# BILL ANALYSIS

Senate Research Center

S.B. 1803
By: Huffman
Health & Human Services
7/26/2013
Enrolled

## AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 1803 amends current law relating to investigations of and payment holds relating to allegations of fraud or abuse and investigations of and hearings on overpayments and other amounts owed by providers in connection with the Medicaid program or other health and human services programs.

## RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (executive commission) and the State Office of Administrative Hearings, jointly, in SECTION 2 (Section 531.102, Government Code) and SECTION 3 (Section 531.1201, Government Code) of this bill.

Rulemaking authority previously granted to the Health and Human Services Commission (HHSC) is transferred to the executive commissioner in SECTION 2 (Section 531.102, Government Code) of this bill.

Rulemaking authority is expressly granted to the office of inspector general of HHSC, acting through HHSC, in SECTION 2 (Section 531.102, Government Code) of this bill.

Rulemaking authority previously granted to HHSC is rescinded in SECTION 6 (Section 32.0291, Human Resources Code) of this bill.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," "credible allegation of fraud," "payment hold" rather than "hold on payment," and "physician," and to make nonsubstantive changes.

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

> (f)(1) Requires the Office of Inspector General of the Texas Health and Human Services Commission (OIG) (HHSC), if HHSC receives a complaint or allegation of Medicaid fraud or abuse from any source, to conduct a preliminary investigation as provided by Section 531.118(c), rather than an integrity review, to determine whether there is a sufficient basis to warrant a full investigation. Requires that a preliminary investigation begin not later than the 30th day after the date HHSC receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. Requires that a preliminary investigation be completed not later than the 90th day after it began. Makes conforming changes.
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> (2) Requires OIG, if the findings of a preliminary investigation give OIG reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, to take the following action, as appropriate, not later than the 30th day after the completion of the preliminary investigation:

(A) Makes no change to this subdivision; or

(B) if there is reason to believe that a recipient has defrauded the Medicaid program, OIG is authorized to conduct a full investigation of the suspected fraud, subject to Section 531.118(c).

Makes conforming changes.

(g)(1) Makes no change to this subdivision.

(2) Requires OIG to impose, without prior notice, a payment hold on claims for reimbursement submitted by a provider to compel production of records, when requested by the state's Medicaid fraud control unit, or on the determination that a credible allegation of fraud exists, subject to Subsections (l) and (m), as applicable, rather than 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. Requires OIG to notify the provider of the payment hold in accordance with 42 C.F.R. Section 455.23(b). Requires that the notice of payment hold provided under this subdivision, in addition to the requirements of 42 C.F.R. Section 455.23(b), also include:

(A) the specific basis for the hold, including identification of the claims supporting the allegation at that point in the investigation and a representative sample of any documents that form the basis for the hold; and

(B) a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

Makes nonsubstantive changes.

(3) Requires OIG, on timely written request by a provider subject to a payment hold under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, to file a request with the State Office of Administrative Hearings (SOAH) for an expedited administrative hearing regarding the hold. Requires the provider to request an expedited administrative hearing under this subdivision not later than the 30th day, rather than the 10th day, after the date the provider receives notice from OIG under Subdivision (2). Requires the state and the provider, unless otherwise determined by the administrative law judge for good cause at an expedited administrative hearing, to each be responsible for:

(A) one-half of the costs charged by SOAH;

(B) one-half of the costs for transcribing the hearing;

(C) the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, depositions, and subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and

(D) all other costs associated with the hearing that are incurred by the party, including attorney's fees.

Makes a nonsubstantive change.

(4) Requires the executive commissioner of HHSC (executive commissioner) and SOAH to jointly adopt rules that require a provider, before an expedited

administrative hearing, to advance security for the costs for which the provider is responsible under that subdivision.

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

(6) Requires the executive commissioner, rather than HHSC, to adopt rules that allow a provider subject to a payment hold 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 OIG in the notice provided under that subdivision. Requires a provider to request, rather than seek, an initial informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3) for requesting an expedited administrative hearing. Requires OIG, on receipt of a timely request, to schedule an initial informal resolution meeting not later than the 60th day after the date OIG receives the request, but requires OIG to schedule the meeting on a later date, as determined by OIG, if requested by the provider. Requires OIG to give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the meeting is to be held. Authorizes a provider to request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. Requires OIG, on receipt of a timely request, to schedule a second informal resolution meeting not later than the 45th day after the date OIG receives the request, but requires OIG to schedule the meeting on a later date, as determined by OIG, if requested by the provider. Requires OIG to give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held. Requires a provider to have an opportunity to provide additional information before the second informal resolution meeting for consideration by OIG. Requires that a hearing initiated under Subdivision (3) be stayed, rather than be stayed at OIG's request, until the informal resolution process is completed. Makes a conforming change.

(7) Makes nonsubstantive changes.

(l) Requires OIG to employ a medical director who is a licensed physician under Subtitle B (Physicians), Title 3, Occupations Code, and the rules adopted under that subtitle by the Texas Medical Board, and who preferably has significant knowledge of the Medicaid program. Requires the medical director to ensure that any investigative findings based on medical necessity or the quality of care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before OIG imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(m) Requires OIG to employ a dental director who is a licensed dentist under Subtitle D (Dentistry), Title 3 (Health Professions), Occupations Code, and the rules adopted under that subtitle by the State Board of Dental Examiners, and who preferably has significant knowledge of the Medicaid program. Requires the dental director to ensure that any investigative findings based on the necessity of dental services or the quality of dental care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before OIG imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(n) Requires OIG, acting through HHSC, to adopt rules establishing the criteria for initiating a full scale fraud or abuse investigation, conducting the investigation, collecting evidence, accepting and approving a provider's request to post a surety bond to secure potential recoupments in lieu of a payment hold or other asset or payment guarantee, and establishing minimum training requirements for Medicaid provider fraud or abuse investigators to the extent permitted under federal law.

SECTION 3. Amends Subchapter C, Chapter 531, Government Code, by adding Sections 531.118, 531.119, 531.120, 531.1201, and 531.1202, as follows:

Sec. 531.118. PRELIMINARY INVESTIGATIONS OF ALLEGATIONS OF FRAUD OR ABUSE AND FRAUD REFERRALS. (a) Requires HHSC to maintain a record of all allegations of fraud or abuse against a provider containing the date each allegation was received or identified and the source of the allegation, if available. Provides that the record is confidential under Section 531.1021(g) (relating to providing that all information and materials subpoenaed or compiled by OIG in connection with an audit or investigation or by the office of attorney general in connection with a Medicaid investigation are confidential, and not subject to disclosure, discovery, subpoena, or other legal means of compulsion for their release) and is subject to Section 531.1021(h) (relating to authorizing a person receiving information under 531.1021(g) to disclose the information only in accordance with that subsection and in a manner that is consistent with the authorized purpose for which the person first received the information).

(b) Requires OIG, if HHSC receives an allegation of fraud or abuse against a provider from any source, to conduct a preliminary investigation of the allegation to determine whether there is a sufficient basis to warrant a full investigation. Requires that a preliminary investigation begin not later than the 30th day after the date HHSC receives or identifies an allegation of fraud or abuse.

(c) Requires OIG, in conducting a preliminary investigation, to review the allegations of fraud or abuse and all facts and evidence relating to the allegation and prepare a preliminary investigation report before authorizing the allegation of fraud or abuse to proceed to a full investigation. Requires that the preliminary investigation report document the allegation, the evidence reviewed, if available, the procedures used to conduct the preliminary investigation, the findings of the preliminary investigation, and OIG's determination of whether a full investigation is warranted.

(d) Authorizes a payment hold based on a credible allegation of fraud, if the state's Medicaid fraud control unit or any other law enforcement agency accepts a fraud referral from OIG for investigation, to be continued until that investigation and any associated enforcement proceedings are complete, or the state's Medicaid fraud control unit, another law enforcement agency, or other prosecuting authorities determine that there is insufficient evidence of fraud by the provider.

(e) Requires that a payment hold based on a credible allegation of fraud be discontinued unless HHSC has alternative federal or state authority under which authorizes it to impose a payment hold or OIG makes a fraud referral to another law enforcement agency if the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from OIG for investigation.

(f) Requires OIG, on a quarterly basis, to request a certification from the state's Medicaid fraud control unit and other law enforcement agencies as to whether each matter accepted by the unit or agency on the basis of a credible allegation of fraud referral continues to be under investigation and that the continuation of the payment hold is warranted.

Sec. 531.119. WEBSITE POSTING. Requires OIG to post on its publicly available website a description in plain English of, and a video explaining, the processes and procedures OIG uses to determine whether to impose a payment hold on a provider under this subchapter.

Sec. 531.120. NOTICE AND INFORMAL RESOLUTION OF PROPOSED RECOUPMENT OF OVERPAYMENT OR DEBT. (a) Requires HHSC or OIG to provide a provider with written notice of any proposed recoupment of an overpayment or debt and any damages or penalties relating to a proposed recoupment of an overpayment or debt arising out of a fraud or abuse investigation. Requires that the notice include:

(1) the specific basis for the overpayment or debt;

(2) a description of facts and supporting evidence;

(3) a representative sample of any documents that form the basis for the overpayment or debt;

(4) the extrapolation methodology;

(5) the calculation of the overpayment or debt amount;

(6) the amount of damages and penalties, if applicable; and

(7) a description of administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

(b) Requires a provider to request an initial informal resolution meeting under this section not later than the 30th day after the date the provider receives notice under Subsection (a). Requires OIG, on receipt of a timely request, to schedule an initial informal resolution meeting not later than the 60th day after the date OIG receives the request, but requires OIG to schedule the meeting on a later date, as determined by OIG if requested by the provider. Requires OIG to give notice to the provider of the time and place of the initial informal resolution meeting not later than the 30th day before the date the meeting is to be held. Authorizes a provider to request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. Requires OIG, on receipt of a timely request, to schedule a second informal resolution meeting not later than the 45th day after the date OIG receives the request, but requires OIG to schedule the meeting on a later date, as determined by OIG if requested by the provider. Requires OIG to give notice to the provider of the time and place of the second informal resolution meeting not later than the 20th day before the date the meeting is to be held. Requires a provider to have an opportunity to provide additional information before the second informal resolution meeting for consideration by OIG.

Sec. 531.1201. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) Requires a provider to request an appeal under this section not later than the 15th day after the date the provider is notified that HHSC or OIG will seek to recover an overpayment or debt from the provider. Requires OIG, on receipt of a timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation, to file a docketing request with SOAH or the HHSC appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. Requires OIG to file the docketing request under this section not later than the 60th day after the date of the provider's request for an administrative hearing or not later than the 60th day after the completion of the informal resolution process, if applicable.

(b) Requires the state and the provider, at any administrative hearing under this section before SOAH, unless otherwise determined by the administrative law judge for good cause, to each be responsible for:

(1) one-half of the costs charged by SOAH;

(2) one-half of the costs for transcribing the hearing;

(3) the party's own costs related to the hearing, including the costs associated with preparation for the hearing, discovery, depositions, and

subpoenas, service of process and witness expenses, travel expenses, and investigation expenses; and

(4) all other costs associated with the hearing that are incurred by the party, including attorney's fees.

(c) Requires the executive commissioner and SOAH to jointly adopt rules that require a provider, before an administrative hearing under this section before SOAH, to advance security for the costs for which the provider is responsible under Subsection (b).

(d) Authorizes a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation, following an administrative hearing under Subsection (a), to appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.

Sec. 531.1202. RECORD OF INFORMAL RESOLUTION MEETINGS. Requires HHSC to provide for an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) to be recorded at no expense to the provider who requested the meeting. Requires that the recording of an informal resolution meeting be made available to the provider who requested the meeting.

SECTION 4. Amends the heading to Section 32.0291, Human Resources Code, to read as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND PAYMENT HOLDS.

SECTION 5. Amends Sections 32.0291(b) and (c), Human Resources Code, as follows:

(b) Authorizes HHSC or an agency operating part of the medical assistance program (department), subject to Section 531.102 (Office of Inspector General), Government Code, and notwithstanding any other law, to impose a payment hold on future claims submitted by a provider.

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. Deletes existing text requiring the department to notify the provider of the postpayment hold not later than the fifth working day after the date the hold is imposed.

(c) Provides that a payment hold authorized by this section is governed by the requirements and procedures specified for a payment hold under Section 531.102, Government Code, including the notice requirements under Subsection (g) (relating to requiring OIG to refer a case to the state Medicaid fraud unit) of that section.

Deletes text of existing Subsection (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.

SECTION 6. Repealer: Section 32.0291(d) (relating to requiring HHSC or an agency operating part of the medical assistance program, as appropriate, to adopt rules that allow a provider subject to a postpayment hold to seek an informal resolution of the issues identified by HHSC or an agency operating part of the medical assistance program, as appropriate, within a certain period of time), Human Resources Code.

SECTION 7. Requires the House Committee on Public Health, the House Committee on Human Services, and the Senate Committee on Health and Human Services to periodically request and review information from HHSC and OIG to monitor the enforcement of and the protections provided by the changes in law made by this Act and to recommend additional changes in law to further the purposes of this Act. Requires the House Committee on Public Health and the House Committee on Human Services, in performing the duties required under this section, to perform the duties jointly and the Senate Committee on Health and Human Services to perform the duties independently.

SECTION 8. 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 9. Effective date: September 1, 2013.