed by Subdivision (3). A provider's decision to
24 seek an informal resolution under this subdivision does not extend
25 the time by which the provider must request an expedited
26 administrative hearing under Subdivision (3). However, a hearing
27 initiated under Subdivision (3) shall be stayed at the office's

1 request until the informal resolution process is completed. The
2 period during which the hearing is stayed under this subdivision is
3 excluded in computing whether a hearing was scheduled or held not
4 later than the 60th day after the hearing was requested for purposes
5 of Subdivision (3-a).

6 (4-a) With respect to a provider who timely requests an
7 informal resolution under Subdivision (4):

8 (A) if the informal resolution is not completed
9 on or before the 60th day after the date of the request, the payment
10 hold is automatically terminated on the 60th day after the date of
11 the request and may be reinstated only if prima facie evidence of
12 fraud, waste, or abuse is subsequently presented at a hearing
13 requested and held under Subdivision (3); and

14 (B) if the informal resolution is completed on or
15 before the 60th day after the date of the request, the payment hold
16 may be continued after the completion of the informal resolution
17 only if the office determines that prima facie evidence of fraud,
18 waste, or abuse was presented during the informal resolution
19 process.

20 (5) The executive commissioner [~~office~~] shall, in
21 consultation with the state's Medicaid fraud control unit, adopt
22 rules for the office [~~establish guidelines~~] under which holds on
23 payment or program exclusions:

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

25 (B) shall automatically be imposed on a provider.

26 (6) If a payment hold is terminated, either
27 automatically or after a hearing or informal review, in accordance

1 with Subdivision (3-a) or (4-a), the office shall inform all
2 affected claims payors, including Medicaid managed care
3 organizations, of the termination not later than the fifth day
4 after the date of the termination.

5 (7) A provider in a case in which a payment hold was
6 imposed under this subsection who ultimately prevails in a hearing
7 or, if the case is appealed, on appeal, or with respect to whom the
8 office determines that prima facie evidence of fraud, waste, or
9 abuse was not presented during an informal resolution process, is
10 entitled to prompt payment of all payments held and interest on
11 those payments at a rate equal to the prime rate, as published in
12 The Wall Street Journal on the first day of each calendar year that
13 is not a Saturday, Sunday, or legal holiday, plus one percent.

14 SECTION 2. Sections 531.103(a) and (b), Government Code,
15 are amended to read as follows:

16 (a) The commission, acting through the commission's office
17 of inspector general, and the office of the attorney general shall
18 enter into a memorandum of understanding to develop and implement
19 joint written procedures for processing cases of suspected fraud,
20 waste, or abuse, as those terms are defined by state or federal law,
21 or other violations of state or federal law under the state Medicaid
22 program or other program administered by the commission or a health
23 and human services agency, including the financial assistance
24 program under Chapter 31, Human Resources Code, a nutritional
25 assistance program under Chapter 33, Human Resources Code, and the
26 child health plan program. The memorandum of understanding shall
27 require:

1 (1) the office of inspector general and the office of
2 the attorney general to set priorities and guidelines for referring
3 cases to appropriate state agencies for investigation,
4 prosecution, or other disposition to enhance deterrence of fraud,
5 waste, abuse, or other violations of state or federal law,
6 including a violation of Chapter 102, Occupations Code, in the
7 programs and maximize the imposition of penalties, the recovery of
8 money, and the successful prosecution of cases;

9 (1-a) the office of inspector general to refer each
10 case of suspected provider fraud, waste, or abuse to the office of
11 the attorney general not later than the 20th business day after the
12 date the office of inspector general determines that the existence
13 of fraud, waste, or abuse is reasonably indicated;

14 (1-b) the office of the attorney general to take
15 appropriate action in response to each case referred to the
16 attorney general, which action may include direct initiation of
17 prosecution, with the consent of the appropriate local district or
18 county attorney, direct initiation of civil litigation, referral to
19 an appropriate United States attorney, a district attorney, or a
20 county attorney, or referral to a collections agency for initiation
21 of civil litigation or other appropriate action;

22 (2) the office of inspector general to keep detailed
23 records for cases processed by that office or the office of the
24 attorney general, including information on the total number of
25 cases processed and, for each case:

26 (A) the agency and division to which the case is
27 referred for investigation;

1 (B) the date on which the case is referred; and

2 (C) the nature of the suspected fraud, waste, or
3 abuse;

4 (3) the office of inspector general to notify each
5 appropriate division of the office of the attorney general of each
6 case referred by the office of inspector general;

7 (4) the office of the attorney general to ensure that
8 information relating to each case investigated by that office is
9 available to each division of the office with responsibility for
10 investigating suspected fraud, waste, or abuse;

11 (5) the office of the attorney general to notify the
12 office of inspector general of each case the attorney general
13 declines to prosecute or prosecutes unsuccessfully;

14 (6) representatives of the office of inspector general
15 and of the office of the attorney general to meet not less than
16 quarterly to share case information and determine the appropriate
17 agency and division to investigate each case; ~~and~~

18 (7) the office of inspector general and the office of
19 the attorney general to submit information requested by the
20 comptroller about each resolved case for the comptroller's use in
21 improving fraud detection; and

22 (8) the office of inspector general and the office of
23 the attorney general to develop and implement joint written
24 procedures for processing cases of suspected fraud, waste, or
25 abuse, which must include:

26 (A) procedures for maintaining a chain of custody
27 for any records obtained during an investigation and for

1 maintaining the confidentiality of the records;

2 (B) a procedure by which a provider who is the
3 subject of an investigation may make copies of any records taken
4 from the provider during the course of the investigation before the
5 records are taken or, in lieu of the opportunity to make copies, a
6 requirement that the office of inspector general or the office of
7 the attorney general, as applicable, make copies of the records
8 taken during the course of the investigation and provide those
9 copies to the provider not later than the 10th day after the date
10 the records are taken; and

11 (C) a procedure for returning any original
12 records obtained from a provider who is the subject of a case of
13 suspected fraud, waste, or abuse not later than the 15th day after
14 the final resolution of the case, including all hearings and
15 appeals.

16 (b) An exchange of information under this section between
17 the office of the attorney general and the commission, the office of
18 inspector general, or a health and human services agency does not
19 affect the confidentiality of the information or whether the
20 information is subject to disclosure under Chapter 552.

21 SECTION 3. Section 32.0291, Human Resources Code, is
22 amended to read as follows:

23 Sec. 32.0291. PREPAYMENT REVIEWS AND POSTPAYMENT HOLDS.

24 (a) Notwithstanding any other law and subject to Subsections (a-1)
25 and (a-2), the department may:

26 (1) perform a prepayment review of a claim for
27 reimbursement under the medical assistance program to determine

1 whether the claim involves fraud or abuse; and

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

5 (a-1) The executive commissioner of the Health and Human
6 Services Commission shall adopt rules governing the conduct of a
7 prepayment review of a claim for reimbursement from a medical
8 assistance provider authorized by Subsection (a). The rules must:

9 (1) specify actions that must be taken by the
10 department, or an appropriate person with whom the department
11 contracts, to educate the provider and remedy irregular coding or
12 claims filing issues before conducting a prepayment review;

13 (2) outline the mechanism by which a specific provider
14 is identified for a prepayment review;

15 (3) define the criteria, consistent with the criteria
16 adopted under Section 531.102(e), Government Code, used to
17 determine whether a prepayment review will be imposed, including
18 the evidentiary threshold, such as prima facie evidence, that is
19 required before imposition of that review;

20 (4) prescribe the maximum number of days a provider
21 may be placed on prepayment review status;

22 (5) require periodic reevaluation of the necessity of
23 continuing a prepayment review after the review action is initially
24 imposed;

25 (6) establish procedures affording due process to a
26 provider placed on prepayment review status, including notice
27 requirements, an opportunity for a hearing, and an appeals process;

1 and

2 (7) provide opportunities for provider education
3 while providers are on prepayment review status.

4 (a-2) The department may not perform a random prepayment
5 review of a claim for reimbursement under the medical assistance
6 program to determine whether the claim involves fraud or abuse. The
7 department may only perform a prepayment review of the claims of a
8 provider who meets the criteria adopted under Subsection (a-1)(3)
9 for imposition of a prepayment review.

10 (b) Notwithstanding any other law and subject to Section
11 531.102(g), Government Code, the department may impose a
12 postpayment hold on payment of future claims submitted by a
13 provider if the department has reliable evidence that the provider
14 has committed fraud or wilful misrepresentation regarding a claim
15 for reimbursement under the medical assistance program. [~~The~~
16 ~~department must notify the provider of the postpayment hold not~~
17 ~~later than the fifth working day after the date the hold is~~
18 ~~imposed.~~]

19 (c) A postpayment hold authorized by this section is
20 governed by the requirements and procedures specified for payment
21 holds under Section 531.102, Government Code. [~~On timely written~~
22 ~~request by a provider subject to a postpayment hold under~~
23 ~~Subsection (b), the department shall file a request with the State~~
24 ~~Office of Administrative Hearings for an expedited administrative~~
25 ~~hearing regarding the hold. The provider must request an expedited~~
26 ~~hearing under this subsection not later than the 10th day after the~~
27 ~~date the provider receives notice from the department under~~

1 ~~Subsection (b). The department shall discontinue the hold unless~~
2 ~~the department makes a prima facie showing at the hearing that the~~
3 ~~evidence relied on by the department in imposing the hold is~~
4 ~~relevant, credible, and material to the issue of fraud or wilful~~
5 ~~misrepresentation.~~

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

17 SECTION 4. The executive commissioner of the Health and
18 Human Services Commission shall adopt the rules required by Section
19 32.0291(a-1), Human Resources Code, as added by this Act, not later
20 than November 1, 2009.

21 SECTION 5. If before implementing any provision of this Act
22 a state agency determines that a waiver or authorization from a
23 federal agency is necessary for implementation of that provision,
24 the agency affected by the provision shall request the waiver or
25 authorization and may delay implementing that provision until the
26 waiver or authorization is granted.

27 SECTION 6. This Act takes effect September 1, 2009.