

By: Uresti

S.B. No. 1542

A BILL TO BE ENTITLED

1 AN ACT

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.