By: Uresti S.B. No. 1542

A BILL TO BE ENTITLED

AN ACT

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

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

SECTION 1. Subsections (e) and (g), Section 531.102, Government Code, are amended to read as follows:

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

(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 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 office must notify the provider of the hold on payment not later than the fifth working day after the date the payment hold is imposed. The notice to the provider must include:

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

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

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

(3) On timely written request by a provider subject to a 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 10th day after the date the provider receives notice from the office under Subdivision (2). A provider who submits a timely request for a hearing under this subdivision must be given notice of the following not later than the 30th day before the date the hearing is scheduled:

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

and

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

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

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

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

(4) The commission shall adopt rules that allow a provider subject to a hold on payment under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to seek an informal resolution of the issues identified by the office in the notice provided under that subdivision. A provider must seek an informal resolution under this subdivision not later than the deadline prescribed by Subdivision (3). 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. The period during which the hearing is stayed under this subdivision is excluded in computing whether a hearing was scheduled or held not later than the 60th day after the hearing was requested for purposes of Subdivision (3-a).

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

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

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

(5) The executive commissioner [~~office~~] shall, in consultation with the state's Medicaid fraud control unit, adopt rules for the office [~~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.

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

with Subdivision (3-a) or (4-a), the office shall 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.

(7) A provider in a case in which a payment hold was imposed under this subsection 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, is entitled 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.

SECTION 2. Subsections (a) and (b), Section 531.103, Government Code, are amended to read as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

maintaining the confidentiality of the records;

(B) 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 during the course of the investigation and provide those copies to the provider not later than the 10th day after the date the records are taken; and

(C) 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.

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

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

Sec. 32.0291. PREPAYMENT REVIEWS AND POSTPAYMENT HOLDS. (a) Notwithstanding any other law and subject to Subsections (a-1) and (a-2), 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.

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

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

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

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

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

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

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

and

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

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

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

(c) A postpayment hold authorized by this section is governed by the requirements and procedures specified for payment holds under Section 531.102, Government Code [~~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 4. The executive commissioner of the Health and Human Services Commission shall adopt the rules required by Subsection (a-1), Section 32.0291, Human Resources Code, as added by this Act, not later than November 1, 2009.

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 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, 2009.