SUBJECT: OIG investigations of Medicaid provider fraud

COMMITTEE: Human Services — committee substitute recommended

VOTE: 7 ayes — Raymond, N. Gonzalez, Naishtat, Rose, Sanford, Scott Turner, Zerwas

2 nays — Fallon, Klick

SENATE VOTE: On final passage, April 9 — 31-0

WITNESSES: For — Robert Anderton; Hugo Berlanga, Texas Dentists for Medicaid Reform; Jose Cazares, Texas Dental Association, Texas Academy of General Dentistry; Everett Evans; John Holcomb, Texas Medical Association; Behzad Nazari, Texas Dentists for Medicaid Reform; Juan Villarreal, Harlingen Family Dentistry; Chuck Young, Texas Dentists for Medicaid Reform; (*Registered, but did not testify:* Jay Arnold, South Texas Dental; Susanne Elrod, Texas Council of Community Centers; Marina Hench, Texas Association for Home Care & Hospice; Fred Houston; Lorie Imken; Lee Johnson, Texas Council of Community Centers; Annie Mahoney, Texas Conservative Coalition; Tyler Rudd, Texas Academy of Pediatric Dentistry)

Against — None

On — Douglas Wilson, Health and Human Services Commission - Office of Inspector General; (*Registered, but did not testify:* Karen Nelson, Health and Human Services Commission - Office of Inspector General)

BACKGROUND: Government Code, sec. 531.102 identifies the Health and Human Services Commission's Office of Inspector General as being responsible for the investigation of fraud and abuse in the provision of health and human services, including allegations of fraud or abuse in the Medicaid system.

DIGEST: CSSB 1803 would specify procedures for Office of Inspector General (OIG) investigations of Medicaid fraud and abuse and the providers' appeals processes following determinations of credible allegations of fraud.

Definitions. CSSB 1803 would add the following definitions to Government Code, ch. 531, subch. C, governing Medicaid fraud and abuse:

- "abuse" would mean a provider practice inconsistent with sound business or medical practices that results in an unnecessary cost to the Medicaid program;
- an "allegation of fraud" would be an unverified allegation of Medicaid fraud from any source, including a fraud hotline, claims data analysis, provider audit, law enforcement investigation, and others;
- a "credible allegation of fraud" would be an allegation verified as reliable after careful review on a case-by-case basis of all allegations, facts, and evidence.

"Fraud" would continue to mean an intentional deception or misrepresentation that could knowingly result in an unauthorized benefit to that or another person.

Payment holds. CSSB 1803 would require that the OIG conduct a preliminary investigation of any allegation of fraud or abuse against a provider. Before proceeding to a full investigation, the OIG would prepare a preliminary investigation report documenting the allegation, evidence reviewed (if available), findings, and a determination of whether a full investigation was warranted. The OIG would refer to the Office of Attorney General's Medicaid fraud control unit cases involving a provider's suspected criminal conduct or the destruction, falsification, or withholding of any provider records.

The bill would require that the OIG impose a payment hold without prior notice on claims for Medicaid reimbursement on the determination that a credible allegation of fraud existed, when requested by the fraud control unit, or to compel a provider to produce records.

In cases of a referral from the OIG to the fraud control unit, the unit would be permitted to withhold payment from a provider until its investigation and any associated enforcement proceedings were complete, or the unit or other law enforcement or prosecuting authorities determined there was insufficient evidence of provider fraud. The OIG would be required to request on a quarterly basis the unit's or law enforcement agency's

certification that the credible allegation of fraud continued to be investigated and warranted a payment hold. Any payment hold would be discontinued if the unit declined to accept a referral.

CSSB 1803 would require that the OIG provide notification to a provider of a payment hold in accordance with federal regulations. The notice would include the specific basis for the hold, including the claims supporting the allegation at that point in the investigation, and a representative sample of documents that formed the basis of the hold. The notice also would describe the administrative and judicial due process remedies available to the provider.

The OIG would be required to employ a licensed physician medical director and a licensed dentist dental director, preferably with knowledge of the Medicaid program, to ensure any investigative findings had been reviewed by a qualified expert before the imposition of a payment hold. The OIG would be required to post on its website a description and video explaining the procedures used to determine whether to impose a payment hold.

The bill would require that the Health and Human Services Commission (HHSC) executive commissioner adopt rules for the OIG establishing criteria for initiating and conducting a full fraud or abuse investigation, training investigators, and determining when good causes existed to discontinue, partially discontinue, or not impose a payment hold. The bill would establish numerous criteria by which the OIG would determine good cause for these purposes.

Providers subject to payment holds would be permitted to seek informal resolution of issues identified in the notice of payment withholding according to parameters established by the bill, including in the presence of a neutral third party. At the same time, providers would have the option of seeking an expedited administrative hearing through HHSC's appeals division or the State Office of Administrative Hearings (SOAH). CSSB 1803 would provide criteria for dividing the costs of a hearing.

Following an administrative hearing, a provider subject to an OIG payment hold would be permitted to appeal the final administrative order by filing a petition for judicial review in a district court in Travis County.

Recoupments. CSSB 1803 would require that a provider receive notice of

any proposed recoupment of overpayments, debts, or penalties related to Medicaid fraud. Providers would be allowed to seek informal resolution of the dispute according to the bill's procedures. If the OIG made a final determination of its intent to recoup overpayment from the provider, the provider would receive notice.

The bill would specify that when recoupment was sought for less than $1 million in overpayment, the provider would have the option of seeking an administrative hearing with HHSC's appeals division or SOAH.

When recoupment was sought for $1 million or more, the provider could request an administrative hearing with SOAH or file a petition to appeal the final determination in a district court in Travis County. If a provider chose the administrative hearing, the provider would not be permitted to appeal in district court any administrative order regarding the recoupment.

If any state agency determined a waiver or federal authorization was necessary to implement any provision in the bill, the agency would be required to request the waiver or authorization and delay implementing that provision until it was granted.

CSSB 1803 would take effect September 1, 2013.

SUPPORTERS SAY:

CSSB 1803 would create transparency and improve due process rights in the OIG's Medicaid fraud investigations and enforcement activities.

The bill would protect providers from overzealous investigations by establishing clear and definitive timelines for the OIG's enforcement proceedings, resulting in a more predictable and shorter investigation process. CSSB 1803 also would require that notice be given to providers outlining the specific basis and supporting evidence for any payment hold or attempt to recoup an overpayment, as well as the administrative and judicial remedies available to the provider.

The bill clearly would define a credible allegation of fraud and require the OIG to review each allegation on a case-by-case basis using HHSC-developed criteria. Further, it would require a medical expert review of each allegation to ensure its validity. The bill also would establish clear appeal rights, making available to providers an informal resolution process, administrative hearing through SOAH or HHSC, or judicial review.

In the 10 years since the OIG was created, its investigations and enforcement activities against provider fraud and abuse have spiked disproportionately during the past two years. CSSB 1803 would offer providers a safeguard against losing their livelihoods over minor errors and encourage participation in the Medicaid program.

OPPONENTS SAY:

CSSB 1803 would limit the independence of the OIG by placing it under HHSC guidance and would substantially weaken it by placing numerous barriers in the way of its ability to efficiently investigate and stop Medicaid fraud.

Under the Patient Protection and Affordable Care Act, the federal government will not reimburse Medicaid claims made after a credible allegation of fraud is detected. By making it much more difficult to impose provider holds, the bill would risk costing the state millions of dollars in federal Medicaid payments.

Including the option for a new trial during the payment hold and recoupment appeals process would lengthen fraud cases by years and would allow bad actors to continue billing the Medicaid system. In the event they were found liable, the state would be required to reimburse the federal government for all Medicaid payments made during the appeals process.

NOTES:

The Legislative Budget Board estimates the bill would have a negative fiscal impact of $1.3 million in general revenue related funds during fiscal 2014-15.