BILL ANALYSIS

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S.B. 962
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 962 is a re-file of S.B. 1542, 81st Legislature, Regular Session, 2009, and has the exact same language as the engrossed version of S.B. 1542. In the 81st Legislature, S.B. 1542 passed out of the Senate Health and Human Services Committee by a vote of 9-0, and then passed the Senate unanimously on the local calendar. It also passed out of the House Public Health Committee by a vote of 7-0.

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 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 a 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.

S.B. 962 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. 962 also requires the Office of the Inspector General and the Office of the 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.

As proposed, S.B. 962 amends current law relating to the conduct of investigations, prepayment reviews, and payment holds in cases of suspected fraud, waste, or abuse in the provision of health and human services.

RULEMAKING AUTHORITY

Rulemaking authority previously granted to the Health and Human Services Commission (HHSC) is transferred to the executive commissioner of the Health and Human Services

Commission (executive commissioner) in SECTION 1 (Section 531.102, Government Code) of this bill.

Rulemaking authority previously granted to the office of inspector general is transferred to the executive commissioner in SECTION 1 (Section 531.102, Government Code) of this bill.

Rulemaking authority is expressly granted to the executive commissioner in 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 the 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), Human Resources Code.

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

(2) Sets forth a list of requirements that must be included in the notice notifying the provider of the hold on payment.

(3) Requires a provider who submits a timely request for a hearing under this subdivision to be given notice not later than the 30th day before the date the hearing is scheduled of the date, time, and location of the hearing; and a list of the provider's rights at the hearing, including the right to present witnesses and other evidence.

(3-a) Provides that with respect to a provider who timely requests a hearing under Subdivision (3):

(A) 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 may be reinstated only if prima facie evidence of fraud, waste, or abuse is presented subsequently at the hearing; and

(B) if the hearing is held on or before the 60th day after the date of the request, the payment hold may 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) Requires the executive commissioner, 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 the office in the notice provided under that subdivision. Provides that the period during which a 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):

(A) 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 may be reinstated only if prima facie evidence of fraud, waste, or abuse is presented subsequently at a hearing requested and held under Subdivision (3); and

(B) if the informal resolution is completed on or before the 60th day after the date of the request, the payment hold may 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 at the hearing. Makes a conforming change.

(5) Requires the executive commissioner, rather than the office, to, in consultation with the state's Medicaid fraud control unit, adopt rules for the office, rather than establish guidelines, under which holds on payment or program exclusions may permissively be imposed on a provider, or shall 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 HHSC, acting through HHSC's office, and the office of the attorney general (OAG) to enter into a memorandum of understanding to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, as those terms are defined by state or federal law, or other violations of state or federal law under the state Medicaid program or other program administered by HHSC or a health and human services agency, including the financial assistance program under Chapter 31 (Financial Assistance and Service Programs), Human Resources Code, a nutritional assistance program under Chapter 33 (Nutritional Assistance Programs), Human Resources Code, and the child health plan program. Requires that the memorandum of understanding require certain actions, including:

(8) the office and OAG to develop and implement joint written procedures for processing cases of suspected fraud, waste, or abuse, which must include:

(A) procedures for maintaining a chain of custody for any records obtained during an investigation and for maintaining the confidentiality of the records;

(B) a procedure by which a provider who is the subject of an investigation may make copies of any records taken from the provider during the course of the investigation before the records are taken or, in lieu of the opportunity to make copies, a requirement that the office or OAG, as applicable, make copies of the records taken during the course of the investigation and provide those copies to the provider not later than the 10th day after the date the records are taken; and

(C) a procedure for returning any original records obtained from a provider who is the subject of a case of suspected fraud, waste, or abuse not later than the 15th day after the final resolution of the case, including all hearings and appeals.

(b) Provides than 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 the 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 the Health and Human Services Commission (HHSC) or an agency operating part of the medical assistance program, 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). Requires that the rules:

(1) specify actions that must be taken by HHSC, or an appropriate person with whom HHSC contracts, to educate the provider and remedy irregular coding or claims filing issues before conducting a prepayment review;

(2) outline the mechanism by which a specific provider is identified for a prepayment review;

(3) define the criteria, consistent with criteria adopted under Section 531.102(e), Government Code, used to determine whether a prepayment review will be imposed, including the evidentiary threshold, such as prima facie evidence, that is required before imposition of that review;

(4) prescribe the maximum number of days a provider may be place on prepayment review status;

(5) require periodic reevaluation of the necessity of continuing a prepayment review after the review action is initially imposed;

(6) establish procedures affording due process to a provider placed on prepayment review status, including notice requirements, an opportunity for a hearing, and an appeals process; and

(7) provide opportunities for provider education while providers are on prepayment review status.

(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) for imposition of a prepayment review.

(b) Authorizes HHSC, notwithstanding any other law and subject to Section 531.102(g), 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 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 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 (d) 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 must request an expedited administrative hearing under Subsection (c). Deletes existing text requiring that, however, a hearing initiated under Subsection (c) 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, 2011.

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 delay of implementation until such a waiver or authorization is granted.

SECTION 6. Effective date: September 1, 2011.