BILL ANALYSIS

Senate Research Center

S.B. 1803
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Health & Human Services
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

S.B. 8, 83rd Legislature, Regular Session, 2013, enhances the state's ability to detect and prevent fraud, waste, and abuse in Medicaid and across the health and human services system. In light of this legislation, concerns have been expressed from physicians, physicians groups and other medical providers throughout the state that there is not proper due process in place when the Health and Human Services Commission's Office of Inspector General (OIG) suspects and accuses a provider of Medicaid fraud or abuse. Concerns with the transparency in the process have also been raised as well as conflict of interest in Medicaid overpayment hearings.

The OIG imposes payment holds for various reasons, but recent concerns have arisen out of payment suspensions due to a credible allegation of fraud. This type of payment hold is required by the Patient Protection and Affordable Care Act and the federal regulations promulgated to enforce it (42 CFR §455.23). The OIG is required under federal law to suspend a provider's Medicaid payments when the OIG receives a credible allegation of fraud against the provider. If the OIG receives a credible allegation of fraud and does not place the provider on payment hold, the federal government will discontinue its matching funds, leaving the state fully liable for any additional Medicaid payments to that provider.

S.B. 1803 takes numerous steps to improve due process, transparency, and the expediency of the OIG's process when a provider is accused of a credible allegation of fraud or Medicaid overpayment. In an effort to do this, S.B. 1803 includes a provision relating to the preliminary finding of fraud, defines "credible allegation of fraud," and provides steps for better transparency in the process by requiring the OIG to provide detailed information and material on its processes and findings both to providers and to the public.

As proposed, S.B. 1803 amends current law relating to the Office of the Inspector General.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the Texas Health and Human Services Commission in SECTION 2 (Section 531.102, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Section 531.1011, Government Code, notwithstanding any other law, as follows:

(1)-(6) Makes no changes to these subdivisions.

(7) Defines "appropriate regulatory agency" in this subchapter.

(8) Defines "credible allegation of fraud" in this subchapter.

(9) Defines "preliminary finding of fraud" in this subchapter.

SECTION 2. Amends Section 531.102, Government Code, by amending Subsection (f) and adding Subsections (f-1), (f-2), (f-3), and (j), notwithstanding any other law, as follows:

(f)(1) Requires the Texas Health and Human Services Commission's office of inspector general (HHSC) (office) to conduct an integrity review to determine whether there is sufficient evidence to warrant a preliminary finding of fraud, rather than sufficient basis to warrant a full investigation, if HHSC receives a complaint of Medicaid fraud or abuse from any source. Requires that an integrity review begin no later than the 30th day after the date HHSC receives a complaint, rather than the 30th day after the date HHSC receives a complaint or has reason to believe that fraud or abuse has occurred.

(2) Requires the office, if the findings of an integrity review give the office reason to believe that there is sufficient evidence to warrant a preliminary finding of fraud, to not later than the 30th day after the completion of the integrity review, notify the recipient that the office has made a preliminary determination of fraud with respect to that recipient.

Deletes existing text requiring the office, 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, to take the certain action, as appropriate, not later than the 30th day after the completion of the integrity review.

(3) Redesignates existing Paragraph (A) as Subdivision (3) and makes a nonsubstantive change.

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

(f-1) (a) Requires the office, if the office notifies a recipient that the office has made a preliminary finding of fraud with respect to that recipient under Section (f)(2), to, along with this notification, provide the recipient with:

(1) the specific facts that form the basis of the office's preliminary finding of fraud;

(2) a representative sample of any documents that form the basis of the office's preliminary finding of fraud; and

(3) a document, written in plain English, that describes the office's processes and procedures for determining when and how the office determines whether a preliminary finding of fraud or credible allegation of fraud exists.

(b) Provides that the recipient has thirty days after being notified that the office has made a preliminary finding of fraud with respect to that recipient to respond to the office. Authorizes the recipient's response to include any documentation or any other relevant evidence that the recipient believes would rebut or refute the office's preliminary finding of fraud.

(c) Requires the office, if requested by the recipient, to provide the recipient with an additional thirty days to respond under Subsection (b).

(f-2) (a) Requires the office, in addition to other instances authorized under state or federal law, to impose a hold on payment of claims for reimbursement submitted by the provider if, after reviewing the documentation and other relevant evidence submitted by a provider under section (f-1), the office determines that credible allegation of fraud exists.

(b) Requires the office, at any time after written request by a provider subject to a hold on payment under Subsection (a), to refer the hold, and any documentation or other relevant evidence the office has with respect to the hold to the appropriate regulatory agency.

(c) Requires the office to file a request with the State Office of Administrative Hearings (SOAH) for an expedited administrative hearing regarding the hold if the appropriate regulatory agency is SOAH.

(d) Requires the executive director of the appropriate regulatory agency, if the appropriate regulatory agency is not SOAH, to review the hold and any documentation and any other relevant evidence related to the hold. Requires the executive director of the appropriate regulatory agency to then recommend to the board of the appropriate regulatory agency whether, based on the executive director's review of the hold and the documentation and other relevant evidence submitted by the office, the hold should remain in place or be dissolved. Requires the board of the appropriate regulatory agency to take up and consider the executive director of the appropriate regulatory agency's recommendation under this section at its next board meeting. Authorizes a decision by the board of the appropriate regulatory agency to be appealed directly to a district court in Travis County under this subsection.

(f-3) Requires HHSC to adopt rules that allow a provider subject to a hold on payment under this section, 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. Authorizes a provider to seek an informal resolution under this subsection at any time.

(j) Requires the office to post on its publicly available website a description, in plain English, of the processes and procedures that the office uses to determine whether to impose a hold on a recipient under this section.

(f-4) Authorizes the inspector general, not withstanding any other provision in this section, after reviewing documentation or other relevant evidence regarding a provider, if it is determined by clear and convincing evidence that a credible allegation of fraud exists, to certify that finding. Prohibits the inspector general from delegating a certification under this subsection to any other employee in the Office of Inspector General.

SECTION 3. Amends Subchapter C, Chapter 531, Government Code, by adding Section 531.118, as follows:

Sec. 531.118. HEARINGS ON ACTIONS TAKEN BY OFFICE OF INSPECTOR GENERAL TO RECOVER CERTAIN OVERPAYMENTS UNDER MEDICAID PROGRAM. (a) Entitles a Medicaid provider, from whom the HHSC's office of inspector general (office) seeks to recover an overpayment made to the provider under the Medicaid program, to a hearing on a determination made or other action taken by the office to recover the overpayment. Requires the office, if there is an overpayment issue, to adhere to the following actions:

(b) Requires the office, if HHSC receives a complaint of Medicaid overpayment from any source, to conduct an integrity review to determine whether there is sufficient basis evidence that an overpayment has been made.

(c) Requires the office, if the office notifies a recipient that the office has made a finding of overpayment with respect to that recipient, to, along with this notification, provide the recipient with:

(1) the specific facts that form the basis of the office's preliminary finding of overpayment;

(2) a representative sample of any documents that form the basis of the office's finding of overpayment; and

(3) a document, written in plain English, that describes the office's processes and procedures for determining when and how the office determines whether an overpayment exists.

(d) Provides that if, after reviewing the documentation and other relevant evidence submitted by a provider, the office determines that an overpayment exists, then:

(1) Requires the appropriate regulatory agency as defined in Section 531.1011(7) is SOAH, to file a request with SOAH for an expedited administrative hearing regarding the overpayment, or:

(2) Provides that the appropriate regulatory agency as defined in Section 531.1011(7) is not SOAH, and requires the executive director of the appropriate regulatory agency (executive director) to review the overpayment and any documentation and any other relevant evidence related to the overpayment. Requires the executive director to then recommend to the board of the appropriate regulatory agency (board) whether, based on the executive director's review of the overpayment and the documentation and other relevant evidence submitted by the office, the overpayment should remain in place or be dissolved. Requires the board to take up and consider the executive director's recommendation under this section at its next board meeting. Authorizes a decision by the board of the appropriate regulatory agency to be appealed directly to a district court in Travis County under this subsection.

(3) Requires the office to post on its publicly available Internet website a description, in plain English, of the processes and procedures that the office uses to determine whether to impose a hold on a recipient under this section.

SECTION 4. Requires the appropriate regulatory agencies, no later than January 1, 2014, to adopt the rules necessary to implement the changes in law made by this Act. Requires these rules to include a standard process for all applicable hearings, including an opportunity for the provider to respond to any allegations.

SECTION 5. Provides that Chapters 2001 (Administrative Procedure) and 2003 (State Office of Administrative Hearings) of the Government Code do not apply to hearings that are held by the appropriate regulatory agencies under this subsection.

SECTION 6. Effective date: September 1, 2013.