BILL ANALYSIS

Senate Research Center

S.B. 1435
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Health and Human Services Commission's Office of Inspector General (OIG) is responsible for the investigation of fraud in the Medicaid system. The OIG has a duty to detect, investigate and prevent fraud, abuse, overpayment, and waste in the Medicaid program and across the health and human services system. The OIG provides program oversight of health and human service activities, providers, and recipients and is also responsible for the enforcement of state law relating to the provision of Medicaid services and other health and human services programs. The OIG may impose sanctions upon a finding by the Inspector General of fraud and abuse in Medicaid.

Pursuant to the Patient Protection and Affordable Care Act of 2010, federal regulations require state Medicaid agencies to suspend Medicaid payments to a provider when there is a pending investigation of a "credible allegation of fraud" against the provider, unless the state determines there is good cause not to suspend such payments. If a state Medicaid agency makes a determination that a "credible allegation of fraud" exists, the state agency must refer the case to the OIG Medicaid Fraud Control Unit.

Concerns have been expressed from physicians, physician's groups, and other medical providers that there is not proper due process when the OIG suspects and accuses a provider of Medicaid fraud or abuse. There are also concerns with transparency and expediency in the investigative process.

S.B. 1435 defines "credible allegation of fraud" in compliance with federal government guidelines and clarifies the process for making a determination that a "credible allegation of fraud" exists to justify a hold on Medicaid payments. S.B. 1435 also provides due process procedures for providers who are the subject of a payment hold and/or a recoupment of potential overpayments.

As proposed, S.B. 1435 amends current law relating to providers' rights to due process under the Medicaid program.

RULEMAKING AUTHORITY

Rulemaking authority previously granted to executive commissioner of HHSC (executive commissioner) is modified in SECTION 2 (Section 531.102, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner in SECTION 3 (Section 531.119, Government Code) of this bill.

Rulemaking authority previously granted to the Health and Human Services Commission or an agency operating part of the medical assistance program, as appropriate, is rescinded in SECTION 4 (Section 32.0291, Human Resources Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.1011, Government Code, to define "abuse," "allegation of fraud or abuse," "anonymous allegation," "credible allegation of fraud," "physician," "physician

organization," "prima facie," and "verified by the state" for purposes of this subchapter. Makes nonsubstantive changes.

SECTION 2. Amends Section 531.102, Government Code, by amending Subsections (f) and (g), as follows:

(f)(1) Requires the Health and Human Service Commission's Office of Inspector General (OIG), if the Health and Human Services Commission (HHSC) receives an allegation, rather than complaint, of Medicaid fraud or abuse from any source, to conduct an integrity review in accordance with Section 531.118 to determine whether there is sufficient basis to warrant a full investigation. Deletes existing text requiring that an integrity review begin not later than the 30th day after the date HHSC receives a complaint or has reason to believe that fraud or abuse has occurred. Requires that an integrity review be completed not later than the 90th after it began.

(2) Makes no change to this subdivision.

(g)(1) Provides that certain criminal referral does not preclude OIG from continuing its investigation of the provider, which investigation is authorized to lead to the imposition of appropriate administrative or civil sanctions.

(2) Authorizes OIG, in addition to other instances authorized under state or federal law, to impose without prior notice a hold on payment of claims for reimbursement submitted by a provider to compel production of records, when requested by the state's Medicaid fraud control unit, or upon the determination that a credible allegation of fraud exists in accordance with Section 531.118, rather than requiring OIG, in addition to other instances authorized under state or federal law, to impose without prior notice a hold on payment of claims for reimbursement submitted by a provider to compel production of records, when requested by the state's Medicaid fraud control unit, or on receipt of reliable evidence that the circumstances giving rise to the hold on payment involve fraud or wilful misrepresentation under the state Medicaid program in accordance with 42 C.F.R. Section 455.23, as applicable.

(3) Requires OIG, 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 to compel production of records, to file a request with the State Office of Administrative Hearings (SOAH) for an expedited administrative hearing regarding the hold on payment.

(4) Requires OIG, on timely written request by a provider who is the subject of a hold on payment under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit to compel production of records, to provide the provider with a copy of OIG's preliminary report described under Subdivision 531.118(c)(3) and a calculation of any proposed recoupment amount and any associated damages or penalties.

(5) Authorizes a provider subject to a hold on payment, other than a hold requested by the state's Medicaid fraud control unit to compel records, following an administrative hearing under Subdivision (3), to appeal an order by SOAH by filing a petition for judicial review in a district court in Travis County.

(6) Redesignates existing Subdivision (4) as Subdivision (6). Requires the executive commissioner of HHSC (executive commissioner) to 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 compel records, to seek an informal resolution of the issues identified by OIG in the notice provided under that subdivision. Requires a provider to request, rather than to seek, an informal resolution under this subdivision not later than the deadline prescribed by Subdivision (3). Requires that a provider's decision to request, rather than to

seek, an informal resolution under this subdivision does not extend the time by which the provider is required to request an expedited administrative hearing under Subdivision (3).

(7) Redesignates existing Subdivision (5) as Subdivision (7). Makes no further change.

(8) Entitles a provider in a case in which a hold on payment was imposed under this subsection who ultimately prevails in a hearing or, if the case is appealed, on appeal, to prompt pay of all payments held pursuant to a hold on payment.

(9) Entitles a provider, subject to the availability of federal matching funds as provided by Section 32.002 (Construction of Chapter), Human Resources Code, who is entitled in accordance with Subdivision (8) to prompt payment of all payments held is also entitled to interest on such held 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 3. Amends Subchapter C, Chapter 531, Government Code, by adding Sections 531.118, 531.119, 531.120, and 531.1201, as follows:

Sec. 531.118. INTEGRITY REVIEWS OF ALLEGATIONS OF FRAUD OR ABUSE. (a) Prohibits HHSC from accepting anonymous allegations of fraud or abuse. Requires HHSC to maintain a record of all allegations of fraud or abuse containing information sufficient to independently verify the source of the allegation of fraud or abuse and the date the allegation of fraud or abuse was received or identified.

(b) Requires OIG, if HHSC receives an allegation of fraud or abuse from any source, to conduct an integrity review of each allegation of fraud or abuse to determine whether there is sufficient basis to warrant a full investigation. Requires that an integrity review begin no later than the 30th day after the date HHSC receives or identifies an allegation of fraud or abuse. Requires that an integrity review be completed not later than the 90th day after the date it began.

(c) Requires that an integrity review consist of a review of all allegations, facts, and evidence by OIG and must include:

(1) documentation of the source of the allegation of fraud or abuse;

(2) completion of a preliminary investigation by OIG of the allegation of fraud or abuse;

(3) preparation of a preliminary investigation report documenting the allegations, evidence reviewed, procedures utilized to conduct the preliminary investigation, and findings of the preliminary investigation, including any potential overpayment amount, potential damages or penalties, OIG's determination of whether a full investigation is warranted and, subject to Subdivision (4), whether a credible allegation of fraud exists; and

(4) if the subject of the allegation of fraud or abuse is a physician or a physician organization, a review and final written determination by an expert physician panel, in accordance with Section 531.120, as to whether a credible allegation of fraud exists. Requires OIG, notwithstanding Subdivision (3), to be bound by the expert physician panel's final written determination as to whether credible allegation of fraud exists.

(d) Provides that upon the completion of an integrity review, OIG:

(1) is prohibited from imposing a hold on payment unless OIG determines that a credible allegation of fraud exists.

(2) is authorized to impose a partial hold on payment on the subject provider not later than the 10th day after the date a determination that a credible allegation of fraud exists is made. Prohibits a partial hold on payment imposed under this subdivision from exceeding 50 percent of the reimbursement due a provider under the Medicaid program for items or services furnished by the subject provider. Requires OIG, notwithstanding Subdivision 531.102(f)(2), to refer the case to the state's Medicaid fraud control unit not later than the next business day after a partial hold on payment is imposed, provided that the referral of a credible allegation of fraud does not preclude OIG from continuing its investigation, which is authorized to lead to the imposition of appropriate administrative or civil sanctions.

(e) Prohibits the duration of a partial hold on payment imposed under Subdivision (d)(2) from exceeding 30 days after the date the partial payment hold is imposed.

(f) Requires that the partial hold on payment, if the state's Medicaid fraud control unit declines or fails to accept the referral of a credible allegation of fraud before the 30th day after the date of the referral, terminate upon the earlier of the date that the state's Medicaid fraud control unit declines to accept the referral, or the 30th day after the date the partial hold on payment was imposed.

(g) Authorizes the state's Medicaid fraud control unit, if the state's Medicaid fraud control unit accepts the referral of a credible allegation of fraud, to request:

(1) that the duration of a partial hold on payment be extended;

(2) that a partial hold on payment hold to the subject provider be increased or decreased; or

(3) that a hold on payment not be imposed.

(h) Requires that any hold on payment extended under Subdivision (g)(1) or imposed under Subdivision (g)(2) terminate upon the earlier of the following:

(1) the 180th day after the date the state's Medicaid fraud control unit's request to extend or impose a hold on payment pursuant to Subsection (g), unless, the state's Medicaid fraud control unit certifies in writing that its continuing investigation of the credible allegation of fraud warrants continuation of the hold on payment;

(2) the date the state's Medicaid fraud control unit discontinues its investigation of a credible allegation of fraud or fails to certify that continuation of a payment hold is warranted in accordance with Subsection (j);

(3) the date OIG or the state's Medicaid fraud control unit determines that there is insufficient evidence of fraud;

(4) the date an administrative law judge or judge of any court of competent jurisdiction orders OIG to lift the hold on payment in whole or in part; or

(5) the date the legal proceedings related to the alleged fraud are completed.

(i) Prohibits a continuation of a hold on payment pursuant to Subdivision (h)(1), subject to Subsection (j), from exceeding 90 days after the date the 180-day period expires.

(j) Requires OIG, on a quarterly basis, to request a certification from the state's Medicaid fraud control unit that any matter accepted on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the hold on payment is warranted.

Sec. 531.119. EXPERT PHYSICIAN REVIEW PANEL. (a) Requires the executive commissioner, in consultation with the Texas Medical Board, by rule to provide for an expert physician panel appointed by the executive commissioner to assist with integrity reviews in accordance with Subdivision 531.118(c)(4). Requires each member of the expert physician panel to be a physician actively engaged in the practice of medicine in this state. Requires each member of the expert physician panel to also be authorized to provide services under the Medicaid program. Requires that the rules adopted under this section include provisions governing:

(1) the composition of the panel;

(2) the qualifications for membership on the panel;

(3) length of time a member may serve on the panel;

(4) grounds for removal from the panel;

(5) the avoidance of conflicts of interest, including situations in which the subject physician and the panel member live or work in the same geographical area or are competitors; and

(6) the duties to be performed by the expert physician panel.

(b) Requires that the executive commissioner's rules governing duties performed by the expert physician panel to include provisions requiring that when a physician or a physician organization is the subject of an allegation of fraud or abuse the allegation is reviewed and a determination is made by an expert physician panel of physicians authorized to provide services under the Medicaid program that practice in the same or similar specialty as the subject physician or physician organization. Requires that the executive commissioner's rules governing appointment of panel members to act as expert physician reviewers include a requirement that OIG randomly select, to the extent permitted by Section 531.120(a) and the conflict of interest provisions adopted under this subsection, expert physician panel members to review an allegation of fraud or abuse.

Sec. 531.120. REVIEW BY EXPERT PHYSICIAN PANEL. (a) Requires that the allegation, if a physician or a physician organization is the subject of an allegation of fraud or abuse, be reviewed in accordance with this section by an expert physician panel created under Section 531.119 consisting of physicians who are authorized to provide services under the Medicaid program and practice in the same or similar specialty as the physician or physician organization that is the subject of the allegation of fraud or abuse.

(b) Requires a physician on the expert physician panel who is selected to review an allegation of fraud or abuse pursuant to Subdivision 531.118(c)(4) to review OIG's preliminary investigation report, including the medical records relevant to the report; make a preliminary determination as to a credible allegation of fraud exists; and issue a written preliminary determination of such finding.

(c) Requires a second expert physician reviewer to review the first expert physician's preliminary determination and other information associated with the

allegation of fraud or abuse. Requires the first expert physician, if the second expert physician agrees with the first expert physician's preliminary determination, to issue a final written determination.

(d) Requires a third expert physician reviewer, if the second expert physician does not agree with the first expert physician's preliminary determination, to review the preliminary determination and information associated with the allegation of fraud or abuse and decide between the determinations reached by the first two expert physicians. Requires that the final written determination be issued by the third expert physician or the expert physician with whom the third physician concurs.

(e) Authorizes the selected expert physician reviewers, in reviewing an allegation of fraud or abuse, to consult and communicate with each other about the allegation in formulating their opinions and determinations.

(f) Provides that this subchapter does not create a cause of action against a physician who serves on the expert physician panel created under Section 531.119. Provides that a physician participating on the expert physician panel is immune from administrative, civil, or criminal liability arising from the information reviewed or determinations made while acting as an expert physician reviewer under this section.

Sec. 531.1201. RECOUPMENT OF OVERPAYMENTS OR RECOUPMENT OF DEBT; APPEALS. (a) Requires OIG, on timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt, to provide the provider with a copy of OIG's preliminary report described under Subdivision 531.118(c)(3) and a calculation of the proposed recoupment amount and any associated damages or penalties.

(b) Requires OIG, on timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt, to file a request with SOAH for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties.

(c) Authorizes a provider who is the subject of a recoupment of overpayment or recoupment of debt, following an administrative hearing under Subsection (b), to appeal an order by SOAH by filing a petition for judicial review in a district court in Travis County.

SECTION 4. Amends Section 32.0291(b), Human Resources Code, as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND POSTPAYMENT HOLDS. (a) Authorizes HHSC or an agency operating part of the medical assistance program (department), as appropriate, notwithstanding any other law, to perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse, and 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) Authorizes the department, notwithstanding any other law and subject to Section 531.102, Government Code, to impose a postpayment hold on payment of future claims submitted by a provider upon the determination that a credible allegation of fraud exists in accordance with Section 531.118, Government Code.

Deletes existing text authorizing the department, notwithstanding any other law, to 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.

(c) Provides that a postpayment hold authorized by this section is governed by the requirements and procedures specified for a hold on payment under Section 531.102, Government Code, including the notice requirements pursuant to Subsection 531.102(f), Government Code.

Deletes existing Subchapter (c) requiring the department, on timely written request by a provider subject to a postpayment hold under Subsection (b), to file a request with SOAH for an expedited administrative hearing regarding the hold. Deletes existing text requiring the provider to 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). Deletes existing text requiring the department to 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.

Deletes existing Subsection (d) requiring the department to 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. Deletes exsting text requiring a provider to seek an informal resolution under this subsection not later than the deadline prescribed by Subsection (c). Deletes existing text providing that 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). Deletes existing text requiring a hearing initiated under Subsection (c) to be stayed at the department's request until the informal resolution process is completed.

SECTION 5. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 6. Effective date: September 1, 2013.