AN ACT

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.

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:

(A) a practice by a provider that is inconsistent with sound fiscal, business, or medical practices and that results in:

(i) an unnecessary cost to the Medicaid program; or

(ii) the reimbursement of services that are not medically necessary or that fail to meet professionally recognized standards for health care; or

(B) a practice by a recipient that results in an unnecessary cost to the Medicaid program.

(2) "Allegation of fraud" means an allegation of Medicaid fraud received by the commission from any source that has not been verified by the state, including an allegation based on:

(A) a fraud hotline complaint;

(B) claims data mining;

(C) data analysis processes; or

(D) a pattern identified through provider audits, civil false claims cases, or law enforcement investigations.

(3) "Credible allegation of fraud" means an allegation of fraud that has been verified by the state. An allegation is considered to be credible when the commission has:

(A) verified that the allegation has indicia of reliability; and

(B) reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(4) "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.

(5) [~~(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.

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

(7) "Physician" includes an individual licensed to practice medicine in this state, a professional association composed solely of physicians, a partnership composed solely of physicians, a single legal entity authorized to practice medicine owned by two or more physicians, and a nonprofit health corporation certified by the Texas Medical Board under Chapter 162, Occupations Code.

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

(9) [~~(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.

(10) [~~(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.

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

(f)(1) If the commission receives a complaint or allegation of Medicaid fraud or abuse from any source, the office must conduct a preliminary investigation as provided by Section 531.118(c) [~~an~~

~~integrity review~~] to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation [~~An integrity review~~] must begin not later than the 30th day after the date the commission receives a complaint or allegation or has reason to believe that fraud or abuse has occurred. A preliminary investigation [~~An integrity review~~] shall be completed not later than the 90th day after it began.

(2) If the findings of a preliminary investigation [~~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 preliminary investigation [~~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, subject to Section 531.118(c).

(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 shall impose without prior notice a payment 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 the determination that a credible allegation of fraud exists, subject to Subsections (l) and (m), as applicable [~~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 payment hold [~~on payment~~] in accordance with 42 C.F.R. Section 455.23(b). In addition to the requirements of 42 C.F.R. Section 455.23(b), the notice of payment hold provided under this subdivision must 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.

(3) On timely written request by a provider subject to

a payment hold [~~on payment~~] under Subdivision (2), other than a hold requested by the state's Medicaid fraud control unit, the office 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 administrative hearing under this subdivision not later than the 30th [~~10th~~] day after the date the provider receives notice from the office under Subdivision (2). Unless otherwise determined by the administrative law judge for good cause at an expedited administrative hearing, the state and the provider shall each be responsible for:

(A) one-half of the costs charged by the State Office of Administrative Hearings;

(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.

(4) The executive commissioner and the State Office of Administrative Hearings shall 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) Following an expedited administrative hearing under Subdivision (3), a provider subject to a payment hold, other

than a hold requested by the state's Medicaid fraud control unit, may appeal a final administrative order by filing a petition for judicial review in a district court in Travis County.

(6) The executive commissioner [~~commission~~] shall adopt rules that allow a provider subject to a [~~hold on~~] 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 the office in the notice provided under that subdivision. A provider must request [~~seek~~] an initial informal resolution meeting under this subdivision not later than the deadline prescribed by Subdivision (3) for requesting an expedited administrative hearing. On receipt of a timely request, the office shall schedule an initial informal resolution meeting not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall 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. A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office, if requested by the provider. The office shall 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. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office. A provider's decision to 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) [~~(5)~~] The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds [~~on payment~~] or program exclusions:

(A) may permissively be imposed on a provider; or

(B) shall automatically be imposed on a provider.

(l) The office shall employ a medical director who is a licensed physician under Subtitle B, 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. The medical director shall ensure that any investigative findings based on medical necessity or the quality of medical care have been reviewed by a qualified expert as described by the Texas Rules of Evidence before the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(m) The office shall employ a dental director who is a licensed dentist under Subtitle D, Title 3, 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. The dental director shall 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 the office imposes a payment hold or seeks recoupment of an overpayment, damages, or penalties.

(n) To the extent permitted under federal law, the office, acting through the commission, shall 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. Subchapter C, Chapter 531, Government Code, is amended by adding Sections 531.118, 531.119, 531.120, 531.1201, and 531.1202 to read as follows:

Sec. 531.118. PRELIMINARY INVESTIGATIONS OF ALLEGATIONS OF FRAUD OR ABUSE AND FRAUD REFERRALS. (a) The commission shall 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. The record is confidential under Section 531.1021(g) and is subject to Section 531.1021(h).

(b) If the commission receives an allegation of fraud or abuse against a provider from any source, the commission's office of inspector general shall conduct a preliminary investigation of

the allegation to determine whether there is a sufficient basis to warrant a full investigation. A preliminary investigation must begin not later than the 30th day after the date the commission receives or identifies an allegation of fraud or abuse.

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

(d) If the state's Medicaid fraud control unit or any other law enforcement agency accepts a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud may be continued until:

(1) that investigation and any associated enforcement proceedings are complete; or

(2) 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) If the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from the office for investigation, a payment hold based on a credible allegation of fraud must be discontinued unless the commission has

alternative federal or state authority under which it may impose a payment hold or the office makes a fraud referral to another law enforcement agency.

(f) On a quarterly basis, the office must 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. The commission's office of inspector general shall post on its publicly available website a description in plain English of, and a video explaining, the processes and procedures the office 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) The commission or the commission's office of inspector general shall 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. The notice must 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) A provider must 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). On receipt of a timely request, the office shall schedule an initial informal resolution meeting not later than the 60th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office if requested by the provider. The office shall 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. A provider may request a second informal resolution meeting not later than the 20th day after the date of the initial informal resolution meeting. On receipt of a timely request, the office shall schedule a second informal resolution meeting not later than the 45th day after the date the office receives the request, but the office shall schedule the meeting on a later date, as determined by the office if requested by the provider. The office shall 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. A provider must have an opportunity to provide additional information before the second informal resolution meeting for consideration by the office.

Sec. 531.1201. APPEAL OF DETERMINATION TO RECOUP OVERPAYMENT OR DEBT. (a) A provider must request an appeal under this section not later than the 15th day after the date the provider is notified that the commission or the commission's office of inspector general will seek to recover an overpayment or debt from the provider. 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, the office of inspector general shall file a docketing request with the State Office of Administrative Hearings or the Health and Human Services Commission appeals division, as requested by the provider, for an administrative hearing regarding the proposed recoupment amount and any associated damages or penalties. The office shall 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) Unless otherwise determined by the administrative law judge for good cause, at any administrative hearing under this section before the State Office of Administrative Hearings, the state and the provider shall each be responsible for:

(1) one-half of the costs charged by the State Office of Administrative Hearings;

(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) The executive commissioner and the State Office of Administrative Hearings shall jointly adopt rules that require a provider, before an administrative hearing under this section before the State Office of Administrative Hearings, to advance security for the costs for which the provider is responsible under Subsection (b).

(d) Following an administrative hearing under Subsection (a), a provider who is the subject of a recoupment of overpayment or recoupment of debt arising out of a fraud or abuse investigation may 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. The commission shall, at no expense to the provider who requested the meeting, provide for an informal resolution meeting held under Section 531.102(g)(6) or 531.120(b) to be recorded. The recording of an informal resolution meeting shall be made available to the provider who requested the meeting.

SECTION 4. The heading to Section 32.0291, Human Resources Code, is amended to read as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND PAYMENT [~~POSTPAYMENT~~] HOLDS.

SECTION 5. Subsections (b) and (c), Section 32.0291, Human Resources Code, are amended to read as follows:

(b) Subject to Section 531.102, Government Code, and notwithstanding [~~Notwithstanding~~] any other law, the department may impose a payment [~~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. The department must notify the provider of the postpayment hold not later than the fifth working day after the date the hold is imposed~~].

(c) 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) of that section. [~~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.~~]

SECTION 6. Subsection (d), Section 32.0291, Human Resources Code, is repealed.

SECTION 7. The House Committee on Public Health, the House

Committee on Human Services, and the Senate Committee on Health and Human Services shall periodically request and review information from the Health and Human Services Commission and the commission's office of inspector general 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. In performing the duties required under this section, the House Committee on Public Health and the House Committee on Human Services shall perform the duties jointly and the Senate Committee on Health and Human Services shall perform the duties independently.

SECTION 8. If before implementing any provision of this Act a state agency determines that a waiver or authorization from a federal agency is necessary for the 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 9. This Act takes effect September 1, 2013.

President of the Senate

Speaker of the House

I hereby certify that S.B. No. 1803 passed the Senate on April 9, 2013, by the following vote: Yeas 31, Nays 0; and that the Senate concurred in House amendments on May 21, 2013, by the following vote: Yeas 31, Nays 0.

Secretary of the Senate

I hereby certify that S.B. No. 1803 passed the House, with amendments, on May 17, 2013, by the following vote: Yeas 119, Nays 20, three present not voting.

Chief Clerk of the House

Approved:

Date

Governor