BILL ANALYSIS

Senate Research Center

C.S.S.B. 1803
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Health & Human Services
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Committee Report (Substituted)

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 8, 83rd Legislature, Regular Session, 2013, enhances the state's ability to detect and prevent fraud, waste, and abuse in Medicaid and across the health and human services system. In light of this legislation, concerns have been expressed from physicians, physicians groups, and other medical providers throughout the state that there is not proper due process in place when the Health and Human Services Commission's Office of Inspector General (OIG) suspects and accuses a provider of Medicaid fraud or abuse. Concerns with the transparency in the process have also been raised as well as conflict of interest in Medicaid overpayment hearings.

The OIG imposes payment holds for various reasons, but recent concerns have arisen out of payment suspensions due to a credible allegation of fraud. This type of payment hold is required by the Patient Protection and Affordable Care Act and the federal regulations promulgated to enforce it (42 CFR §455.23). The OIG is required under federal law to suspend a provider's Medicaid payments when the OIG receives a credible allegation of fraud against the provider. If the OIG receives a credible allegation of fraud and does not place the provider on payment hold, the federal government will discontinue its matching funds, leaving the state fully liable for any additional Medicaid payments to that provider.

C.S.S.B. 1803 amends current law relating to the office of inspector general of the Health and Human Services Commission.

RULEMAKING AUTHORITY

Rulemaking authority previously granted to the Health and Human Services Commission (HHSC) is transferred to the executive director of HHSC 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Rulemaking authority previously granted to HHSC is rescinded in SECTION 4 (Section 32.0291, Human Resources Code) of this bill.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," "payment hold" rather than "hold on payment," and "physician;" to redefine "fraud;" and to make nonsubstantive changes.

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

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

(2) Authorizes, rather than requires, the office of inspector general of the Texas Health and Human Services Commission (OIG) (HHSC) 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, 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 that the notice of payment hold provided under this subsection, notwithstanding the requirements of 42 C.F.R. Section 455.23(b), also include:

(A) the specific basis for the hold, including, if available, identification of the claims supporting the allegation at that point in the investigation; and

(B) a description of administrative and judicial due process remedies, including an informal review, a formal administrative appeal hearing, or both.

(3) Requires the state and the subject provider, unless otherwise determined by the administrative law judge for good cause at the expedited administrative hearing regarding the hold, to each be responsible for one-half of the costs charged by the State Office of Administrative Hearings (SOAH), for one-half of the costs for transcribing the hearing and for each party's own additional costs associated with discovery, depositions, subpoenas, services of process and witness expenses, preparation for the administrative hearing, investigation costs, travel expenses, investigation expenses, and all other costs, including attorney's fees, associated with the case.

(4) Authorizes a provider subject to a hold on payment, 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 administrative hearing under Subdivision (3).

(5) Requires the executive commissioner of HHSC, rather than HHSC, 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 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 informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3). Requires OIG, on timely request, to schedule an informal resolution meeting not later than the 60th day after the date OIG receives the request from the provider, but authorizes OIG to schedule a meeting later if requested by the provider. Requires OIG to give notice to the provider of the time and place of the informal resolution meeting not later than the 30th day before the date the informal resolution meeting is held. Authorizes a provider to request a second informal resolution not later than 10 days after the date of the initial informal resolution meeting. Requires OIG, upon timely request, to schedule a second informal resolution meeting not later than the 45th day after the date OIG receives the request from the provider, but authorizes OIG to schedule a meeting later 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 second informal resolution meeting is held. Requires that a provider have an opportunity to provide additional information before the second 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.

(6) Redesignates existing Subdivision (5) as Subdivision (6) and makes no further 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. Requires the medical director to ensure that any investigative findings based on medical necessity or 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, 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.

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. (a) Requires HHSC to maintain a record of all allegations of fraud against a Medicaid provider containing the date the allegation of fraud was received or identified and the source of the allegation, if available. Requires that this record remain confidential under Sections 531.1021(g) (relating to all information and materials subpoenaed or compiled by OIG in connection with an audit or investigation or by OIG of the attorney general in connection with a Medicaid fraud investigation being confidential and not subject to disclosure, except that this information may be disclosed to the state auditor's office, law enforcement agencies, and other entities as permitted by other law) and (h) (relating to a person who receives information under Subsection (g) being authorized to disclose the information only in accordance with Subsection (g) 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 against a Medicaid provider from any source, to conduct an integrity review of each allegation of fraud to determine whether there is sufficient basis to warrant a full investigation. Requires that an integrity review begin not later than the 30th day after the date HHSC receives or identifies an allegation of fraud.

(c) Requires that an integrity review consist of a review of all allegations, facts and evidence by OIG and result in a preliminary investigation report documenting the allegations, evidence reviewed, if available, procedures utilized to conduct the preliminary investigation, findings of the preliminary investigation, and OIG's determination of whether a full investigation is warranted before the allegation proceeds to a full investigation.

(d) Authorizes that a payment hold based upon a credible allegation of fraud be continued until such time as that investigation and any associated enforcement proceedings are completed if the Medicaid fraud control unit or other law enforcement agency accepts a fraud referral from OIG for investigation.

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

(f) Requires OIG, on a quarterly basis, to request a certification from the state's Medicaid fraud control unit or other law enforcement agency 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 payment hold is warranted.

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

Sec. 531.120. INFORMAL RESOLUTION OF PROPOSED OVERPAYMENTS. (a) Requires HHSC or OIG to provide a provider with written notice of intent to recover any proposed overpayment or debt amount and any related damages or penalties arising out of a fraud or abuse investigation. Requires that the notice include the specific basis for overpayment, a description of facts and supporting evidence, if available, extrapolation methodology, the calculation of overpayment amount, damages and penalties, if applicable, and a description of administrative and judicial due process remedies, including an informal review, a formal administrative appeal hearing, or both.

(b) Requires a provider to request an informal resolution meeting under this subsection not later than the 15th day after the date the provider receives notice under Subsection (a). Requires OIG, upon receipt of a timely request, to schedule an informal resolution meeting not later than the 60th day after the date OIG receives the request from the provider, but authorizes OIG to schedule a hearing later if requested by the provider. Requires OIG to give notice to the provider of the time and place of the informal resolution meeting not later than the 30th day before the date the informal resolution meeting is held. Authorizes a provider to request a second informal resolution not later than ten days after the initial informal resolution meeting. Requires OIG, upon 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 from the provider, but authorizes OIG to schedule a meeting later 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 informal resolution meeting is held. Requires a provider to have an opportunity to provide additional information before the second resolution meeting for consideration by OIG.

Sec. 531.1201. RECOUPMENT OF OVERPAYMENTS OF RECOUPMENT OF DEBT; APPEALS. (a) Requires a provider to request an appeal under this section not later than the 15th day after the date the provider receives notice under Section 531.120(a). 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 60 days after the provider's request for an administrative hearing or not later than the 60 days after the completion of the informal resolution process, if applicable. Requires the state and the subject provider, unless otherwise determined by the administrative law judge at the administrative hearing under this subsection for good cause, to each be responsible for one-half of the costs charged by SOAH, for one-half of the costs for transcribing the hearing and for each party's own additional costs associated with discovery, depositions, subpoenas, services of process and witness expenses, preparation for the administrative hearing, investigation costs, travel expenses, investigation expenses, and all other costs, including attorney's fees, associated with the case.

(b) 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.

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

Sec. 32.0291. New heading: PREPAYMENT REVIEWS AND PAYMENT HOLDS. (a) Makes no change to this subsection.

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

hold on payment of future claims submitted by a provider. Makes a conforming change.

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 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. 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 existing 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 is required to 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.