BILL ANALYSIS

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S.B. 1542
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

State and federal laws allow the Texas Health and Human Services Commission Office of Inspector General to conduct random "prepayment reviews" of Medicaid claims submitted by physicians or health care providers who are suspected of fraud, waste, and abuse. The prepayment review mechanisms are considered by program integrity officials to be a useful tool in deterring and detecting wasteful or fraudulent claims. Yet, the law does not specify what types of events trigger the reviews nor does the agency have rules that articulate how and when prepayment review is conducted.

The prepayment review process is costly and burdensome to physicians and providers. When placed on review, the physician or provider is required to drop all claims to paper and submit copies of the medical record associated with each claim. Physicians and providers often do not know why the prepayment review is being conducted, do not know what steps need to be taken to ameliorate the billing problems that triggered the review, and are unable to request an appeal if a claim is denied while on prepayment review.

The Medicaid billing system is complicated and replete with rules not necessarily consistent with those of Medicare or commercial insurance carriers. As such, billing mistakes will certainly be made, most of which are unintended errors, rather than intentional fraud. When mistakes are made, physicians and providers should be required to correct them and make restitution. At the same time, if the Medicaid program is to retain and attract a sufficient network of providers, those providers must trust that when billing errors are made, they will be informed in timely way of those errors, allowed to correct them, and be afforded due process to appeal a decision by the agency that may have been made in error.

As proposed, S.B. 1542 requires the executive commissioner of the Health and Human Services Commission to adopt rules governing the use of prepayment reviews and strengthens due process and notice provisions associated with payment holds. S.B. 1542 also requires the Office of Inspector General and the Office of Attorney General to develop and implement joint written procedures regarding the chain of custody for medical records taken in fraud or abuse investigations. This bill also ensures due process for physicians and providers accused of Medicaid fraud or abuse, enabling the state in its efforts to recruit more physicians and providers to participate in the program.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission (HHSC) in SECTION 1 (Section 531.102, Government Code) and SECTION 3 (Section 32.0291, Human Resources Code), of this bill.

Rulemaking authority previously granted to HHSC is rescinded in SECTION 3 (Section 32.0291, Human Resources Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Sections 531.102(e) and (g), Government Code, as follows:

> (e) Requires the executive commissioner of the Health and Human Services Commission (executive commissioner), rather than the Health and Human Services Commission (HHSC), in consultation with the inspector general, by rule to set specific claims criteria

that, when met, require the Office of Inspector General (office) to begin an investigation. Requires that the claims criteria adopted under this subsection be consistent with the criteria adopted under Section 32.0291(a-1) (relating to the authorization of HHSC to perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether it involves fraud or abuse).

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

(2) Requires that the notice to the provider of medical assistance or third-party billing vendor services (provider) include an information statement indicating the nature of a payment hold; a statement of the reason the payment hold is being imposed, the provider's suspected violation, and the evidence to support that suspicion; and a statement that the provider is entitled to request a hearing regarding the payment hold or an informal resolution of the identified issues, the time within which the request is required to be made, and the procedures and requirements for making the request, including that a request for a hearing is required to be in writing.

(3) Requires a provider who submits a timely request for a hearing under this subdivision to be given notice of certain information not later than the 30th day before the date the hearing is scheduled.

(3-a) Provides that with respect to a provider who timely requests a hearing under Subdivision (3) if the hearing is not scheduled on or before the 60th day after the date of the request, the payment hold is automatically terminated on the 60th day after the date of the request and is authorized to be reinstated only if prima facie evidence of fraud, waste, or abuse is presented subsequently at the hearing; and if the hearing is held on or before the 60th day after the date of the request, the payment hold is authorized to be continued after the hearing only if the hearing officer determines that prima facie evidence of fraud, waste, or abuse was presented at the hearing.

(4) Provides that the period during which the hearing is stayed under this subdivision is excluded in computing whether a hearing was scheduled or held not later than the 60th day after the hearing was requested for purposes of Subdivision (3-a).

(4-a) Provides that with respect to a provider who timely requests an informal resolution under Subdivision (4) if the informal resolution is not completed on or before the 60th day after the date of the request, the payment hold is automatically terminated on the 60th day after the date of the request and is authorized to be reinstated only if prima facie evidence of fraud, waste, or abuse is subsequently presented at a hearing requested and held under Subdivision (3); and if the informal resolution is completed on or before the 60th day after the date of the request, the payment hold is authorized to be continued after the completion of the informal resolution only if the office determines that prima facie evidence of fraud, waste, or abuse was presented during the informal resolution process.

(5) Requires the executive commissioner, in consultation with the state's Medicaid fraud control unit, to adopt rules for the office, rather than requiring the office, in consultation with the state's Medical fraud control unit, to establish guidelines, under which holds on payment or program exclusions are authorized to permissively be imposed on a provider or are required to automatically be imposed on a provider.

(6) Requires the office, if a payment hold is terminated, either automatically or after a hearing or informal review, in accordance with Subdivision (3-a) or (4-a), to inform all affected claims payors, including Medicaid managed care organizations, of the termination not later than the fifth day after the date of the termination.

(7) Entitles a provider in a case in which a payment hold was imposed under this subsection who ultimately prevails in a hearing or, if the case is appealed, on appeal, or with respect to whom the office determines that prima facie evidence of fraud, waste, or abuse was not presented during an informal resolution process, to prompt payment of all payments held and interest on those 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 2. Amends Sections 531.103(a) and (b), Government Code, as follows:

(a) Requires the memorandum of understanding entered into by HHSC, acting through HHSC's office of inspector general, and the office of the attorney general (OAG), to require certain actions, including the office and OAG to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, which is required to include certain procedures.

(b) Provides that an exchange of information under this section between OAG and HHSC, the office, or a health and human services agency does not affect the confidentiality of the information or whether the information is subject to disclosure under Chapter 552 (Public Information).

SECTION 3. Amends Section 32.0291, Human Resources Code, as follows:

Sec. 32.0291. PREPAYMENT REVIEWS AND POSTPAYMENT HOLDS. (a) Authorizes HHSC, notwithstanding any other law and subject to Subsections (a-1) and (a-2), to perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse and 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.

(a-1) Requires the executive commissioner to adopt rules governing the conduct of a prepayment review of a claim for reimbursement from a medical assistance provider authorized by Subsection (a). Sets forth the requirements of the rules.

(a-2) Prohibits HHSC from performing a random prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse. Authorizes HHSC to only perform a prepayment review of the claims of a provider who meets the criteria adopted under Subsection (a-1)(3) (relating to the criteria adopted under Section 531.102(e) [relating to the criteria that requires the office to being an investigation], Government Code) imposition of a prepayment review.

(b) Authorizes HHSC, notwithstanding any other law and subject to Section 531.102(g) (relating to duties of office if it suspects fraud), Government Code, to impose a postpayment hold on payment of future claims submitted by a provider if HHSC 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 HHSC 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 postpayment hold authorized by this section is governed by the requirements and procedures specified for payment holds under Section 531.102, Government Code. Deletes existing text requiring HHSC, on timely written request by a provider subject to a postpayment hold under Subsection (b), to file a request with the State Office of Administrative Hearings 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 HHSC under Subsection (b). Deletes existing text requiring HHSC to discontinue the hold unless HHSC

makes a prima facie showing at the hearing that the evidence relied on by HHSC in imposing the hold is relevant, credible, and material to the issue of fraud or wilful misrepresentation. Deletes existing Subsection (b) requiring HHSC 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 HHSC 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 that a hearing initiated under Subsection (c), however, be stayed at HHSC's request until the informal resolution process is completed.

SECTION 4. Requires the executive commissioner to adopt the rules required by Section 32.0291(a-1), Human Resources Code, as added by this Act, not later than November 1, 2009.

SECTION 5. Requires an agency affected by provisions of this Act to request any necessary waiver or authorization from a federal agency and authorizes delay of implementation until such federal waivers or authorizations are obtained.

SECTION 6. Effective date: September 1, 2009.