By: Hinojosa S.B. No. 1435

A BILL TO BE ENTITLED

AN ACT

relating to providers' rights to due process under the Medicaid program.

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

SECTION 1. Section 531.1011, Government Code, is amended to read as follows:

Sec. 531.1011. DEFINITIONS. For purposes of this subchapter:

(1) "Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care, including beneficiary practices that result in unnecessary cost to the Medicaid program.

(2) "Allegation of fraud or abuse" means an allegation of Medicaid fraud or abuse received by the commission from any source, that has not been verified by the state, including an allegation based upon fraud hotline complaints, claims mining data, data analysis processes or patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

(3) "Anonymous allegation" means an allegation of fraud or abuse that lacks sufficient information to independently

verify the source of the allegation.

(4) "Credible allegation of fraud" means an allegation of fraud that has been verified by the state.

(5)[~~(1)~~] "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to that person or some other person, including any act that constitutes fraud under applicable federal or state law.

(6)[~~(2)~~] "Furnished" refers to items or services provided directly by, or under the direct supervision of, or ordered by a practitioner or other individual (either as an employee or in the individual's own capacity), a provider, or other supplier of services, excluding services ordered by one party but billed for and provided by or under the supervision of another.

(7)[~~(3)~~] "Hold on payment" means the temporary denial of reimbursement under the Medicaid program for items or services furnished by a specified provider.

(8) "Physician" means an individual licensed to practice medicine in this state.

(9) "Physician organization" means a professional association composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code, or a partnership composed solely of physicians.

(10)[~~(4)~~] "Practitioner" means a physician or other individual licensed under state law to practice the individual's

profession.

(11) "Prima facie" means sufficient to establish a fact or raise a presumption unless disproved.

(12)[~~(5)~~] "Program exclusion" means the suspension of a provider from being authorized under the Medicaid program to request reimbursement of items or services furnished by that specific provider.

(13)[~~(6)~~] "Provider" means a person, firm, partnership, corporation, agency, association, institution, or other entity that was or is approved by the commission to:

(A) provide medical assistance under contract or provider agreement with the commission; or

(B) provide third-party billing vendor services under a contract or provider agreement with the commission.

(14) "Verified by the state" means the office has conducted an integrity review in accordance with Section 531.118 and a determination has been made that prima facie evidence exists to support an allegation of fraud or abuse.

SECTION 2. Section 531.102, Government Code, is amended by amending subsections (f) and (g) to read as follows:

(f)(1) If the commission receives an allegation[~~complaint~~] of Medicaid fraud or abuse from any source, the office must conduct an integrity review in accordance with Section 531.118 to determine whether there is sufficient basis to warrant a full investigation[~~An integrity review must begin not later than the 30th day after the date the commission receives a complaint or has reason to believe that fraud or abuse has occurred. An integrity~~

~~review shall be completed not later than the 90th day after it began~~].

(2) If the findings of an integrity review give the office reason to believe that an incident of fraud or abuse involving possible criminal conduct has occurred in the Medicaid program, the office must take the following action, as appropriate, not later than the 30th day after the completion of the integrity review:

(A) if a provider is suspected of fraud or abuse involving criminal conduct, the office must refer the case to the state's Medicaid fraud control unit, provided that the 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; or

(B) if there is reason to believe that a recipient has defrauded the Medicaid program, the office may conduct a full investigation of the suspected fraud.

(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 <u>may</u> [~~shall~~] 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[~~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~~]. The office must notify the provider of the hold on payment in accordance with 42 C.F.R. Section 455.23(b).

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

(4) 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, the office shall provide the provider with a copy of the office'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) Following an administrative hearing under Subdivision (3), a provider subject to a hold on payment, other than

a hold requested by the state's Medicaid fraud control unit to compel records, may appeal an order by the State Office of Administrative Hearings by filing a petition for judicial review in a district court in Travis County.

(6) The executive commissioner 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 compel records, to seek an informal resolution of the issues identified by the office in the notice provided under that subdivision. A provider must request[~~seek~~] an informal resolution under this subdivision not later than the deadline prescribed by Subdivision (3). A provider's decision to request [~~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.

(7) The office shall, in consultation with the state's Medicaid fraud control unit, 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.

(8) 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, is entitled to prompt pay of all payments held pursuant to a hold on payment.

(9) Subject to the availability of federal matching

funds as provided by Section 32.002, Human Resources Code, a provider 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. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.118, 531.119, 531.120, and 531.1201.

Sec. 531.118. INTEGRITY REVIEWS OF ALLEGATIONS OF FRAUD OR ABUSE. (a) The commission may not accept anonymous allegations of fraud or abuse. The commission shall 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) If the commission receives an allegation of fraud or abuse from any source, the office must conduct an integrity review of each allegation of fraud or abuse to determine whether there is sufficient basis to warrant a full investigation. An integrity review must begin not later than the 30th day after the date the commission receives or identifies an allegation of fraud or abuse. An integrity review shall be completed not later than the 90th day after the date it began.

(c) An integrity review shall consist of a review of all allegations, facts, and evidence by the office and must include:

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

(2) completion of a preliminary investigation by the office 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, the office'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. Notwithstanding Subdivision (3), the office shall be bound by the expert physician panel's final written determination as to whether credible allegation of fraud exists.

(d) Upon the completion of an integrity review, the office of inspector general:

(1) may not impose a hold on payment unless the office determines that a credible allegation of fraud exists.

(2) may 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. A partial hold on payment imposed under this subdivision shall not exceed 50 percent of the reimbursement due a provider under the Medicaid program for items or services furnished by the subject provider. Notwithstanding Subdivision 531.102(f)(2), the office must 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 the office from continuing its investigation, which may lead to the imposition of appropriate administrative or civil sanctions.

(e) The duration of a partial hold on payment imposed under Subdivision (d)(2) shall not exceed 30 days after the date the partial payment hold is imposed.

(f) 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, the partial hold on payment shall terminate upon the earlier of:

(1) the date that the state's Medicaid fraud control unit declines to accept the referral; or

(2) the 30th day after the date the partial hold on payment was imposed.

(g) If the state's Medicaid fraud control unit accepts the referral of a credible allegation of fraud, the state's Medicaid fraud control unit may 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) Any hold on payment extended under Subdivision (g)(1) or imposed under Subdivision (g)(2) shall 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 the office 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 the office 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) Subject to Subsection (j), a continuation of a hold on payment pursuant to Subdivision (h)(1) shall not exceed 90 days after the date the 180-day period expires.

(j) On a quarterly basis, the office must 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) The executive commissioner, in consultation with the Texas Medical Board, by rule shall provide for an expert physician panel appointed by the executive commissioner to assist with integrity reviews in accordance with Subdivision 531.118(c)(4). Each member of the expert physician panel must be a physician actively engaged in the practice of medicine in this state. Each member of the expert physician panel must also be authorized to provide services under the Medicaid program. The rules adopted under this section must 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) The executive commissioner's rules governing duties performed by the expert physician panel must 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. The executive

commissioner's rules governing appointment of panel members to act as expert physician reviewers must include a requirement that the office 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) If a physician or a physician organization is the subject of an allegation of fraud or abuse, the allegation shall 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) 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) shall:

(1) review the office's preliminary investigation report, including the medical records relevant to the report;

(2) make a preliminary determination as to a credible allegation of fraud exists; and

(3) issue a written preliminary determination of such finding.

(c) A second expert physician reviewer shall review the first expert physician's preliminary determination and other information associated with the allegation of fraud or abuse. If

the second expert physician agrees with the first expert physician's preliminary determination, the first expert physician shall issue a final written determination.

(d) If the second expert physician does not agree with the first expert physician's preliminary determination, a third expert physician reviewer shall 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. The final written determination shall be issued by the third expert physician or the expert physician with whom the third physician concurs.

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

(f) This subchapter does not create a cause of action against a physician who serves on the expert physician panel created under Section 531.119. 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) On timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt, the office of inspector general shall provide the provider with a copy of the office'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) On timely written request by a provider who is the subject of a recoupment of overpayment or recoupment of debt, the office of inspector general shall file a request with the State Office of Administrative Hearings for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties.

(c) Following an administrative hearing under Subsection (b), a provider who is the subject of a recoupment of overpayment or recoupment of debt may appeal an order by the State Office of Administrative Hearings by filing a petition for judicial review in a district court in Travis County.

SECTION 4. Section 32.0291, Human Resources Code, is amended by amending subsection (b) to read as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND POSTPAYMENT HOLDS. (a) Notwithstanding any other law, 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.

(b) Notwithstanding any other law and subject to Section 531.102, Government Code, the department may 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[~~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) 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[~~(c) 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 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, 2013.