No. 14-1088

In the Supreme Court of Texas

TEXAS HEALTH AND HUMAN SERVICES COMMISSION AND OFFICE OF THE INSPECTOR GENERAL,

Petitioner,

v.

HARLINGEN FAMILY DENTISTRY, P.C., Respondent.

On Petition for Review from the Third Court of Appeals, Austin, Texas No. 03-14-00069-CV

PETITION FOR REVIEW

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STATEMENT OF THE CASE

Nature of the Case:

This is an Administrative Procedure Act challenge to the authority of the Texas Health and Human Services Commission to promulgate rules authorizing the Office of the Inspector General to impose a temporary, permissive payment hold on a Medicaid provider upon finding that the provider has committed a Medicaid program violation. This case also involves challenges to other rules relating to HHSC's authority to impose other payment holds and retain payments held.

Trial Court:

The Honorable Lora J. Livingston 419th District Court, Travis County, Texas

Trial Court Disposition:

The trial court rendered judgment that the challenged rules were valid. CR.756.

Parties in Court of Appeals:

Appellant(s): Harlingen Family Dentistry, P.C.; and Trueblood Dental Associates, P.A.

Appellee(s): Texas Health and Human Services Commission and Office of the Inspector General

Court of Appeals:

Third Court of Appeals, Austin, Texas

Court of Appeals's Disposition:

The court of appeals reversed the trial court's final judgment and invalidated the challenged rules. Harlingen Family Dentistry, P.C. et al. v. Texas Health and Human Services Commission and Office of Inspector General, No. 03-14-00069-CV, 2014 WL 6844947, (Tex. App.—Austin Nov. 25, 2014, pet. filed) (Jones, C.J. (author), with Rose, J., and Goodwin, J.).

STATEMENT OF JURISDICTION

This Court has jurisdiction over this case pursuant to Texas Constitution article V, §3 and Texas Government Code §22.001(a)(2), (a)(3), and (a)(6). Jurisdiction exists because the Third Court of Appeals applied a legal standard contrary to that articulated by the Texas Supreme Court in considering whether the HHSC was authorized to promulgate the rules at issue. Tex. Gov'T. Code §22.001(a)(2). This case also involves the construction of a statute necessary to a determination of the case, namely Texas Government Code §531.102(g)(2) and (g)(7). *Id.* §22.001(a)(3).

Finally, the Court has jurisdiction because the legal principles at stake—(1) the legal standard governing the statutory construction inquiry in a rule-validity challenge; and (2) an agency's authority to promulgate a payment-hold rule—are significant and extend well beyond the circumstances of this case. *Id.* §22.001(a)(6).

ISSUES PRESENTED

- 1. Did the Third Court of Appeals apply the wrong legal standard when it required an agency rule itself to be both reasonable as good policy and "necessary" in order to be valid? Op. at 12. Should the court instead have upheld the "agency's interpretation of [the ambiguous] statute it is charged by the Legislature with enforcing so long as the construction is reasonable and does not contradict the plain language" of the statute? R.R. Comm'n of Tex. v. Texas Citizens for a Safe Future & Clean Water, 336 S.W.3d 619, 625 (Tex. 2011) (internal quotation marks & citation omitted).
- 2. Did the Health and Human Services Commission (HHSC) have discretion to promulgate a rule authorizing the Office of the Inspector General (OIG) to impose a pre-notice temporary hold on payments to a Medicaid provider who has committed a Medicaid program violation? 1 Tex. ADMIN. CODE

- §371.1709(a)(2) (2012); 1 TEX. ADMIN. CODE §371.1703(b)(5) (2005) repealed 37 Tex. Reg. 7989-90 (2012) (proposed Aug. 10, 2012).
- 3. Did the court lack subject-matter jurisdiction over the challenges to 1 Tex. Admin. Code §371.1709(a)(3) and (a)(4)(2012), which were never the basis of any hold against Harlingen Family Dentistry, P.C. (HFD) or Trueblood Dental Associates, P.A. (Trueblood), (together, Plaintiffs)?
- 4. Unbriefed issue: If there was jurisdiction over the challenges to rules 371.1709(a)(3) and (a)(4), did the court nevertheless err in invalidating them?
- 5. Unbriefed issue: Did the court also lack subject matter-jurisdiction over the repealed rules, which may still operate in some contexts, because HFD nonsuited its challenge to them, and because they were not the basis for a hold imposed against Trueblood? 1 Tex. ADMIN. CODE §371.1703(b)(5), (b)(6) (2005) (repealed).

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PETITION FOR REVIEW

TO THE HONORABLE SUPREME COURT OF TEXAS:

This Court should grant review of the Third Court of Appeals opinion,¹ which invalidates an HHSC rule that authorizes OIG to impose a permissive, temporary payment hold against a Medicaid provider who has violated the Medicaid program (the violation-hold rule). 1 Tex. Admin. Code §371.1709(a)(2) (2012); see 1 Tex. Admin. Code §371.1703(b)(5) (2005) (repealed). The court applied the wrong legal standard to the statutory-construction inquiry and struck down the rule, finding it to be

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¹ App. A. Citations are to the slip opinion.

unreasonable as a matter of policy wisdom and not strictly necessary to the statutory scheme. The court also invalidated two other permissive-hold provisions that Plaintiffs lacked standing to challenge. *See* 1 TEX. ADMIN. CODE §371.1709(a)(3), (a)(4) (2012).

These erroneous rulings deal a harsh blow to Defendants' ability to fulfill their statutory mandate to *prevent* and not simply remedy the Medicaid abuse that contributes to Texas's expenditure of "as much on orthodontic services as the rest of the country's Medicaid programs spent on orthodontic services combined." Despite the significant public interests at stake, the Third Court denied both parties' requests for oral argument and resolved the case in a short opinion that issued just one day after the case was submitted for decision. This case merits this Court's attention and a closer review. Defendants respectfully request that this Court clarify the legal standard and reverse the judgment as to the rules authorizing OIG to impose permissive payment holds.

² STAFF OF H.R., COMM. ON OVERSIGHT & GOV'T. REFORM, 112TH CONG., REP. ON UNCOVERING WASTE, FRAUD, & ABUSE IN THE MEDICAID PROGRAM 4 (Comm. Print 2012), http://oversight.house.gov/wp-content/uploads/2012/04/Uncovering-Waste-Fraud-and-Abuse-in-the-Medicaid-Program-Final-3.pdf.

³ App. B. Docket, Case 03-14-0069-CV, Case Events (reflecting submission on 11/24/2014 and opinion issued 11/25/2014).

STATEMENT OF FACTS

Governing Statutes

HHSC administers the Medicaid program in Texas through a partnership with the federal government.⁴ *See* 42 U.S.C. §1396a(a), (b); 42 C.F.R. §430.10. Texas Government Code Section 531 directs HHSC to "supervise the administration of the Medicaid Program," and "monitor and ensure the effective use of all federal funds received by a health and human services agency." Tex. Gov'T Code §531.0055(b)(1), (b)(3). To this end, HHSC's executive commissioner is required to "adopt rules and policies for the operation of and provision of health and human services by the health and human services agencies." *Id.* §531.0055(e).

Section 531 also establishes OIG as a division or office within HHSC. OIG's legislative mandate is the "prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state," including Medicaid services, and the "enforcement of state law relating to the provision of those services." *Id.* §531.102(a). The Legislature has vested OIG with sanction powers to fulfill its mandate, including authority to impose a payment hold. Section 531.102 directs that

(g)(2) In addition to other instances authorized under state or federal law, [OIG] shall impose without prior notice a payment hold on claims for reimbursement submitted by a provider to compel production of records,

⁴ Many federal and state Medicaid statutes govern the Medicaid program that HHSC administers. The most relevant are discussed here.

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. The office must notify the provider of the payment hold in accordance with 42 C.F.R. Section 455.23(b). . . .

. . . .

- (g)(7) [OIG] shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds or program exclusions:
 - (A) may permissively be imposed on a provider; or
 - (B) shall automatically be imposed on a provider.

Id. §531.102. ⁵

In addition, the Texas Human Resources Code provides that HHSC may

- (1) perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse; and
- (2) 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.

TEX. HUM. RES. CODE §32.0291(a).⁶ That section also gives HHSC parallel authority with OIG to impose payment holds under Government Code Section 531.102. *See id.* §32.0291(b).

⁵ See Appellees' Br. 3-9 & Apps. E, F, G (post-rule-promulgation amendments do not affect validity).

⁶ See Appellees' Br. 3-9 & Apps. C, D, H (post-rule-promulgation amendments do not affect validity).

The Violation-hold Rule in Context

HHSC has promulgated a rule that authorizes OIG to impose permissive payment holds in certain circumstances, and compels OIG to impose payment holds in others. *See* 1 TEX. ADMIN. CODE §371.1709 (2012), *amended* 39 Tex. Reg. 374-75 (2014)⁷. The violation-hold rule is a permissive-hold provision. It appears at §371.1709(a)(2), and states:

- (a) OIG may impose a payment hold against any person if it determines that the person committed an act for which a person is subject to administrative actions or sanctions, including the following:
-
- (2) commits a program violation.

Id. §371.1709(a)(2). A program violation is defined as the failure to comply with the contract, state or federal statutes, state or federal rules, as well as "any action that constitutes grounds for enforcement . . . that forms the basis for an investigation, audit, or other review that results in a notice of potential or final action for cause." Id. §371.1607(63).

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⁷ The 2014 amendments to Rule 371.1709 do not change subsections (a) or (b) or their subparts. Plaintiffs challenged the 2012 version, and the parties' briefs addressed the 2012 version. *See* Appelles' Br. App. B. The opinion referenced both the 2012 and 2014 versions. Op. at 1, 9.

By contrast, rule 371.1709 requires OIG to impose a payment hold in the three circumstances in which Texas Government Code §531.102(g)(2) requires OIG to impose an automatic payment hold. *Id.* §371.1709(b)(1)-(b)(3).

Rule 371.1709 also imposes notice and procedure requirements on holds, including that OIG provide "written notice of a payment hold no later than the fifth (5th) business day after the date the payment hold is imposed." *Id.* §371.1709(c)(1)(2012). The 2012 rules provided that a person subject to a hold may "request an expedited informal review," *id.* §371.1709(d), which must occur no later than "60 days after the date OIG receives a timely request," *id.* §371.1613(c).

Procedural Facts

In 2011, HHSC instituted a payment hold against HFD pursuant to former rules 1 Tex. Admin. Code §371.1703(b)(3) and (b)(5) (2005) (repealed).⁸ These repealed provisions are the precursors to rule 371.1709 (b)(3) (the fraud-allegation rule) and (a)(2) (the violation-hold rule), respectively.

HFD sought administrative review of the payment holds. CR.26. Following a hearing, *id.*, the administrative law judge issued a proposal for decision finding that OIG lacked authority to maintain the hold against HFD under former rule 371.1703(b)(3),

⁸ "The current rules are substantially similar to the old rules, and HHSC contends that the same statutory authority exists for both the old rules and the current rules." Op. at 8 n.2.

but that OIG did have authority to maintain a hold against HFD under former rule 371.1703(b)(5) based on prima facie evidence of:

Billing or causing claims to be submitted to the Medicaid program for services or items that are not reimbursable by the Medicaid program; failing to comply with the terms of the Medicaid program provider agreement; and failing to comply with a Medicaid program procedure manual.

CR.61. Because nine percent of HFD's cases reviewed were so affected, the proposal recommended withholding nine percent of HFD's orthodontic Medicaid payments on future claims. CR.55-56. HHSC issued a final order adopting the proposal. CR.70-71.

HFD filed suit in district court under Texas Government Code §2001.038, challenging the validity of the violation-hold rule, which was the basis of the hold against it, and also rules 371.1709(a)(3) and (a)(4) (authorizing permissive holds in other circumstances), which were not. CR.5-6, CR.22. HFD also challenged the repealed predecessors to these rules. CR.22. In addition, HFD challenged the validity of rule 371.1709(e)(2) (2012), which permitted HHSC to retain withheld funds after the termination of a hold. CR.22-23.

In January 2013, OIG imposed payment holds on Trueblood pursuant to rules 371.1709(a)(2) and (b)(3) only. CR.164. Trueblood intervened as a Plaintiff and joined HFD on all issues. CR.145. Following a hearing, the district court upheld the rules. CR.756.

HFD then nonsuited its challenge to the repealed rules. Supp. CR.21-23. On appeal, the Third Court denied both parties' requests for oral argument; reversed the judgment; and invalidated all of the challenged rules. Op. at 13-15.

STANDARD OF REVIEW

The construction of a statute is a question of law that this Court reviews de novo. R.R. Comm'n of Tex. v. Tex. Citizens for a Safe Future & Clean Water, 336 S.W.3d 619, 624 (Tex. 2011). This Court also reviews de novo the question whether there was subjectmatter jurisdiction over a claim. Tex. Dep't of Parks & Wildlife v. Miranda, 133 S.W.3d 217, 226 (Tex. 2004).

SUMMARY OF THE ARGUMENT

The court applied the wrong legal standard when it held that the substance of the violation-hold rule must be "necessary and reasonable," and invalidated the rule as bad policy that was "[un]necessary" to the statutory scheme. Op. at 12. Where a statute is ambiguous, the statutory-construction inquiry asks only whether the "agency's interpretation of a statute it is charged by the Legislature with enforcing . . . is reasonable and does not contradict the plain language of the statute." *Tex. Citizens*, 336 S.W.3d at 625 (citation and internal quotation marks omitted). That standard considers neither the wisdom of the rule, nor demands that the rule be indispensable to the statutory scheme.

Defendants' interpretation should be upheld under the Texas Citizens standard.

The violation-hold rule accords with Defendants' mandate to prevent Medicaid waste

and abuse, and the Legislature has acknowledged that such permissive payment holds would be "authorized" in circumstances where the Legislature does not require mandatory holds. Tex. Gov't Code §531.102(g)(2), (g)(7). In addition, the court lacked jurisdiction to invalidate rules 371.1709(a)(3) and (a)(4) because Plaintiffs had no standing to challenge them.

ARGUMENT

I. THERE ARE GOOD REASONS TO GRANT REVIEW.

This case merits this Court's review for three reasons. First, the Third Court applied an erroneous legal standard, based on a misinterpretation of this Court's holding in *Bullock v. Hewlett-Packard Co.*, 628 S.W.2d 754 (Tex. 1982). If not overruled, this standard would sow significant confusion in the Third Court's case-law addressing rule-validity challenges that turn on issues of statutory construction.

Citing *Bullock*, the court added to the legal standard—which considers only the reasonableness of the agency's statutory construction and whether it conflicts with plain text⁹—an *additional requirement* that the rule itself be "necessary and reasonable" in order to be promulgated under implied statutory authority. Op. at 12 (citing *Bullock*, 628 S.W.2d at 756). The court interpreted "reasonable" to mean good policy and "necessary" to mean indispensable to the statutory scheme. *Id.* at 12-13. *Bullock* imposes no such requirement. If left to govern future cases, this additional requirement would

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⁹ R.R. Comm'n of Tex. 336 S.W.3d at 629.

subject rules to a policy-merit litmus test. It would also invalidate a large swath of agency action that is harmonious with—although not necessary to—a statutory scheme.

Second, the court's ruling jeopardizes the validity of Texas payment-hold rules generally. Citing concerns for the fairness of payment holds, the court refused to find authority for payment holds except in the three circumstances where the Legislature had mandated them, ignoring the statute's contemplation of rules authorizing permissive holds in other circumstances. Op. at 11. But payment holds are not the disconcerting anomalies that the court deemed them to be. Payment holds are common features of many Texas regulations, reflecting the Legislature's priority of *preventing* the misuse of State money rather than simply recovering money through costly and often ineffective claw-backs. *See*, *e.g.*, 30 Tex. Admin. Code §334.313(b)(2) (authorizing Commission on Environmental Quality to "withhold payment" on a claim portions requiring more information). No authority supports subjecting them to extra scrutiny.

Finally, this Court should hear the case because of the significant public interests at stake. This case directly impacts Texas's efforts to prevent the pervasive Medicaid abuse that contributes to Texas's losses of "hundreds of millions of dollars." Issues regarding Defendants' enforcement priorities are for the Legislature to address. The question for the court is whether Defendants reasonably interpreted the statutes at issue to allow the violation-hold rule.

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¹⁰ Oversight Report, *supra* note 1, at 4.

II. THE VIOLATION-HOLD RULE WAS A VALID EXERCISE OF THE AGENCY'S DISCRETION.

A. The Court Applied the Wrong Legal Standard and Invalidated the Rule Based on Policy Preferences.

The court applied the wrong legal standard to the rule-validity inquiry. Under Texas law, where a plaintiff challenges a legislative rule as being without statutory authority, the court simply interprets and applies the law if it is unambiguous. *Tex. Coast Utils. Coal. v. R.R. Comm'n*, 423 S.W.3d 355, 363 n. 16 (Tex. 2014). By contrast, where a statute is ambiguous, the court "must uphold the enforcing agency's construction if it is reasonable and in harmony with the statute." *Tex. Citizens*, 336 S.W.3d at 629.

The court here never actually addressed ambiguity, but its quotation of the "in harmony" requirement indicates that the court found Government Code §531.102(g)(2) to be ambiguous. See Op. at 10. Where the law is ambiguous, this Court has held that the validity standard consists of just one requirement: "we only require an agency's interpretation of a statute it is charged with administering to be reasonable and in accord with the statute's plain language" in order to uphold the rule. Tex. Citizens, 336 S.W.3d at 628 (emphasis added). This standard gives deference to the agency. "In a complex regulatory scheme" like that governing Texas Medicaid, this "deference is particularly important," given the agencies' "unique understanding" of the statutes they administer. Id. at 629-30; Sm. Pharmacy Solutions, Inc. v. Tex. HHSC, 408 S.W.3d 549, 557-58 (Tex. App.—Austin 2013, pet. denied).

The court erred by ignoring the words "only require." *Tex. Citizens*, 336 S.W.3d at 628. Instead, the court grafted on to that legal standard a *second* requirement that the rule itself be "necessary and reasonable." Op. 12-13. Citing *Bullock*, the Court reasoned that this "necessary and reasonable" requirement is a prerequisite to finding implied statutory authority for an agency to adopt the particular rule. Op. at 12 (citing *Bullock*, 628 S.W.2d at 756). The court explained that, for implied authority to exist, the rule had to be (1) "reasonable," which the court interpreted to mean good policy; and (2) "necessary" to accomplishing the legislative mandate. Op. at 12-13.

But *Bullock* says nothing of the sort. *Bullock* does not mention implied authority,¹¹ much less a different legal standard that survived *Texas Citizens*. *Bullock*, 628 S.W.2d at 756. Rather, *Bullock* explicitly repudiates the notion that a rule must "be, in the court's opinion, wise, desirable, or even necessary" in order to be valid. *Id*.

Yet the court considered all three of these prohibited factors as justifications for invalidating the rule under its "necessary and reasonable" requirement. Op. 12-13. The court expressly weighed the wisdom and desirability of the rule in emphasizing—repeatedly—that the rule authorized OIG to "impose a payment hold whenever it believes a provider has committed any program violation, *no matter how minor* and

¹¹ Implied authority consists of powers that are "reasonably necessary to carry out the [agency's] express responsibilities given to it by the Legislature." *Tex. Coast*, 423 S.W.3d at 359. Thus, to the extent implied authority is concerned, the standard asks whether *Defendants' construction* of an ambiguous statute (as conveying *a power* that is *reasonably necessary* to carry out its express responsibilities) was reasonable and not contrary to the text. *See Tex. Citizens*, 336 S.W.3d at 629.

irrespective of whether there is any indication of fraud or *intentional* abuse." Op. at 11 (emphasis added); *see id.* at 12. The court ignored that the statutory text declares OIG's mandate to be the "prevention . . . of fraud, waste, and abuse," not simply large-scale and intentional fraud and abuse. Tex. Gov't Code § 531.102(a).

The court also considered whether the rule itself was necessary, and struck the rule down upon finding it "neither reasonable nor necessary . . . for HHSC to be permitted to impose a pre-notice payment hold, without the opportunity for an administrative hearing regarding the hold, on a provider who commits a Medicaid-program violation merely to enforce its rules or ensure the proper and efficient operation of the program." Op. at 12-13. Requiring this degree of necessity would fundamentally alter agency discretion. Regulatory schemes are made up of numerous components that are harmonious with the statute. But few of these components are indispensable to the agency's mission, such that a somewhat different rule could not have accomplished the task. If an agency may promulgate only the necessary, defined at this level of granularity, discretion is a dead letter.

Ultimately, the court reweighed the rule's pros and cons and substituted its own policy choice for that of HHSC. Op. at 13 (reasoning that the violation hold rule "could actually impair" HHSC's mission, as "it could result in Medicaid providers withdrawing from the program, declaring bankruptcy, or otherwise being unable to continue providing services for which they are not being paid"). This was HHSC's call to make, not the court's.

In any event, HHSC's rule was hardly the radical choice that the court deemed it to be. Agencies of other states, tasked with effectuating the same federal Medicaid law, have issued rules allowing payment holds based on program violations. See, e.g., IOWA ADMIN. CODE r. 441-79.2 (249A) §§79.2(8), 79.2(2)(f) (authorizing department to withhold, without prior notice, "payments on pending and subsequently received claims ... due to a sanction," grounds for which include "performing an act" which violates a Medicaid statute, rule, regulation, ordinance or applicable contractual provision); see Ch. 16 WYO. CODE R. §15 (2011) (authorizing department to "suspend payments" to the [Medicaid] provider for: (b) Failure to comply with the provisions of the provider agreement, . . . [or] (d) Violation of Medicaid, Department, or other state or federal statute, rule, or law relating to provisions of services."); N.Y. COMP. CODES R. & REGS. tit. 18, \\$518.7(a)(1)(a)-(b), 515.2 (a)(1) (allowing department to "withhold payments" to a Medicaid provider without prior notice when "it has determined that a provider has abused the program or has committed an unacceptable practice," which includes conduct contrary to "the official rules and regulations").

New York's rule has withstood multiple challenges, most notably the "due process" challenges that so concerned the Third Court. *See, e.g., Plaza Health Labs., Inc. v. Perales*, 88 CIV. 6649 (JFK), 1992 WL 35937, at *3 (S.D.N.Y. Feb. 19, 1992) (finding,

¹² Op. 12 & n.4.

based on the federal law's requirement¹³ that state Medicaid plans "provide for procedures of prepayment . . . claims review, including review of appropriate data with respect to the . . . provider of service," that plaintiff had "no property interest" in payment pending investigation (quoting 42 U.S.C. §1396a(a)(37)(B)(1988)); *cf.* Appellees' Br. 55-62 (citing other cases in extensive discussion of why there is no due process violation).

Just as tellingly, even before that rule issued, a reviewing court upheld a New York agency's pre-hearing Medicaid-payment hold pursuant to the agency's "preaudit procedure," without demanding explicit authorization for a hold triggered by precisely those circumstances. *Siddiqui v. N.Y. State Dep't of Soc. Servs*, 116 A.D.2d 909, 911 (N.Y. App. Div. 1986) ("The public must be assured that Medicaid funds will not be paid to an untrustworthy provider of services. To effect this requirement, the Department, which is charged with administering the Medicaid program, is vested with broad discretion in fashioning sanctions to adequately protect the program." (citations omitted)).

In short, the court here should not have allowed its policy concerns to override or add to the legal standard, thereby disadvantaging Defendants in protecting Texas's Medicaid program against this same preventable abuse. The court should have applied the correct standard and upheld the rule.

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¹³ This requirement has not changed. 42 U.S.C. §1396a(a)(37)(B)(2015).

B. The Violation-Hold Rule Is Valid Under the Correct Legal Standard.

The governing statutes unambiguously authorized HHSC to promulgate the payment-hold rule. Assuming *arguendo* that these statutes are ambiguous, Defendants' interpretation of those statutes as authorizing the payment-hold rule must be upheld because it is reasonable and not in conflict with the plain text. *Tex. Citizens*, 336 S.W.3d at 629.

To begin, the Legislature obligates HHSC to "monitor and ensure the effective use of all federal funds received by a health and human services agency." TEX. GOV'T CODE §531.0055(b)(3). This mandate has no exception for cases involving "minor" misuses of Medicaid funds.

OIG's legislative mandate is even more specific: it is the "prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery" of Medicaid services. *Id.* §531.102(a) (emphasis added). Medicaid abuse and waste cannot be prevented unless they are thwarted before they occur, as through a payment hold. The court did not disagree. Instead, it wrote prevention right out of OIG's mandate. Op. at 10 (describing OIG as responsible for "the investigation of fraud and abuse" in the provision of services, with no mention of prevention (citing §531.102(a))).

In light of these statutes and others, Defendants reasonably interpreted Texas Government Code §531.102(g)(2) to authorize HHSC's rule that allows OIG to impose

a temporary payment hold on a Medicaid provider upon finding that the provider has committed a program violation. That section states:

In addition to other instances authorized under state or federal law, [OIG] shall impose without prior notice a payment hold on 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,

TEX. GOV'T CODE §531.102(g)(2) (emphasis added). The italicized phrase negates any notion that payment holds are limited to the circumstances listed in §531.102(g)(2), where a payment hold is required and not permissive. Lest this was unclear, the Legislature explicitly directed that

[OIG] *shall*, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds or program exclusions;

- (A) May permissively be imposed on a provider; or
- (B) Shall automatically be imposed on a provider.

Id. §531.102(g)(7) (emphasis added).

Because §531.102(g)(2) contains requirements only for automatic holds, §531.102(g)(2)'s phrase "other instances authorized" must mean that HHSC can adopt rules authorizing permissive holds in other circumstances not listed therein. Otherwise, (g)(7)'s directive would require OIG to establish "guidelines" for exercising a power that it does not have. Here, it was reasonable for HHSC to interpret the statute as allowing it to adopt the payment-violation hold rule, which furthers not only HHSC's

mandate to ensure the effective use of Medicaid funds, but also OIG's mandate to prevent Medicaid abuse before it happens.

For these reasons, Defendants' construction of the statute as allowing the payment-hold rule is at least a reasonable construction, if not the only reasonable construction, of §531.102. Under *Texas Citizens*, the court should have upheld the rule.

III. THERE WAS NO JURISDICTION TO INVALIDATE THE OTHER PERMISSIVE-HOLD RULES.

Defendants did not have standing to challenge rules 371.1709(a)(3) and (a)(4), which allow OIG to impose a temporary payment hold upon a provider who is "affiliated with a person who commits a program violation," or "for any other reason provided by statute or regulation," respectively. 1 Tex. ADMIN. CODE §371.1709(a)(3), (a)(4).

A plaintiff has standing to challenge rule validity only where it is "alleged that the rule or its threatened application interferes with or impairs, or threatens to interfere with or impair, a legal right or privilege of the plaintiff." TEX. GOV'T CODE \$2001.038(a). Neither Plaintiff pleaded that it was subject to or threatened with a hold under either rule. 14 CR.1-23, 145-63.

¹⁴ At a hearing, Defendants' counsel discussed standing in acknowledging that Plaintiffs were proper parties to the suit. RR.4. Defendants' counsel, however, never acknowledged that Plaintiffs had pleaded sufficient facts to challenge current rules 371.1709(a)(3) and (a)(4), and any such admission could not bind the state Defendants or confer jurisdiction. Tex. Gov't Code §402.004.

Standing is "a prerequisite to subject-matter jurisdiction," and "essential to a court's power to decide a case." *Bland Indep. Sch. Dist. v. Blue*, 34 S.W.3d 547, 553 (Tex. 2000). "Subject matter jurisdiction is an issue that may be raised for the first time on appeal; it may not be waived by the parties." *Tex. Ass'n of Bus. v. Tex. Air Control Bd.*, 852 S.W.2d 440, 445 (Tex. 1993). Because Plaintiffs lacked standing to challenge these two rules, the court had no subject matter jurisdiction to invalidate them.

CONCLUSION

Defendants respectfully request that this Court grant review and reverse the judgment invalidating rules 371.1709(a)(2), (a)(3), and (a)(4).

Respectfully submitted.

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CERTIFICATE OF SERVICE

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CERTIFICATE OF COMPLIANCE

In compliance with Texas Rule of Appellate Procedure 9.4(i)(2), this brief contains **4,130** words, excluding the portions of the brief exempted by Rule 9.4(i)(1).

/s/ April L. Farris April L. Farris

APPENDIX

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TEXAS COURT OF APPEALS, THIRD DISTRICT, AT AUSTIN

NO. 03-14-00069-CV

Harlingen Family Dentistry, P.C.; and Trueblood Dental Associates, P.A., Appellants

v.

Texas Health and Human Services Commission and Office of the Inspector General,
Appellees

FROM THE DISTRICT COURT OF TRAVIS COUNTY, 419TH JUDICIAL DISTRICT NO. D-1-GN-13-002402, HONORABLE LORA J. LIVINGSTON, JUDGE PRESIDING

OPINION

Harlingen Family Dentistry, P.C. and Trueblood Dental Associates, P.A. (collectively, the Dental Groups) filed suit in Travis County district court challenging certain rules adopted by the Texas Health and Human Services Commission (HHSC). *See* Tex. Gov't Code § 2001.038 (permitting challenge to validity or applicability of agency rule). The challenged rules permit HHSC and its Office of Inspector General (OIG) to impose a payment hold against a Medicaid provider in certain circumstances. *See* 1 Tex. Admin. Code § 371.1709(a)(2), (3), (4) (2012) (Tex. Health & Human Servs. Comm'n, Payment Hold). The Dental Groups also challenged a rule permitting the OIG to retain funds that were accumulated during a payment hold even after the hold has been terminated and to use those funds to offset any monies that may be determined to be owed as a result of an ongoing investigation of the provider. *Id.* § 371.1709(e)(2). After the trial court rendered

judgment that the challenged rules were valid, the Dental Groups perfected this appeal. We will reverse the trial court's judgment and render judgment that the challenged rules are not valid.

ANALYSIS

In their sole issue on appeal, the Dental Groups contend the trial court erred in finding that the challenged administrative rules are a valid exercise of HHSC's statutory rulemaking authority. We presume that an agency rule is valid, and the party challenging the rule has the burden of demonstrating its invalidity. See Texas Ass'n of Psychological Assocs. v. Texas State Bd. of Exam'rs of Psychologists, 439 S.W.3d 597, 603 (Tex. App.—Austin 2014, no pet.). To establish a rule's facial invalidity, the challenger must show that the rule (1) contravenes specific statutory language; (2) is counter to the statute's general objectives; or (3) imposes additional burdens, conditions, or restrictions in excess of or inconsistent with the relevant statutory provisions. See Ware v. Texas Comm'n on Law Enforcement Officer Standards & Educ., No. 03-12-00740-CV, 2013 WL 2157244, at *2 (Tex. App.—Austin May 16, 2013, no pet.) (mem. op.); Office of Pub. Util. Counsel v. Public Util. Comm'n, 131 S.W.3d 314, 321 (Tex. App.—Austin 2004, pet. denied). An agency's rules must comport with the agency's authorizing statute. See id. A state administrative agency has only the authority expressly provided by statute or necessarily implied in order to carry out the express powers the legislature has given it. See Public Util. Comm'n v. City Pub. Serv. Bd., 53 S.W.3d 310, 315 (Tex. 2001); Public Util. Comm'n of Tex. v. GTE-Southwest, Inc., 901 S.W.2d 401, 407 (Tex. 1995). An agency may not exercise what is effectively a new power on the theory that such exercise is expedient for the agency's purposes. GTE Southwest, 901 S.W.2d at 407.

The Dental Groups contend that HHSC exceeded its statutory authority by promulgating the challenged rules permitting certain pre-notice payment holds. The dispute, therefore, turns principally on the construction of a statute, a question of law that we review de novo. See First Am. Title Ins. Co. v. Combs, 258 S.W.3d 627, 632 (Tex. 2008). Our primary objective in construing statutes is to give effect to the legislature's intent. Galbraith Eng'g Consultants, Inc. v. Pochucha, 290 S.W.3d 863, 867 (Tex. 2009). The plain meaning of the text is the best expression of legislative intent unless a different meaning is supplied by legislative definition or is apparent from the context, or unless the plain meaning would lead to absurd or nonsensical results that the legislature could not have intended. City of Rockwall v. Hughes, 246 S.W.3d 621, 625-26 (Tex. 2008); see Tex. Gov't Code § 311.011 ("Words and phrases shall be read in context and construed according to the rules of grammar and common usage."). We look to the entire act in determining the legislature's intent with respect to a specific provision. Taylor v. Firemen's & Policemen's Civil Serv. Comm'n, 616 S.W.2d 187, 190 (Tex. 1981); Northwest Austin Mun. Util. Dist. No. 1 v. City of Austin, 274 S.W.3d 820, 828 (Tex. App.—Austin 2008, pet. denied). The doctrine of unius est exclusio alterius has long been recognized in this state: "[I]t is a settled rule that the express mention or enumeration of one person, thing, consequence or class is equivalent to an express exclusion of all others." Johnson v. Second Injury Fund, 688 S.W.2d 107, 108-09 (Tex. 1985). Although the doctrine is not an absolute rule, it can be helpful in determining legislative intent. Mid-Century Ins. Co. v. Kidd, 997 S.W.2d 265, 274 (Tex. 1999). We believe it is helpful in the present case.

The Challenged Rules

The first set of challenged rules purports to grant HHSC and the OIG authority to impose a pre-notice payment hold on providers under certain circumstances. The Dental Groups argue that the rules exceed the limited authority the legislature granted HHSC to impose such payment holds on a Medicaid provider's reimbursement claims for services provided. Specifically, the Dental Groups maintain that because the challenged rules purport to permit a payment hold in instances that do not involve evidence of fraud by the provider, they exceed HHSC's statutory authority and therefore are invalid. The issue in this case, then, reduces to whether HHSC has the authority to adopt rules permitting the OIG to impose a pre-notice payment hold on a Medicaid provider for a program violation that does not involve evidence of or allegations of fraud.

When the challenged rules were promulgated in 2005, two statutes expressly authorized a pre-notice hold on payment to a Medicaid provider. Government Code section 531.102(g)(2) provided:

In addition to other instances authorized under state or federal law, the [OIG] *shall impose without prior notice a hold on payment of claims* for reimbursement submitted by a provider *to compel production of records or when requested by the state's Medicaid fraud control unit*, as applicable. The office must notify the provider of the hold on payment not later than the fifth working day after the date the payment hold is imposed.

Act of June 2, 2003, 78th Leg., R.S., ch. 198, § 2.19(a), 2003 Tex. Gen. Laws 611, 652 (emphasis added) (amended 2005) (current version at Tex. Gov't Code § 531.102(g)(2)). Section 531.102 also provided that, on timely written request by the provider, HHSC "shall file a request with the State

Office of Administrative Hearings for an expedited administrative hearing regarding the hold." *Id.* (current version at Tex. Gov't Code § 531.102(g)(3)).

In addition, Human Resources Code section 32.0291(b) provided:

Notwithstanding any other law, [HHSC] may impose a 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.

Act of June 2, 2003, 78th Leg., R.S., ch. 198, § 2.103, 2003 Tex. Gen. Laws 611, 690 (emphasis added) (amended 2013) (current version at Tex. Hum. Res. Code § 32.0291(b)). The plain language of these statutes *authorized* HHSC to impose a payment hold if it had "reliable evidence that the provider has committed fraud or wilful misrepresentation" and *required* the OIG to impose a payment hold "to compel production of records or when requested by the state's Medicaid fraud unit."

It was within the context of the foregoing statutory framework that HHSC adopted rule 371.1703(b), since amended, which provided in pertinent part:

- § 371.1703(b) Payment Hold. A payment hold on payments of future claims submitted for reimbursement will be imposed, without prior notice, after it is determined that prima facie evidence exists to support the payment hold. . . . The instances in which a payment hold may be imposed without prior notice are:
- (1) to compel production of records;
- (2) when requested by the Attorney General's Medicaid Fraud Control Unit, as applicable;

- (3) in the instance of fraud or willful misrepresentation;
- (4) when the U.S. Health and Human Services imposes a payment hold (suspension of payments) against the provider for Medicare violations and that provider or person is also a provider in the Medicaid program;
- (5) for any reason specified in §§ 371.1609, 371.1617, 371.1621 of this subchapter, or any other provisions delineated in these rules; or
- (6) for any other reason specified by statute or regulation.

1 Tex. Admin. Code § 371.1703(b) (2005) (Tex. Health & Human Servs. Comm'n, Payment Hold) (emphasis added) *repealed* 37 Tex. Reg. 7989-90 (2012) (proposed August 10, 2012). Subsections (5) and (6) of the rule clearly expanded the circumstances under which a pre-notice payment hold could be imposed beyond those identified in Government Code section 531.021(g)(2) and Human Resources Code section 32.0291(b). For instance, subsection (5) of old rule 371.1703(b) provided that a hold would be imposed, without prior notice, for the "program violations" listed in rule 371.1617, which set out a "non-exclusive" list of acts that constituted program violations, including submitting claims for non-reimbursable items, failing to properly maintain records, and failing to comply with the terms of the Medicaid program contract or provider agreement.¹ Subsection (6) of old rule 371.1703(b) stated that a payment hold would be imposed "for any other

¹ Subsection (5) referenced two other HHSC rules. Old rule 371.1609 set forth the OIG's responsibilities in relation to Medicaid and other provider fraud and abuse, including investigating possible cases of fraud or abuse and imposing administrative monetary penalties and damages against providers. The reference to section 371.1621 appears to be an error, as that rule was repealed contemporaneously with adoption of the 2005 rules. Otherwise, it may have been intended to refer to old rule 371.1721, which set forth program violations subject to assessment of administrative damages and penalties by the OIG, or to old rule 371.1629, which addressed the OIG's use of administrative actions to identify program violations.

reason specified by statute *or regulation*." (Emphasis added.) This provision would permit HHSC to adopt a rule authorizing a payment hold in any conceivable circumstance and justify the hold on the basis that it was "specified by . . . regulation." We believe that neither Government Code section 531.102(g)(2) nor Human Resources Code section 32.0291(b), as they existed at the time the rules were adopted, provided authority for pre-notice payment holds under the broad circumstances set forth in old rule 371.1703(b)(5) and (6).

In 2011 the legislature amended Government Code section 531.102(g)(2) to add a third basis for the OIG to impose a payment hold, but the new basis was essentially identical to the one for which HHSC was already authorized to impose a hold under section 32.0291(b) of the Human Resources Code:

In addition to other instances authorized under state or federal law, the [OIG] shall impose without prior notice a 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 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 422.23, as applicable. The office must notify the provider of the hold on payment in accordance with 42 C.F.R. Section 422.23(b).

Act of May 28, 2011, 82d Leg., R.S., ch. 879, § 3.11, 2011 Tex. Gen. Laws 2228, 2234-35 (emphasis added) (further amended 2013) (current version at Tex. Gov't Code § 531.102(g)(2)). The effect of this 2011 amendment was to require the OIG to impose a payment hold upon receipt of reliable evidence of fraud or wilful misrepresentation as required by 42 C.F.R. § 455.23, which provides that a "State Medicaid agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud" 42 C.F.R. § 455.23.

Thereafter, HHSC replaced old rule 371.1703 with current rule 371.1709. See 1 Tex.

Admin. Code § 371.1709. The challenged portions of this rule now provide:²

§ 371.1709 Payment Hold

(a) OIG may impose a payment hold against any person if it determines that the person committed an act for which a person is subject to administrative actions or sanctions, including the following:

. . .

- (2) commits a program violation;
- (3) is affiliated with a person who commits a program violation; or
- (4) for any other reason provided by statute or regulation.

.

(e) Scope and effect of payment hold.

. . .

(2) After a payment hold is terminated for any reason, OIG may retain the funds accumulated during the payment hold to offset any overpayment, criminal restitution, penalty or other assessment, or agreed-upon amount that may result from ongoing investigation of the person, including any payment amount accepted by the prosecuting authorities made in lieu of a prosecution to reimburse the Medicaid or other HHS program.

² Challenged old rule 371.1703(b)(5) corresponds to current rule 371.1709(a)(2), and challenged old rule 371.1703(b)(6) corresponds to current rule 371.1709(a)(4). The current rules are substantially similar to the old rules, and HHSC contends that the same statutory authority exists for both the old rules and the current rules.

1 Tex. Admin. Code § 371.1709 (2014) (Tex. Health & Human Servs. Comm'n, Payment Hold). Subsection (b) of rule 371.1709, which the Dental Groups do not challenge, reflects the 2011 amendment to Government Code section 531.102(g)(2) and provides that the OIG must impose a payment hold against a person (1) to compel production of records or documents; (2) when requested to by the state's Medicaid Fraud Unit; or (3) upon receipt of reliable evidence that verifies a credible allegation of fraud. *Id.* § 371.1709(b)(1), (2), (3). By contrast, subsection (a) quoted above, the validity of which the Dental Groups do challenge, authorizes the OIG to impose a payment hold if a provider commits a "program violation," "is affiliated with a person who commits a program violation," or "for any other reason provided by statute or regulation." *See id.* § 371.1709(a)(2), (3), (4). Again, we agree with the Dental Groups that Government Code section 531.102(g)(2), as amended in 2011, does not provide authority for pre-notice payment holds under the circumstances set forth in rule 371.1709(a)(2), (3), or (4).

Finally, in 2013 the legislature again amended both Government Code section 531.102(g)(2) and Human Resources Code section 32.0291. As amended, Human Resources Code section 32.0291(b) now provides that HHSC's imposition of a payment hold is subject to Government Code section 531.102. Deleted from that section is the language that specifically authorized HHSC to impose a pre-notice payment hold upon receipt of credible evidence of fraud or willful misrepresentation by the provider.³ As with the previous versions, the amendments to

³ The 2013 amendments to section 531.102(g)(2) added: (1) a requirement that the OIG employ experts to review certain investigative findings before imposing a payment hold without prior notice, and (2) additional requirements to the content of the notice to be sent to the provider after a payment hold has been imposed, specifically, that the notice inform the provider of the basis for the hold and describe the administrative and judicial due-process remedies available to the

these statutes do not transform them into a legislative grant of authority for the imposition of a prenotice payment hold under the circumstances set forth in rule 371.170(a)(2), (3), or (4). Thus, such authority, if it exists, must be found elsewhere in HHSC's enabling legislation, either expressly or by necessary implication.

As HHSC correctly states in its brief, the determining factor in deciding whether an administrative agency has exceeded its rule-making authority is whether the rules are "in harmony" with the general objectives of the legislation involved. *Railroad Comm'n of Tex. v. Lone Star Gas Co.*, 844 S.W.2d 679, 685 (Tex. 1992); *Gulf Coast Coal. of Cities v. Public Util. Comm'n*, 161 S.W.3d 706, 711 (Tex. App.—Austin 2005, no pet.). For an administrative rule to be "in harmony" with legislative objectives, it must not impose additional burdens, conditions, or restrictions in excess of or inconsistent with relevant statutory provisions. *Gulf Coast Coal. of Cities*, 161 S.W.3d at 712. This is a question of law determined through statutory construction. *Id.* Here, the Dental Groups argue that administrative rules permitting a payment hold without prior notice under the broad circumstances provided for in rule 371.1709(a) contravene the legislative language and intent, as expressed in Government Code section 531.102(g)(2), that such holds are to be imposed only in the narrow circumstances identified in that statute.

OIG is the arm of HHSC responsible for "the investigation of fraud and abuse in the provision of health and human services." Tex. Gov't Code § 531.102(a). The statutory provisions in the Government Code pertinent to the OIG, including section 531.102, relate to the OIG's

provider, including the right to seek an informal resolution and the right to a formal administrative hearing. See Tex. Gov't Code § 531.102(g)(2).

statutorily defined function to detect fraud and process cases of suspected fraud, waste, or abuse. *See id.* § 531.103. Through the challenged rules, HHSC grants the OIG authority, and assumes authority for itself, to impose a payment hold whenever it believes a provider has committed any program violation, no matter how minor and irrespective of whether there is any indication of fraud or other intentional abuse. As noted above, the rules significantly expand the circumstances under which a pre-notice payment hold can be imposed beyond those enumerated in Government Code section 531.021(g)(2). Thus, the challenged rules are inconsistent with the legislature's directives related to those payment holds that it has expressly authorized.

In addition, we note that a provider subject to a payment hold imposed pursuant to the challenged rules is not expressly given the right to the procedural protections that the legislature mandated be available when a pre-notice payment hold is imposed for the more serious circumstances involving Medicaid fraud or refusal to produce requested documents or records. If HHSC has the authority to impose a payment hold under any circumstances, rather than being limited to the circumstances identified in section 531.102(g)(2), the result would be that providers who were subjected to a mandatory payment hold based on allegations of fraud are given *more* procedural protections (such as a contested-case hearing at the State Office of Administrative Appeals (SOAH)) than a provider who committed a less serious "program violation." As written, the rules permit the OIG to impose a payment hold, without notice and in the absence of fraud, and yet avoid the due-process notice procedures and expedited administrative review the legislature required in connection with the payment holds it expressly authorized. "Implied authority is not authority to depart from

the intent of the statute." *Texas Dep't of Human Servs. v. Christian Care Ctrs., Inc.*, 826 S.W.2d 715, 721 (Tex. App.—Austin 1992, writ denied).

We hold that HHSC's adoption of rules that permit pre-notice payment holds to be imposed for any alleged violation of the Medicaid program, no matter how minor, is inconsistent with the intent of Government Code chapter 531, subchapter C, which is to address and remediate Medicaid fraud and abuse and permit payment holds under circumstances involving fraud or abuse of the Medicaid program. *See* Tex. Gov't Code § 531.102(a). The fact that the challenged rules lack the due-process notice and hearing requirements that are the hallmark of legislation expressly authorizing the imposition of pre-notice payment holds bolsters our conclusion.

We are cognizant that the legislature gave HHSC full rulemaking authority as necessary for the proper and efficient operation of the Medicaid program. *See* Tex. Hum. Res. Code § 32.021(c). A means of enforcing the administrative rules can certainly be implied from the grant of this authority. *See Christian Care Ctrs.*, 826 S.W.2d at 720. In fact, HHSC has adopted rules permitting it to impose a variety of sanctions for non-fraud-related program violations. Implied statutory authority, however, is limited to what is necessary and reasonable. *See Bullock v. Hewlett-Packard Co.*, 628 S.W.2d 754, 756 (Tex. 1982). The Government Code expressly grants the OIG authority to assess administrative penalties on HHSC's behalf. *See* Tex. Gov't Code § 531.102(h). It is neither reasonable nor necessary, however, for HHSC to be permitted to impose a pre-notice payment hold, without the opportunity for an administrative hearing regarding the hold, on a provider who commits a Medicaid-program violation merely to enforce its rules or ensure the

proper and efficient operation of the program.⁴ In fact, doing so could actually impair that mission, as it could result in Medicaid providers withdrawing from the program, declaring bankruptcy, or otherwise being unable to continue providing services for which they are not being paid until the matter triggering the hold has been resolved. We hold that the trial court erred in concluding that old rules 371.1703(b)(5) and (6) and current rules 371.1709(a)(2), (3), and (4) are valid.⁵

We next consider the validity of challenged rule 371.1709(e)(2), which provides that when HHSC has imposed a pre-notice payment hold on Medicaid reimbursement funds pursuant to either section 371.1709(a) or 371.1709(b), it may retain seized funds even after that hold is terminated for any reason. Because we have concluded that rules 371.1709(a)(2), (3), and (4) are not valid, we need only consider the validity of rule 371.1709(e)(2) in the context of a payment hold imposed pursuant to rule 371.1709(b), i.e., for any of the three grounds set forth in

11.3 Clarify OIG's authority to place payment holds only in serious circumstances

This recommendation would clarify that OIG's payment hold authority applies only in circumstances requiring a serious enforcement tool to mitigate ongoing financial risk to the state, such as a pattern of billing behaviors or practices that indicate fraud. . . . Payment holds would not be authorized for standard overpayment cases or non-fraudulent errors. OIG would not be authorized to apply payment holds to aid in bargaining and settlement negotiations. This recommendation would not affect OIG's existing authority to pursue and recover overpayments.

Sunset Advisory Commission, Health & Human Servs. Comm'n, Staff Report, at 159 (Oct. 2014).

⁴ We also observe that if the legislature did in fact grant HHSC the authority to impose payment holds, without prior notice, for "program violations," it likely would, and may be constitutionally required to, mandate that the provider subject to the hold be entitled to an expedited administrative hearing at SOAH challenging the agency action.

⁵ Our holding appears to be consistent with the findings of the Sunset Advisory Commission Staff report regarding OIG payment holds. In their report issued in October 2014, the Staff recommended as follows:

Government Code section 531.102(g)(2). *See* Tex. Gov't Code § 531.102(g)(2) (providing for payment hold to compel production of documents, when requested by state's Medicaid Fraud Control Unit, or on receipt of credible evidence of fraud). The duration of a payment hold imposed pursuant to section 531.102(g)(2) is not indefinite but depends initially on the outcome of the expedited SOAH hearing regarding the hold. *See Janek v. Harlingen Family Dentistry, P.C.*, No. 03-13-00625-CV; 2014 WL 5653501, at *5 (Tex. App.—Austin Oct. 30, 2014, no pet. h.). When rule 371.1709(2)(e) was adopted in 2012, Government Code section 531.102(g)(2) required that a hold placed by the OIG be imposed "in accordance with 42 C.F.R. 455.23, as applicable." Act of May 28, 2011, 82d Leg., R.S., ch. 879, § 3.11, 2011 Tex. Gen. Laws 2234-24 (amended 2013) (current version at Tex. Gov't Code § 531.102(g)(2)). The referenced section of the Code of Federal Regulations provides:

- Notice of the hold must be sent to the provider and must state that the suspension is "for a temporary period" and "cite the circumstances under which the suspension will be terminated."
- Suspension of payment actions will be temporary and will not continue after (1) the agency or prosecuting authorities determine there is insufficient evidence of fraud by the provider or (2) legal proceedings related to the alleged fraud are completed.
- If a state Medicaid agency referral and investigation leads to a payment suspension, the payment suspension may be continued until such time as the investigation and any enforcement proceedings are completed.

42 C.F.R. § 455.23.

Thus, a payment hold imposed pursuant to Government Code section 531.102(g) is temporary and must end under the circumstances outlined in the applicable federal and state

regulations. As we held in Janek v. Harlingen Family Dentistry, HHSC's right to possess funds

pursuant to a payment hold for fraud depends solely on the existence of credible evidence of such

fraud. In the absence of such evidence, "the State's right to temporary possession of the funds no

longer exist[s]." Janek, 2014 WL 5653501, at *5. Once the statutory basis for imposing the hold

ceases to exist, HHSC no longer has the authority to possess those funds. The same is true for funds

accumulated pursuant to a hold imposed for the other reasons identified in section 531.102(g)(2).

Accordingly, a rule permitting the OIG to continue to possess a Medicaid provider's funds

when the justification for imposing the temporary payment hold has terminated is in excess of

HHSC's statutory authority. For this reason, we hold that current rule 371.1709(e)(2) is invalid, and

the trial court erred in concluding otherwise.

CONCLUSION

For the reasons stated above, we sustain the Dental Groups' sole appellate issue

and reverse the trial court's judgment. We render judgment that old rules 371.1703(b)(5) and (6)

and current rules 371.1709(a)(2), (3), (4) and 371.1709(e)(2) are invalid.

J. Woodfin Jones, Chief Justice

Before Chief Justice Jones, Justices Rose and Goodwin

Reversed and Rendered

Filed: November 25, 2014

15

B

Case Detail Page 1 of 4

CASE: 03-14-00069-CV

DATE FILED: 02/06/2014

CASE TYPE: ADMINISTRATIVE LAW

STYLE: HARLINGEN FAMILY DENTISTRY, P.C.; AND TRUEBLOOD DENTAL ASSOCIATES, P.A.

V.: TEXAS HEALTH AND HUMAN SERVICES COMMISSION AND OFFICE OF THE INSPECTOR GENERAL

ORIG PROC: NO

TRANSFER FROM:

TRANSFER IN:

TRANSFER CASE:

TRANSFER TO:

TRANSFER OUT:

PUB SERVICE: WEST PUBLISHING

APPELLATE BRIEFS

DATE	EVENT TYPE	DESCRIPTION	DOCUMENT
10/30/2014	REPLY BRIEF FILED	APPELLANT	BRIEF [PDF/442 KB]
08/22/2014	BRIEF FILED - ORAL ARGUMENT REQUESTED	APPELLEE	BRIEF [PDF/14.67 MB]
06/25/2014	BRIEF FILED - ORAL ARGUMENT REQUESTED	APPELLANT	BRIEF [PDF/2.70 MB]
06/24/2014	BRIEF RECEIVED - ORAL ARGUMENT REQUESTED	APPELLANT	

CASE EVENTS

MOTION FOR EXTENSION OF TIME 102/05/2015 TO FILE PETITION MOTION OR WRIT GRANTED DISPOSED BY SUPREME COURT MOTION FOR EXTENSION OF TIME	DOCUMENT	DISPOSITION	DESCRIPTION	EVENT TYPE	DATE
EXTENSION OF TIME				EXTENSION OF TIME TO FILE PETITION FOR REVIEW DISPOSED BY	02/05/2015
12/31/2014 FOR REVIEW GRANTED DISPOSED BY SUPREME COURT		MOTION OR WRIT GRANTED		EXTENSION OF TIME TO FILE PETITION FOR REVIEW DISPOSED BY	12/31/2014

Case Detail Page 2 of 4

DATE	EVENT TYPE	DESCRIPTION	DISPOSITION	DOCUMENT
				JUDGMENT
				[PDF/67 KB]
11 /25 /2014	OPINION ISSUED		REVERSED AND	OPINION
11/25/2014	OPINION ISSUED		RENDERED	[PDF/120 KB]
				NOTICE
				[PDF/50 KB]
11/24/2014	SUBMITTED			
	SET FOR			NOTICE
11/03/2014	SUBMISSION ON BRIEFS			[PDF/77 KB]
				BRIEF
10/30/2014	REPLY BRIEF FILED	APPELLANT		[PDF/442 KB]
	ODAL ADCUMENT			[. 5., 112 10]
10/15/2014	ORAL ARGUMENT DENIED			
	MOTION FOR			
10/13/2014	EXTENSION OF TIME	APPELLANT	MOTION OR WRIT	NOTICE
	TO FILE REPLY BRIEF DISPOSED		GRANTED	[PDF/81 KB]
	MOTION FOR			
10/10/2014	EXTENSION OF TIME	APPELLANT		MOTION
., ., .	TO FILE REPLY BRIEF FILED			[PDF/228 KB]
00/22/2014	CASE READY TO BE			
09/22/2014	SET			
	MOTION FOR		MOTION OF WATER	NOTICE
09/11/2014	EXTENSION OF TIME TO FILE REPLY BRIEF	APPELLANT	MOTION OR WRIT	[PDF/81 KB]
	DISPOSED			[PDF/61 KB]
	MOTION FOR			MOTION
09/10/2014	EXTENSION OF TIME TO FILE REPLY BRIEF	APPELLANT		MOTION
	FILED			[PDF/120 KB]
	BRIEF FILED - ORAL			BRIEF
08/22/2014	ARGUMENT REQUESTED	APPELLEE		[PDF/14.67 MB]
	SUPPLEMENTAL			NOTICE
08/13/2014	CLERKS RECORD	DISTRICT CLERK		NOTICE
	FILED			[PDF/75 KB]
	MOTION FOR EXTENSION OF TIME		MOTION OR WRIT	NOTICE
07/23/2014	TO FILE BRIEF	APPELLEE	GRANTED GRANTED	[PDF/74 KB]
	DISPOSED			
07/22/2014	MOTION FOR	ADDELLEE		MOTION
07/23/2014	TO FILE BRIEF FILED	APPELLEE		[PDF/65 KB]
				LETTER
07/09/2014	LETTER RECEIVED	APPELLEE		[PDF/63 KB]
	BRIEF FILED - ORAL			
06/25/2014	ARGUMENT	APPELLANT		BRIEF
	REQUESTED			[PDF/2.70 MB]

Case Detail Page 3 of 4

DATE	EVENT TYPE	DESCRIPTION	DISPOSITION	DOCUMENT
06/24/2014	BRIEF RECEIVED - ORAL ARGUMENT REQUESTED	APPELLANT		
06/23/2014	MOTION FOR EXTENSION OF TIME TO FILE BRIEF DISPOSED	APPELLANT	MOTION OR WRIT GRANTED	NOTICE [PDF/73 KB]
06/23/2014	MOTION FOR EXTENSION OF TIME TO FILE BRIEF FILED	APPELLANT		MOTION [PDF/220 KB]
05/20/2014	MOTION FOR EXTENSION OF TIME TO FILE BRIEF DISPOSED	APPELLANT	MOTION OR WRIT GRANTED	NOTICE [PDF/73 KB]
05/20/2014	MOTION FOR EXTENSION OF TIME TO FILE BRIEF FILED	APPELLANT		MOTION [PDF/230 KB]
04/25/2014	RECORD CHECKED OUT			
04/18/2014	REPORTERS RECORD FILED	COURT REPORTER		NOTICE [PDF/76 KB]
04/08/2014	NOTICE OF LATE RECORD	COURT REPORTER		NOTICE [PDF/85 KB]
03/11/2014	RECORD CHECKED OUT			
03/10/2014	RECORD CHECKED OUT			
02/20/2014	CLERKS RECORD FILED	DISTRICT CLERK		NOTICE [PDF/71 KB]
02/06/2014	DOCKETING STATEMENT FILED	APPELLANT		
02/06/2014	NOTICE OF APPEAL FILED IN COURT OF APPEALS	APPELLANT		NOTICE [PDF/83 KB]

CALENDARS

SET DATE	CALENDAR TYPE	REASON SET
02/04/2015	STATUS	MANDATE TO ISSUE
12/31/2014	APPEAL TO HIGHER COURT	HIGHER COURT REVIEW

PARTIES

PARTY	PARTYTYPE	REPRESENTATIVE
HARLINGEN FAMILY DENTISTRY, P.C.	APPELLANT	MR. JASON D. RAY
OFFICE OF THE INSPECTOR GENERAL	APPELLEE	MS. ANN HARTLEY

Case Detail Page 4 of 4

PARTY	PARTYTYPE	REPRESENTATIVE	
TEXAS HEALTH AND HUMAN SERVICES COMMISSION	APPELLEE	MS. ANN HARTLEY	
TRUEBLOOD DENTAL ASSOCIATES, P.A.	APPELLANT	MR. JASON D. RAY MR. BILL ALESHIRE	

TRIAL COURT INFORMATION

COURT: 419TH DISTRICT COURT

COUNTY: TRAVIS

COURT JUDGE: HONORABLE LORA J. LIVINGSTON

COURT CASE: D-1-GN-13-002402

COURT REPORTER: LASONYA THOMAS

PUNISHMENT:

 \mathbf{C}

DC BK14030 PG1128

Notice sent (Final Interlocutory None
Disp Parties: ALL
Disp code: (CVD) CLS 4018

Ped not ogs:

CAUSE NO. D-1-GN-13-002402

Filed in The District Court of Travis County, Texas

JAN 27,2014

Amalia Rodriguez Mendoza, Clerk

HARLINGEN FAMILY DENTISTRY, P.C.,

Petitioner,

AND

sudge.

TRUEBLOOD DENTAL ASSOCIATES,

P.A.,

Intervenor

VS.

TEXAS HEALTH AND HUMAN SERVICES COMMISSION, and OFFICE OF INSPECTOR GENERAL,

Respondents

IN THE DISTRICT COURT

419th JUDICIAL DISTRICT

TRAVIS COUNTY, TEXAS

FINAL JUDGMENT

On January 21, 2014 the Court heard the challenge, under Texas Government Code Section 2001.038, of Harlingen Family Dentistry, P.C. and Trueblood Dental Associates, P.A. to the following rules adopted by the Texas Health and Human Services Commission:

1 Tex. Admin. Code § 371.1703(b)(5) (2005) (repealed)

1 Tex. Admin. Code § 371.1703(b)(6) (2005) (repealed)

1 TEX. ADMIN. CODE § 371.1709(a)(2) (2012)

1 TEX. ADMIN. CODE § 371.1709(a)(3) (2012)

1 TEX. ADMIN. CODE § 371.1709(a)(4) (2012)

1 TEX. ADMIN. CODE § 371.1709(e)(2) (2012).

1

FINAL JUDGMENT, Cause No. D-1-GN-13-002402

All parties appeared and, after considering argument of counsel, the Court finds that all the challenged rules are valid and judgment is hereby entered in favor of Respondents Texas Health and Human Services Commission and Office of Inspector General.

All relief requested by any party and not granted herein is denied. This judgment disposes of all parties and all claims and is final.

Signed this ____

The Honorable Lora Livingston

Presiding Judge

Approved as to form:

Jason Ray

Attorney for Harlingen Family Dentistry, P.C.

Bill Aleshire

Attorney for Trueblood Dental Associates, P.A.

Ann Hartley

Attorney for Texas Health and Human Services Commission

and Office of Inspector General

FINAL JUDGMENT, Cause No. D-1-GN-13-002402

2

TEXAS COURT OF APPEALS, THIRD DISTRICT, AT AUSTIN

JUDGMENT RENDERED NOVEMBER 25, 2014

NO. 03-14-00069-CV

Harlingen Family Dentistry, P.C.; and Trueblood Dental Associates, P.A., Appellants

v.

Texas Health and Human Services Commission and Office of the Inspector General,
Appellees

APPEAL FROM 419TH DISTRICT COURT OF TRAVIS COUNTY BEFORE CHIEF JUSTICE JONES, JUSTICES ROSE AND GOODWIN REVERSED AND RENDERED -- OPINION BY CHIEF JUSTICE JONES

This is an appeal from the judgment signed by the trial court on January 23, 2014. Having reviewed the record and the parties' arguments, the Court holds that there was reversible error in the trial court's judgment. Therefore, the Court reverses the trial court's judgment and renders judgment that old rules 1 Tex. Admin. Code § 371.1703(b)(5) and (6) (2005) (repealed) and current rules 1 Tex. Admin. Code § 371.1709(a) (2), (3), (4) and § 371.1709 (e)(2) are invalid. The appellees shall pay all costs relating to this appeal, both in this Court and the court below.

D

Tex. Admin. Code tit. 1, § 371.1709

Texas Administrative Code Currentness

Title 1. Administration

Part 15. Texas Health and Human Services Commission

Chapter 371. Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity

Subchapter G. Administrative Actions and Sanctions

Division 3. Administrative Actions and Sanctions

→→ § 371.1709. Payment Hold

- (a) OIG may impose a payment hold against any person if it determines that the person committed an act for which a person is subject to administrative actions or sanctions, including the following:
 - (1) is subject to a suspension of payments by the U.S. Department of Health and Human Services for Medicare violations;
 - (2) commits a program violation;
 - (3) is affiliated with a person who commits a program violation; or
 - (4) for any other reason provided by statute or regulation.
- (b) OIG imposes a payment hold against a person:
 - (1) to compel the production records or documents when a request made by a Requesting Agency is refused;
 - (2) when requested by the state's Medicaid Fraud Control Unit; or
 - (3) upon determination a credible allegation of fraud exists.
- (c) Whenever OIG's investigation leads to the initiation of a payment hold in whole or part, OIG will make a fraud referral to the Medicaid Fraud Control Unit as required by 42 CFR § 455.23(d).
- (d) Notice.

Tex. Admin. Code tit. 1, § 371.1709

agency;

(1) Unless OIG receives a request from a law enforcement agency to temporarily withhold notice to a person of payment hold, OIG provides written notice of a payment hold no later than the fifth (5th) business day after the date the payment hold is imposed. A law enforcement agency may request a delay in sending notice for up to 30 days. The request may be renewed up to twice and in no event may exceed 90 days.

renewed up to twice and in no event may exceed 90 days.
(2) Notice of payment hold includes:
(A) a description of the hold;
(B) the basis for the hold;
(C) the effect of the hold;
(D) the duration of the hold; and
(E) a statement of the person's right to request an informal resolution meeting or a payment hold hearing regarding the imposition of the payment hold.
(3) If the payment hold is based on a credible allegation of fraud, written notice will also:
(A) state that the payments are being suspended according to 42 CFR § 455.23;
(B) state the general allegations as to why the payment hold has been imposed;
(C) state that the hold is for a temporary period and will be lifted after either:
(i) OIG or a prosecuting authority determines that there is insufficient evidence of fraud by the person; or
(ii) legal proceedings related to the person's alleged fraud are completed;
(D) specify the types of Medicaid claims or business units to which the payment suspension is effective;

(E) inform the provider of the right to submit written evidence for consideration by the

Tex. Admin. Code tit. 1, § 371.1709

(F) state 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

(G) describe administrative and judicial due process remedies, including the provider's right to seek informal resolution, a formal administrative appeal hearing, or both.

(e) Due process.

- (1) After receiving a notice of payment hold, a person has a right to the informal resolution process in accordance with § 371.1613of this subchapter (relating to Informal Resolution Process). A request for an IRM does not expand the time allowed to the provider to request an administrative hearing.
- (2) A person may request a payment hold hearing after receipt of a notice of payment hold in accordance with § 371.1615(d) of this subchapter (relating to Appeals). OIG must receive the written request for an appeal no later than 30 days after the date the person receives the notice.
- (f) Scope and effect of payment hold.
 - (1) Once a person is placed on payment hold, payment of Medicaid or other HHS program claims for specific procedures or services and any other payments to the person from an HHS agency will be limited or denied.
 - (2) 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:
 - (A) that investigation and any associated enforcement proceedings are complete; or
 - (B) 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.
 - (3) If the state's Medicaid fraud control unit or any other law enforcement agency declines to accept a fraud referral from OIG for investigation, a payment hold based on a credible allegation of fraud will 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.

Tex. Admin. Code tit. 1, § 371.1709

(4) After a payment hold is terminated for any reason, OIG may retain the funds accumulated during the payment hold to offset any overpayment, criminal restitution, penalty or other assessment, or agreed-upon amount that may result from ongoing investigation of the person, including any payment amount accepted by the prosecuting authorities made in lieu of a prosecution to reimburse the Medicaid or other HHS program.

- (5) The payment hold may be terminated or partially lifted upon the following events:
 - (A) OIG or a prosecuting authority determines that there is insufficient evidence of fraud by the person if the hold is based upon an allegation of fraud;
 - (B) legal proceedings related to the person's alleged fraud are completed if the hold is based upon an allegation of fraud;
 - (C) the Medicaid Fraud Control Unit asks OIG to lift the hold if the hold is based upon the Unit's request;
 - (D) the duration of the hold expires if the hold was imposed for a specific, limited time;
 - (E) OIG and the person have agreed to lift the hold in whole or in part during an informal resolution;
 - (F) OIG determines in its sole discretion that there is insufficient evidentiary or legal basis for maintaining the hold;
 - (G) OIG determines in its sole discretion that it is in the best interests of the Medicaid program to lift the hold;
 - (H) OIG determines that a payment hold would adversely affect clients' access to care or as otherwise determined to be "good cause" as defined in 42 CFR § 455.23(e);
 - (I) an administrative law judge or judge of any court of competent jurisdiction orders OIG to lift the hold in whole or in part; or
 - (J) all proceedings against the provider, including any appeals and judicial review, have been exhausted and all overpayments and other reimbursements are satisfied.

Source: The provisions of this §371.1709 adopted to be effective October 14, 2012, 37

Tex. Admin. Code tit. 1, § 371.1709

TexReg 7989; amended to be effective April 15, 2014, 39 TexReg 2833.

1 TAC § 371.1709, 1 TX ADC § 371.1709

Current through 40 Tex.Reg. No. 866, dated February 20, 2015, as effective on or before February 27, 2015

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END OF DOCUMENT

E

Texas Administrative Code

Title 1. Administration

(c) Notice.

Part 15. Texas Health and Human Services Commission
Chapter 371. Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity
Subchapter G. Administrative Actions and Sanctions
Division 3. Administrative Actions and Sanctions

1 TAC § 371.1709 Tex. Admin. Code tit. 1, § 371.1709

§ 371.1709. Payment Hold

Currentness

(a) OIG may impose a payment hold against any person if it determines that the person committed an act for which a person is subject to administrative actions or sanctions, including the following:
(1) is subject to a suspension of payments by the U.S. Department of Health and Human Services for Medicare violations
(2) commits a program violation;
(3) is affiliated with a person who commits a program violation; or
(4) for any other reason provided by statute or regulation.
(b) OIG imposes a payment hold against a person:
(1) to compel the production records or documents when a request made by a Requesting Agency is refused;
(2) when requested by the state's Medicaid Fraud Control Unit; or
(3) upon receipt of reliable evidence that verifies a credible allegation of fraud.

(1) Unless OIG receives a request from a law enforcement agency to temporarily withhold notice to a person of payment hold, OIG provides written notice of a payment hold no later than the fifth (5th) business day after the date the payment hold is imposed. A law enforcement agency may request a delay in sending notice for up to 30 days. The request may be

renewed up to twice and in no event may exceed 90 days.

	(2) Notice of payment hold includes:
	(A) a description of the hold;
	(B) the basis for the hold;
	(C) the effect of the hold;
	(D) the duration of the hold; and
	(E) a statement of the person's right to request an informal review or an expedited administrative appeal hearing regarding the imposition of the payment hold.
	(3) If the payment hold is based on reliable evidence that verifies a credible allegation of fraud, written notice will also:
	(A) state that the payments are being suspended according to 42 CFR § 455.23;
	(B) state the general allegations as to why the payment hold has been imposed;
	(C) state that the hold is for a temporary period and will be lifted after either:
	(i) OIG or a prosecuting authority determines that there is insufficient evidence of fraud by the person; or
	(ii) legal proceedings related to the person's alleged fraud are completed;
	(D) specify the types of Medicaid claims or business units to which the payment suspension is effective; and
	(E) inform the provider of the right to submit written evidence for consideration by the agency.
(d) l	Due process.
	(1) A person may request an expedited informal review after receipt of a notice of payment hold in accordance with § 371.1613(e) of this subchapter (relating to Informal Review). OIG must receive the written request for the informal review no later than the tenth calendar day after the date the person receives the notice. A request for an informal review does no expand the time allowed to the provider to request an administrative hearing.

- (2) Within ten days of receipt of the notice of payment hold, the person receiving the notice may submit to OIG any documentary evidence or written argument regarding whether payment hold is warranted and any related issues to be considered during the informal review. Submission of documentary evidence or written argument, however, is no guarantee that OIG will not ultimately maintain imposition of the hold.
- (3) A person may request an expedited administrative appeal hearing after receipt of a notice of payment hold in accordance with § 371.1615(d) of this subchapter (relating to Appeals). OIG must receive the written request for an appeal no later than the tenth calendar day after the date the person receives the notice.
- (4) If both an informal review and an administrative hearing are requested, the administrative hearing and all pertinent discovery, prehearing conferences, and all other issues and activities regarding the administrative hearing will be abated until all informal review discussions have concluded without settlement or resolution of the issues.
- (e) Scope and effect of payment hold.
 - (1) Once a person is placed on payment hold, payment of Medicaid or other HHS program claims for specific procedures or services and any other payments to the person from an HHS agency will be limited or denied.
 - (2) After a payment hold is terminated for any reason, OIG may retain the funds accumulated during the payment hold to offset any overpayment, criminal restitution, penalty or other assessment, or agreed-upon amount that may result from ongoing investigation of the person, including any payment amount accepted by the prosecuting authorities made in lieu of a prosecution to reimburse the Medicaid or other HHS program.
 - (3) The payment hold may be terminated or partially lifted upon the following events:
 - (A) OIG or a prosecuting authority determines that there is insufficient evidence of fraud by the person if the hold is based upon an allegation of fraud;
 - (B) legal proceedings related to the person's alleged fraud are completed if the hold is based upon an allegation of fraud;
 - (C) the Medicaid Fraud Control Unit asks OIG to lift the hold if the hold is based upon the Unit's request;
 - (D) the duration of the hold expires if the hold was imposed for a specific, limited time;
 - (E) OIG and the person have agreed to lift the hold in whole or in part during an informal resolution;
 - (F) OIG determines in its sole discretion that there is insufficient evidentiary or legal basis for maintaining the hold;

- (G) OIG determines in its sole discretion that it is in the best interests of the Medicaid program to lift the hold;
- (H) OIG determines that a payment hold would adversely affect clients' access to care;
- (I) an administrative law judge or judge of any court of competent jurisdiction orders OIG to lift the hold in whole or in part; or
- (J) all proceedings against the provider, including any appeals and judicial review, have been exhausted and all overpayments and other reimbursements are satisfied.

Credits

Source: The provisions of this §371.1709 adopted to be effective October 14, 2012, 37 TexReg 7989.

Current through December 31, 2012. Copr. (C) 2012. All rights reserved.

1 TAC § 371.1709, 1 TX ADC § 371.1709

End of Document

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F

1 TAC § 371.1703 Tex. Admin. Code tit. 1, § 371.1703 TEXAS ADMINISTRATIVE CODE TITLE 1. ADMINISTRATION

PART 15. TEXAS HEALTH AND HUMAN SERVICES COMMISSION
CHAPTER 371. MEDICAID AND OTHER HEALTH AND HUMAN
SERVICES FRAUD AND ABUSE PROGRAM INTEGRITY
SUBCHAPTER G. LEGAL ACTION RELATING TO PROVIDERS OF MEDICAL ASSISTANCE
DIVISION 5. RECOVERY OF OVERPAYMENTS

Current through December 31, 2005

§ 371.1703. Recovery of Overpayments

- (a) The Inspector General and its agents recover all overpayments made to providers within the Medicaid or other HHS program, whether the overpayment resulted from error (by the provider, the claims administrator, or an operating agency), misunderstanding, or a program violation proven to result from fraud or abuse. When the Inspector General's investigation reveals evidence of a program violation (which may or may not include an overpayment), the Inspector General determines and imposes the appropriate administrative enforcement.
- (b) Payment Hold. A payment hold on payments of future claims submitted for reimbursement will be imposed, without prior notice, after it is determined that prima facie evidence exists to support the payment hold. The payment hold may be imposed prior to completion of an investigation. It is used to withhold payments to providers that may be used subsequently to offset the overpayment or penalty amount when the investigation is complete. The provider or person will be notified of the payment hold not later than the fifth (5th) working day after the date the hold is imposed. With the exception of a payment hold imposed as a result of paragraph (2) of this subsection, the provider or person may request an informal review and/or an expedited administrative appeal hearing. These requests must be received in writing in the method prescribed by the Inspector General not later than the 10th day after the date the active provider receives notice of the payment hold. 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 appeal hearing. On timely written request by a provider subject to a payment hold, the Inspector General will file a request for an expedited administrative hearing regarding the payment hold. Should the provider request both an informal review and an expedited administrative appeal hearing, the expedited administrative appeal hearing will be abated until the informal review process is completed. The instances in which a payment hold may be imposed without prior notice are:
- (1) to compel production of records;
- (2) when requested by the Attorney General's Medicaid Fraud Control Unit, as applicable;
- (3) in the instance of fraud or willful misrepresentation;
- (4) when the U.S. Health and Human Services imposes a payment hold (suspension of payments) against the provider for Medicare violations and that provider or person is also a provider in the Medicaid program;
- (5) for any reasons specified in §§371.1609, 371.1617, 371.1621 of this subchapter, or any other provisions delineated in these rules; or
- (6) for any other reason specified by statute or regulation.
- (c) Injunction to Prevent Disposing of Assets and Application to Debts. Based on the results of investigative findings and evidence that potential fraud exists and a potential overpayment, penalty, or damage has been identified, a method that may be used by the Inspector General, as a fiduciary for the state, is injunctive relief. The purpose of the injunctive relief is to ensure assets remain to reimburse the state funds owed such as recoupment of overpayments and assessed damages and penalties, investigative costs, and other costs specified in §371.1705 of this subchapter. The Inspector General, for purposes of Medicaid or other HHS program reimbursement, will request that the Attorney General obtain an injunction to prevent a provider or person from disposing of an asset(s) identified by the Inspector General as potentially subject to recovery due to the provider's

or person's fraud or abuse. Upon final resolution of the case, any funds derived from the forfeited asset(s), after offsetting any expenses attributable to the sale of those assets, will be applied, by the Inspector General, to the unpaid debt.

- (d) Payment of recoupments. At the Inspector General's discretion, overpayments may be collected in a lump sum or through installments. The Inspector General may collect recoupments by deducting them incrementally from prospective or retrospective payments owed to the provider. If collection is made through installments, the provider must comply with the payment plan established by the Inspector General. A payment plan will be for a reasonable length of time as determined by the Inspector General considering the circumstances of each individual case.
- (e) Other collection methods. When providers have not paid funds owed to the Medicaid or other HHS program, the Inspector General will utilize numerous means necessary to aggressively collect funds owed. Some of these tools are: utilizing a collection agency, collecting from Medicare for Medicaid provider debts, requesting the State Comptroller to place a hold on all state voucher revenue for a provider or person from all state agencies, requesting the Attorney General's Collection Division to file suit in district court, and receiving and reporting credit information on providers and persons with outstanding debts.
- (f) Overpayments caused by an Order. An ordering provider or person causes an overpayment to be made to themselves or to another provider as a result of a false statement, misrepresentation, or omission of pertinent facts:
- (1) on a claim, attachments to a claim, medical records, document serving as an order for services, or any other documentation used to adjudicate a claim for payment;
- (2) any documentation submitted or maintained by the provider to support representations made on claims;
- (3) any documentation submitted or maintained by the provider to support the need or the medical necessity of the service; or
- (4) other documents used to establish fees, daily payment rates, or payments.

Source: The provisions of this §371.1703 adopted to be effective January 9, 2005, 29 TexReg 12128.

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42 C.F.R. § 430.10 Page 1

Effective:[See Text Amendments]

Code of Federal Regulations Currentness

Title 42. Public Health

Chapter IV. Centers for Medicare & Medicaid Services, Department of Health and Human Services (Refs & Annos)

Subchapter C. Medical Assistance Programs

Part 430. Grants to States for Medical Assistance Programs (Refs & Annos)

Subpart B. State Plans

 \rightarrow § 430.10 The State plan.

The State plan is a comprehensive written statement submitted by the agency describing the nature and scope of its Medicaid program and giving assurance that it will be administered in conformity with the specific requirements of title XIX, the regulations in this Chapter IV, and other applicable official issuances of the Department. The State plan contains all information necessary for CMS to determine whether the plan can be approved to serve as a basis for Federal financial participation (FFP) in the State program.

SOURCE: 53 FR 36571, Sept. 21, 1988; 77 FR 29028, May 16, 2012, unless otherwise noted.

AUTHORITY: Sec. 1102 of the Social Security Act (42 U.S.C. 1302).

42 C. F. R. § 430.10, 42 CFR § 430.10

Current through March 5, 2015; 80 FR 11945.

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Effective: April 1, 2014

United States Code Annotated Currentness

Title 42. The Public Health and Welfare

¬□ Chapter 7. Social Security (Refs & Annos)

¬□ Subchapter XIX. Grants to States for Medical Assistance Programs (Refs & Annos)

→ § 1396a. State plans for medical assistance

(a) Contents

A State plan for medical assistance must--

- (1) provide that it shall be in effect in all political subdivisions of the State, and, if administered by them, be mandatory upon them;
- (2) provide for financial participation by the State equal to not less than 40 per centum of the non-Federal share of the expenditures under the plan with respect to which payments under section 1396b of this title are authorized by this subchapter; and, effective July 1, 1969, provide for financial participation by the State equal to all of such non-Federal share or provide for distribution of funds from Federal or State sources, for carrying out the State plan, on an equalization or other basis which will assure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan;
- (3) provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness;
- (4) provide (A) such methods of administration (including methods relating to the establishment and maintenance of personnel standards on a merit basis, except that the Secretary shall exercise no authority with respect to the selection, tenure of office, and compensation of any individual employed in accordance with such methods, and including provision for utilization of professional medical personnel in the administration and, where administered locally, supervision of administration of the plan) as are found by the Secretary to be necessary for the proper and efficient operation of the plan, (B) for the training and effective use of paid subprofessional staff, with particular emphasis on the full-time or part-time employment of recipients and other persons of low income, as community service aides, in the administration of the plan and for the use of nonpaid or partially paid volunteers in a social service volunteer program in providing services to applicants and recipients and in assisting

any advisory committees established by the State agency, (C) that each State or local officer, employee, or independent contractor who is responsible for the expenditure of substantial amounts of funds under the State plan, each individual who formerly was such an officer, employee, or contractor and each partner of such an officer, employee, or contractor shall be prohibited from committing any act, in relation to any activity under the plan, the commission of which, in connection with any activity concerning the United States Government, by an officer or employee of the United States Government, an individual who was such an officer or employee, or a partner of such an officer or employee is prohibited by section 207 or 208 of Title 18, and (D) that each State or local officer, employee, or independent contractor who is responsible for selecting, awarding, or otherwise obtaining items and services under the State plan shall be subject to safeguards against conflicts of interest that are at least as stringent as the safeguards that apply under chapter 21 of Title 41 to persons described in section 2102(a)(3) of Title 41;

- (5) either provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan; or provide for the establishment or designation of a single State agency to administer or to supervise the administration of the plan, except that the determination of eligibility for medical assistance under the plan shall be made by the State or local agency administering the State plan approved under subchapter I or XVI of this chapter (insofar as it relates to the aged) if the State is eligible to participate in the State plan program established under subchapter XVI of this chapter, or by the agency or agencies administering the supplemental security income program established under subchapter XVI or the State plan approved under part A of subchapter IV of this chapter if the State is not eligible to participate in the State plan program established under subchapter XVI of this chapter;
- (6) provide that the State agency will make such reports, in such form and containing such information, as the Secretary may from time to time require, and comply with such provisions as the Secretary may from time to time find necessary to assure the correctness and verification of such reports;

(7) provide--

- (A) safeguards which restrict the use or disclosure of information concerning applicants and recipients to purposes directly connected with--
 - (i) the administration of the plan; and
 - (ii) the exchange of information necessary to certify or verify the certification of eligibility of children for free or reduced price breakfasts under the Child Nutrition Act of 1966 and free or reduced price lunches under the Richard B. Russell National School Lunch Act, in accordance with section 9(b) of that Act, using data standards and formats estab-

lished by the State agency; and

- (B) that, notwithstanding the Express Lane option under subsection (e)(13), the State may enter into an agreement with the State agency administering the school lunch program established under the Richard B. Russell National School Lunch Act under which the State shall establish procedures to ensure that--
 - (i) a child receiving medical assistance under the State plan under this subchapter whose family income does not exceed 133 percent of the poverty line (as defined in section 9902(2) of this title, including any revision required by such section), as determined without regard to any expense, block, or other income disregard, applicable to a family of the size involved, may be certified as eligible for free lunches under the Richard B. Russell National School Lunch Act and free breakfasts under the Child Nutrition Act of 1966 without further application; and
 - (ii) the State agencies responsible for administering the State plan under this subchapter, and for carrying out the school lunch program established under the Richard B. Russell National School Lunch Act (42 U.S.C. 1751 et seq.) or the school breakfast program established by section 4 of the Child Nutrition Act of 1966 (42 U.S.C. 1773), cooperate in carrying out paragraphs (3)(F) and (15) of section 9(b) of that Act;
- (8) provide that all individuals wishing to make application for medical assistance under the plan shall have opportunity to do so, and that such assistance shall be furnished with reasonable promptness to all eligible individuals;

(9) provide--

- (A) that the State health agency, or other appropriate State medical agency (whichever is utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title), shall be responsible for establishing and maintaining health standards for private or public institutions in which recipients of medical assistance under the plan may receive care or services,
- (B) for the establishment or designation of a State authority or authorities which shall be responsible for establishing and maintaining standards, other than those relating to health, for such institutions,
- (C) that any laboratory services paid for under such plan must be provided by a laboratory which meets the applicable requirements of section 1395x(e)(9) of this title or paragraphs (16) and (17) [FN1] of section 1395x(s) of this title, or, in the case of a laboratory which is in a rural health clinic, of section 1395x(aa)(2)(G) of this title, and

(**D**) that the State maintain a consumer-oriented website providing useful information to consumers regarding all skilled nursing facilities and all nursing facilities in the State, including for each facility, Form 2567 State inspection reports (or a successor form), complaint investigation reports, the facility's plan of correction, and such other information that the State or the Secretary considers useful in assisting the public to assess the quality of long term care options and the quality of care provided by individual facilities;

(10) provide--

- (A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17), (21), and (28) of section 1396d(a) of this title, to--
 - (i) all individuals--
 - (I) who are receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI of this chapter, or part A or part E of subchapter IV of this chapter (including individuals eligible under this subchapter by reason of section 602(a)(37) [FN2], 606(h) [FN2], or 673(b) of this title, or considered by the State to be receiving such aid as authorized under section 682(e)(6) [FN2] of this title),
 - (II) (aa) with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter (or were being paid as of the date of the enactment of section 211(a) of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193) and would continue to be paid but for the enactment of that section), (bb) who are qualified severely impaired individuals (as defined in section 1396d(q) of this title), or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under subchapter XVI of this chapter if subparagraphs (A) and (B) of section 1382(c)(7) of this title were applied without regard to the phrase "the first day of the month following",
 - (III) who are qualified pregnant women or children as defined in section 1396d(n) of this title,
 - (IV) who are described in subparagraph (A) or (B) of subsection (l)(1) of this section and whose family income does not exceed the minimum income level the State is required to establish under subsection (l)(2)(A) of this section for such a family; [FN3]
 - (V) who are qualified family members as defined in section 1396d(m)(1) of this title; [FN3]

- (VI) who are described in subparagraph (C) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(B) of this section for such a family,
- (VII) who are described in subparagraph (D) of subsection (l)(1) of this section and whose family income does not exceed the income level the State is required to establish under subsection (l)(2)(C) of this section for such a family; [FN4]
- (VIII) beginning January 1, 2014, who are under 65 years of age, not pregnant, not entitled to, or enrolled for, benefits under part A of subchapter XVIII of this chapter, or enrolled for benefits under part B of subchapter XVIII of this chapter, and are not described in a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) does not exceed 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved, subject to subsection (k); [FN5]or
- (**IX**) who--
 - (aa) are under 26 years of age;
 - (bb) are not described in or enrolled under any of subclauses (I) through (VII) of this clause or are described in any of such subclauses but have income that exceeds the level of income applicable under the State plan for eligibility to enroll for medical assistance under such subclause;
 - (cc) were in foster care under the responsibility of the State on the date of attaining 18 years of age or such higher age as the State has elected under section 675(8)(B)(iii) of this title; and
 - (**dd**) were enrolled in the State plan under this subchapter or under a waiver of the plan while in such foster care; [FN6]
- (ii) at the option of the State, to [FN7] any group or groups of individuals described in section 1396d(a) of this title (or, in the case of individuals described in section 1396d(a)(i) of this title, to [FN7] any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but--
 - (I) who meet the income and resources requirements of the appropriate State plan described in clause (i) or the supplemental security income program (as the case may be),

- (II) who would meet the income and resources requirements of the appropriate State plan described in clause (i) if their work-related child care costs were paid from their earnings rather than by a State agency as a service expenditure,
- (III) who would be eligible to receive aid under the appropriate State plan described in clause (i) if coverage under such plan was as broad as allowed under Federal law,
- (IV) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan described in clause (i), supplemental security income benefits under subchapter XVI of this chapter, or a State supplementary payment; [FN3]
- (V) who are in a medical institution for a period of not less than 30 consecutive days (with eligibility by reason of this subclause beginning on the first day of such period), who meet the resource requirements of the appropriate State plan described in clause (i) or the supplemental security income program, and whose income does not exceed a separate income standard established by the State which is consistent with the limit established under section 1396b(f)(4)(C) of this title,
- (VI) who would be eligible under the State plan under this subchapter if they were in a medical institution, with respect to whom there has been a determination that but for the provision of home or community-based services described in subsection (c), (d), or (e) of section 1396n of this title they would require the level of care provided in a hospital, nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan, and who will receive home or community-based services pursuant to a waiver granted by the Secretary under subsection (c), (d), or (e) of section 1396n of this title,
- (VII) who would be eligible under the State plan under this subchapter if they were in a medical institution, who are terminally ill, and who will receive hospice care pursuant to a voluntary election described in section 1396d(o) of this title; [FN3]
- (VIII) who is a child described in section 1396d(a)(i) of this title-
 - (aa) for whom there is in effect an adoption assistance agreement (other than an agreement under part E of subchapter IV of this chapter) between the State and an adoptive parent or parents,
 - (bb) who the State agency responsible for adoption assistance has determined cannot be placed with adoptive parents without medical assistance because such child has

special needs for medical or rehabilitative care, and

(cc) who was eligible for medical assistance under the State plan prior to the adoption assistance agreement being entered into, or who would have been eligible for medical assistance at such time if the eligibility standards and methodologies of the State's foster care program under part E of subchapter IV of this chapter were applied rather than the eligibility standards and methodologies of the State's aid to families with dependent children program under part A of subchapter IV of this chapter; [FN3]

(IX) who are described in subsection (l)(1) of this section and are not described in clause (i)(IV), clause (i)(VI), or clause (i)(VII); [FN3]

(X) who are described in subsection (m)(1) of this section; [FN3]

(XI) who receive only an optional State supplementary payment based on need and paid on a regular basis, equal to the difference between the individual's countable income and the income standard used to determine eligibility for such supplementary payment (with countable income being the income remaining after deductions as established by the State pursuant to standards that may be more restrictive than the standards for supplementary security income benefits under subchapter XVI of this chapter), which are available to all individuals in the State (but which may be based on different income standards by political subdivision according to cost of living differences), and which are paid by a State that does not have an agreement with the Commissioner of Social Security under section 1382e or 1383c of this title; [FN3]

(XII) who are described in subsection (z)(1) of this section (relating to certain TB-infected individuals); [FN3]

(XIII) who are in families whose income is less than 250 percent of the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 9902(2) of this title) applicable to a family of the size involved, and who but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income (subject, notwithstanding section 1396o of this title, to payment of premiums or other cost-sharing charges (set on a sliding scale based on income) that the State may determine);

(XIV) who are optional targeted low-income children described in section 1396d(u)(2)(B) of this title;

(XV) who, but for earnings in excess of the limit established under section 1396d(q)(2)(B) of this title, would be considered to be receiving supplemental security income, who is at least 16, but less than 65, years of age, and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish;

(XVI) who are employed individuals with a medically improved disability described in section 1396d(v)(1) of this title and whose assets, resources, and earned or unearned income (or both) do not exceed such limitations (if any) as the State may establish, but only if the State provides medical assistance to individuals described in subclause (XV);

(XVII) who are independent foster care adolescents (as defined in section 1396d(w)(1) of this title), or who are within any reasonable categories of such adolescents specified by the State;

(XVIII) who are described in subsection (aa) of this section (relating to certain breast or cervical cancer patients); [FN4]

(XIX) who are disabled children described in subsection (cc)(1); [FN4]

(XX) beginning January 1, 2014, who are under 65 years of age and are not described in or enrolled under a previous subclause of this clause, and whose income (as determined under subsection (e)(14)) exceeds 133 percent of the poverty line (as defined in section 1397jj(c)(5) of this title) applicable to a family of the size involved but does not exceed the highest income eligibility level established under the State plan or under a waiver of the plan, subject to subsection (hh); [FN4]

(XXI) who are described in subsection (ii) (relating to individuals who meet certain income standards); [FN4] or

(**XXII**) who are eligible for home and community-based services under needs-based criteria established under paragraph (1)(A) of section 1396n(i) of this title, or who are eligible for home and community-based services under paragraph (6) of such section, and who will receive home and community-based services pursuant to a State plan amendment under such subsection;

(**B**) that the medical assistance made available to any individual described in subparagraph (A)--

- (i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and
- (ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);
- (C) that if medical assistance is included for any group of individuals described in section 1396d(a) of this title who are not described in subparagraph (A) or (E), then--
 - (i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance, (II) the amount, duration, and scope of medical assistance made available to individuals in the group, and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be no more restrictive than the methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be no more restrictive than the methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups;
 - (ii) the plan must make available medical assistance--
 - (I) to individuals under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i), and
 - (II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);
 - (iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and
 - (iv) if such medical assistance includes services in institutions for mental diseases or in an intermediate care facility for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1396d(a) of this title or the care and services listed in any 7 of the paragraphs numbered (1) through (24) of such section;

- (**D**) for the inclusion of home health services for any individual who, under the State plan, is entitled to nursing facility services;
- (E)(i) for making medical assistance available for medicare cost-sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title;
- (ii) for making medical assistance available for payment of medicare cost-sharing described in section 1396d(p)(3)(A)(i) of this title for qualified disabled and working individuals described in section 1396d(s) of this title;
- (iii) for making medical assistance available for medicare cost sharing described in section 1396d(p)(3)(A)(ii) of this title subject to section 1396d(p)(4) of this title, for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title but is less than 110 percent in 1993 and 1994, and 120 percent in 1995 and years thereafter of the official poverty line (referred to in such section) for a family of the size involved; and
- (iv) subject to sections 1396u-3 and 1396d(p)(4) of this title, for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with March 2015) for medicare cost-sharing described in section 1396d(p)(3)(A)(ii) of this title for individuals who would be qualified medicare beneficiaries described in section 1396d(p)(1) of this title but for the fact that their income exceeds the income level established by the State under section 1396d(p)(2) of this title and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;
- (F) at the option of a State, for making medical assistance available for COBRA premiums (as defined in subsection (u)(2) of this section) for qualified COBRA continuation beneficiaries described in subsection (u)(1) of this section; and
- (G) that, in applying eligibility criteria of the supplemental security income program under subchapter XVI of this chapter [42 U.S.C.A. § 1381 et seq.] for purposes of determining eligibility for medical assistance under the State plan of an individual who is not receiving supplemental security income, the State will disregard the provisions of subsections (c) and (e) of section 1382b of this title;
- except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1396d(a) of this title to individuals meeting the age requirements pre-

scribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of subchapter XVIII of this chapter to individuals eligible therefor (either pursuant to an agreement entered into under section 1395v of this title or by reason of the payment of premiums under such subchapter by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of subchapter XVIII of this chapter for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1396o(a)(2) or (b)(2) of this title shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1396d(o) of this title to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under subchapter XVIII of this chapter, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (1)(1)(A) of this section who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and section 1396o(b) of this title, (IX) the making available of respiratory care services in accordance with subsection (e)(9) of this section shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A) of this section, provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1396r-4(a)(1)(A) of this title, as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1396e of this title shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) of this section who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2) of this section), (XIII) the medical assistance made available to an individual described in subsection (z)(1) of this section who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2) of this section), (XIV) the medical assistance made available to an individual described in subsection (aa) of this section who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer [FN8] (XV) the medical assistance made available to an individual described in subparagraph (A)(i)(VIII) shall be limited to medical assistance described in subsection (k)(1), (XVI) [FN9] the medical assistance made available to an individual described in subsection (ii) shall be limited to family planning services and supplies described in section 1396d(a)(4)(C) of this title including medical diagnosis and treatment services that are provided pursuant to a family planning service in a family planning setting [FN10] and (XVII) [FN9] if an individual is described in subclause (IX) of subparagraph (A)(i) and is also described in subclause (VIII) of that subparagraph, the medical assistance shall be made available to the individual through subclause (IX) instead of through subclause (VIII);

(11) (A) provide for entering into cooperative arrangements with the State agencies responsible for administering or supervising the administration of health services and vocational rehabilitation services in the State looking toward maximum utilization of such services in the provision of medical assistance under the plan, (B) provide, to the extent prescribed by the Secretary, for entering into agreements, with any agency, institution, or organization receiv-

ing payments under (or through an allotment under) subchapter V of this chapter, (i) providing for utilizing such agency, institution, or organization in furnishing care and services which are available under such subchapter or allotment and which are included in the State plan approved under this section [FN11] (ii) making such provision as may be appropriate for reimbursing such agency, institution, or organization for the cost of any such care and services furnished any individual for which payment would otherwise be made to the State with respect to the individual under section 1396b of this title, and (iii) providing for coordination of information and education on pediatric vaccinations and delivery of immunization services, and (C) provide for coordination of the operations under this subchapter, including the provision of information and education on pediatric vaccinations and the delivery of immunization services, with the State's operations under the special supplemental nutrition program for women, infants, and children under section 17 of the Child Nutrition Act of 1966 [42 U.S.C.A. 1786];

(12) provide that, in determining whether an individual is blind, there shall be an examination by a physician skilled in the diseases of the eye or by an optometrist, whichever the individual may select;

(13) provide--

- (A) for a public process for determination of rates of payment under the plan for hospital services, nursing facility services, and services of intermediate care facilities for the mentally retarded under which--
 - (i) proposed rates, the methodologies underlying the establishment of such rates, and justifications for the proposed rates are published,
 - (ii) providers, beneficiaries and their representatives, and other concerned State residents are given a reasonable opportunity for review and comment on the proposed rates, methodologies, and justifications,
 - (iii) final rates, the methodologies underlying the establishment of such rates, and justifications for such final rates are published, and
 - (iv) in the case of hospitals, such rates take into account (in a manner consistent with section 1396r-4 of this title) the situation of hospitals which serve a disproportionate number of low-income patients with special needs;
- (B) for payment for hospice care in amounts no lower than the amounts, using the same methodology, used under part A of subchapter XVIII of this chapter and for payment of amounts under section 1396d(o)(3) of this title; except that in the case of hospice care

which is furnished to an individual who is a resident of a nursing facility or intermediate care facility for the mentally retarded, and who would be eligible under the plan for nursing facility services or services in an intermediate care facility for the mentally retarded if he had not elected to receive hospice care, there shall be paid an additional amount, to take into account the room and board furnished by the facility, equal to at least 95 percent of the rate that would have been paid by the State under the plan for facility services in that facility for that individual; and

- (C) payment for primary care services (as defined in subsection (jj)) furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine at a rate not less than 100 percent of the payment rate that applies to such services and physician under part B of subchapter XVIII of this chapter (or, if greater, the payment rate that would be applicable under such part if the conversion factor under section 1395w-4(d) of this title for the year involved were the conversion factor under such section for 2009);
- (14) provide that enrollment fees, premiums, or similar charges, and deductions, cost sharing, or similar charges, may be imposed only as provided in section 13960 of this title;
- (15) provide for payment for services described in clause (B) or (C) of section 1396d(a)(2) of this title under the plan in accordance with subsection (bb) of this section;
- (16) provide for inclusion, to the extent required by regulations prescribed by the Secretary, of provisions (conforming to such regulations) with respect to the furnishing of medical assistance under the plan to individuals who are residents of the State but are absent therefrom:
- (17) except as provided in subsections (e)(14), (e)(14), [FN12] (1)(3), (m)(3), and (m)(4) of this section, include reasonable standards (which shall be comparable for all groups and may, in accordance with standards prescribed by the Secretary, differ with respect to income levels, but only in the case of applicants or recipients of assistance under the plan who are not receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV of this chapter, and with respect to whom supplemental security income benefits are not being paid under subchapter XVI of this chapter, based on the variations between shelter costs in urban areas and in rural areas) for determining eligibility for and the extent of medical assistance under the plan which (A) are consistent with the objectives of this subchapter, (B) provide for taking into account only such income and resources as are, as determined in accordance with standards prescribed by the Secretary, available to the applicant or recipient and (in the case of any applicant or recipient who would, except for income and resources, be eligible for aid or assistance in the form of money payments under any plan of the State approved under subchapter I, X, XIV, or XVI, or part A of subchapter IV, or to have paid with respect to him supplemental security

income benefits under subchapter XVI of this chapter) as would not be disregarded (or set aside for future needs) in determining his eligibility for such aid, assistance, or benefits, (C) provide for reasonable evaluation of any such income or resources, and (D) do not take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21 or (with respect to States eligible to participate in the State program established under subchapter XVI of this chapter), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1382c of this title (with respect to States which are not eligible to participate in such program); and provide for flexibility in the application of such standards with respect to income by taking into account, except to the extent prescribed by the Secretary, the costs (whether in the form of insurance premiums, payments made to the State under section 1396b(f)(2)(B) of this title, or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred for medical care or for any other type of remedial care recognized under State law;

- (18) comply with the provisions of section 1396p of this title with respect to liens, adjustments and recoveries of medical assistance correctly paid,, [FN13] transfers of assets, and treatment of certain trusts;
- (19) provide such safeguards as may be necessary to assure that eligibility for care and services under the plan will be determined, and such care and services will be provided, in a manner consistent with simplicity of administration and the best interests of the recipients;
- (20) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in institutions for mental diseases--
 - (A) provide for having in effect such agreements or other arrangements with State authorities concerned with mental diseases, and, where appropriate, with such institutions, as may be necessary for carrying out the State plan, including arrangements for joint planning and for development of alternate methods of care, arrangements providing assurance of immediate readmittance to institutions where needed for individuals under alternate plans of care, and arrangements providing for access to patients and facilities, for furnishing information, and for making reports;
 - (B) provide for an individual plan for each such patient to assure that the institutional care provided to him is in his best interests, including, to that end, assurances that there will be initial and periodic review of his medical and other needs, that he will be given appropriate medical treatment within the institution, and that there will be a periodic determination of his need for continued treatment in the institution; and
 - (C) provide for the development of alternate plans of care, making maximum utilization of

available resources, for recipients 65 years of age or older who would otherwise need care in such institutions, including appropriate medical treatment and other aid or assistance; for services referred to in section 303(a)(4)(A)(i) and (ii) or section 1383(a)(4)(A)(i) and (ii) of this title which are appropriate for such recipients and for such patients; and for methods of administration necessary to assure that the responsibilities of the State agency under the State plan with respect to such recipients and such patients will be effectively carried out;

- (21) if the State plan includes medical assistance in behalf of individuals 65 years of age or older who are patients in public institutions for mental diseases, show that the State is making satisfactory progress toward developing and implementing a comprehensive mental health program, including provision for utilization of community mental health centers, nursing facilities, and other alternatives to care in public institutions for mental diseases;
- (22) include descriptions of (A) the kinds and numbers of professional medical personnel and supporting staff that will be used in the administration of the plan and of the responsibilities they will have, (B) the standards, for private or public institutions in which recipients of medical assistance under the plan may receive care or services, that will be utilized by the State authority or authorities responsible for establishing and maintaining such standards, (C) the cooperative arrangements with State health agencies and State vocational rehabilitation agencies entered into with a view to maximum utilization of and coordination of the provision of medical assistance with the services administered or supervised by such agencies, and (D) other standards and methods that the State will use to assure that medical or remedial care and services provided to recipients of medical assistance are of high quality;
- (23) provide that (A) any individual eligible for medical assistance (including drugs) may obtain such assistance from any institution, agency, community pharmacy, or person, qualified to perform the service or services required (including an organization which provides such services, or arranges for their availability, on a prepayment basis), who undertakes to provide him such services, and (B) an enrollment of an individual eligible for medical assistance in a primary care case-management system (described in section 1396n(b)(1) of this title), a medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive services under section 1396d(a)(4)(C) of this title, except as provided in subsection (g) of this section, in section 1396n of this title, and in section 1396u-2(a) of this title, except that this paragraph shall not apply in the case of Puerto Rico, the Virgin Islands, and Guam, and except that nothing in this paragraph shall be construed as requiring a State to provide medical assistance for such services furnished by a person or entity convicted of a felony under Federal or State law for an offense which the State agency determines is inconsistent with the best interests of beneficiaries under the State plan or by a provider or supplier to which a moratorium under subsection (kk)(4) is applied during the period of such moratorium;
- (24) effective July 1, 1969, provide for consultative services by health agencies and other

appropriate agencies of the State to hospitals, nursing facilities, home health agencies, clinics, laboratories, and such other institutions as the Secretary may specify in order to assist them (A) to qualify for payments under this chapter, (B) to establish and maintain such fiscal records as may be necessary for the proper and efficient administration of this chapter, and (C) to provide information needed to determine payments due under this chapter on account of care and services furnished to individuals;

(25) provide--

- (A) that the State or local agency administering such plan will take all reasonable measures to ascertain the legal liability of third parties (including health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) to pay for care and services available under the plan, including--
 - (i) the collection of sufficient information (as specified by the Secretary in regulations) to enable the State to pursue claims against such third parties, with such information being collected at the time of any determination or redetermination of eligibility for medical assistance, and
 - (ii) the submission to the Secretary of a plan (subject to approval by the Secretary) for pursuing claims against such third parties, which plan shall be integrated with, and be monitored as a part of the Secretary's review of, the State's mechanized claims processing and information retrieval systems required under section 1396b(r) of this title;
- (B) that in any case where such a legal liability is found to exist after medical assistance has been made available on behalf of the individual and where the amount of reimbursement the State can reasonably expect to recover exceeds the costs of such recovery, the State or local agency will seek reimbursement for such assistance to the extent of such legal liability;
- (C) that in the case of an individual who is entitled to medical assistance under the State plan with respect to a service for which a third party is liable for payment, the person furnishing the service may not seek to collect from the individual (or any financially responsible relative or representative of that individual) payment of an amount for that service (i) if the total of the amount of the liabilities of third parties for that service is at least equal to the amount payable for that service under the plan (disregarding section 13960 of this title), or (ii) in an amount which exceeds the lesser of (I) the amount which may be collected under section 13960 of this title, or (II) the amount by which the amount payable for that service under the plan (disregarding section 13960 of this title), exceeds the total of

the amount of the liabilities of third parties for that service;

- (**D**) that a person who furnishes services and is participating under the plan may not refuse to furnish services to an individual (who is entitled to have payment made under the plan for the services the person furnishes) because of a third party's potential liability for payment for the service:
- (E) that in the case of prenatal or preventive pediatric care (including early and periodic screening and diagnosis services under section 1396d(a)(4)(B) of this title) covered under the State plan, the State shall--
 - (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to the liability of a third party for payment for such services; and
 - (ii) seek reimbursement from such third party in accordance with subparagraph (B);
- (F) that in the case of any services covered under such plan which are provided to an individual on whose behalf child support enforcement is being carried out by the State agency under part D of subchapter IV of this chapter, the State shall--
 - (i) make payment for such service in accordance with the usual payment schedule under such plan for such services without regard to any third-party liability for payment for such services, if such third-party liability is derived (through insurance or otherwise) from the parent whose obligation to pay support is being enforced by such agency, if payment has not been made by such third party within 30 days after such services are furnished; and
 - (ii) seek reimbursement from such third party in accordance with subparagraph (B);
- (G) that the State prohibits any health insurer (including a group health plan, as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 US.C.A. 1167(1)], a self-insured plan, a service benefit plan, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service), in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under a plan under this subchapter for such State, or any other State;
- (H) that to the extent that payment has been made under the State plan for medical assist-

ance in any case where a third party has a legal liability to make payment for such assistance, the State has in effect laws under which, to the extent that payment has been made under the State plan for medical assistance for health care items or services furnished to an individual, the State is considered to have acquired the rights of such individual to payment by any other party for such health care items or services; and

- (I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974 [29 U.S.C.A. 1167(1)]), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--
 - (i) provide, with respect to individuals who are eligible (and, at State option, individuals who apply or whose eligibility for medical assistance is being evaluated in accordance with subsection (e)(13)(D) of this section) for, or are provided, medical assistance under the State plan under this subchapter (and, at State option, child health assistance under subchapter XXI of this chapter), upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;
 - (ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;
 - (iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and
 - (iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--
 - (I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and
 - (II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;

- (26) if the State plan includes medical assistance for inpatient mental hospital services, provide, with respect to each patient receiving such services, for a regular program of medical review (including medical evaluation) of his need for such services, and for a written plan of care;
- (27) provide for agreements with every person or institution providing services under the State plan under which such person or institution agrees (A) to keep such records as are necessary fully to disclose the extent of the services provided to individuals receiving assistance under the State plan, and (B) to furnish the State agency or the Secretary with such information, regarding any payments claimed by such person or institution for providing services under the State plan, as the State agency or the Secretary may from time to time request;

(28) provide--

- (A) that any nursing facility receiving payments under such plan must satisfy all the requirements of subsections (b) through (d) of section 1396r of this title as they apply to such facilities;
- (B) for including in "nursing facility services" at least the items and services specified (or deemed to be specified) by the Secretary under section 1396r(f)(7) of this title and making available upon request a description of the items and services so included;
- (C) for procedures to make available to the public the data and methodology used in establishing payment rates for nursing facilities under this subchapter; and
- (**D**) for compliance (by the date specified in the respective sections) with the requirements of--
 - (i) section 1396r(e) of this title;
 - (ii) section 1396r(g) of this title (relating to responsibility for survey and certification of nursing facilities); and
 - (iii) sections 1396r(h)(2)(B) and 1396r(h)(2)(D) of this title (relating to establishment and application of remedies);
- (29) include a State program which meets the requirements set forth in section 1396g of this title, for the licensing of administrators of nursing homes;

- (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; and
- (B) provide, under the program described in subparagraph (A), that--
 - (i) each admission to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases is reviewed or screened in accordance with criteria established by medical and other professional personnel who are not themselves directly responsible for the care of the patient involved, and who do not have a significant financial interest in any such institution and are not, except in the case of a hospital, employed by the institution providing the care involved, and
 - (ii) the information developed from such review or screening, along with the data obtained from prior reviews of the necessity for admission and continued stay of patients by such professional personnel, shall be used as the basis for establishing the size and composition of the sample of admissions to be subject to review and evaluation by such personnel, and any such sample may be of any size up to 100 percent of all admissions and must be of sufficient size to serve the purpose of (I) identifying the patterns of care being provided and the changes occurring over time in such patterns so that the need for modification may be ascertained, and (II) subjecting admissions to early or more extensive review where information indicates that such consideration is warranted to a hospital, intermediate care facility for the mentally retarded, or hospital for mental diseases;
- (31) with respect to services in an intermediate care facility for the mentally retarded (where the State plan includes medical assistance for such services) provide, with respect to each patient receiving such services, for a written plan of care, prior to admission to or authorization of benefits in such facility, in accordance with regulations of the Secretary, and for a regular program of independent professional review (including medical evaluation) which shall periodically review his need for such services;
- (32) provide that no payment under the plan for any care or service provided to an individual shall be made to anyone other than such individual or the person or institution providing such care or service, under an assignment or power of attorney or otherwise; except that-
 - (A) in the case of any care or service provided by a physician, dentist, or other individual practitioner, such payment may be made (i) to the employer of such physician, dentist, or

other practitioner if such physician, dentist, or practitioner is required as a condition of his employment to turn over his fee for such care or service to his employer, or (ii) (where the care or service was provided in a hospital, clinic, or other facility) to the facility in which the care or service was provided if there is a contractual arrangement between such physician, dentist, or practitioner and such facility under which such facility submits the bill for such care or service:

- (B) nothing in this paragraph shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the person or institution providing the care or service involved if such assignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of such person or institution from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such person or institution under the plan is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment;
- (C) in the case of services furnished (during a period that does not exceed 14 continuous days in the case of an informal reciprocal arrangement or 90 continuous days (or such longer period as the Secretary may provide) in the case of an arrangement involving per diem or other fee-for-time compensation) by, or incident to the services of, one physician to the patients of another physician who submits the claim for such services, payment shall be made to the physician submitting the claim (as if the services were furnished by, or incident to, the physician's services), but only if the claim identifies (in a manner specified by the Secretary) the physician who furnished the services; and
- (**D**) in the case of payment for a childhood vaccine administered before October 1, 1994, to individuals entitled to medical assistance under the State plan, the State plan may make payment directly to the manufacturer of the vaccine under a voluntary replacement program agreed to by the State pursuant to which the manufacturer (i) supplies doses of the vaccine to providers administering the vaccine, (ii) periodically replaces the supply of the vaccine, and (iii) charges the State the manufacturer's price to the Centers for Disease Control and Prevention for the vaccine so administered (which price includes a reasonable amount to cover shipping and the handling of returns);

(33) provide--

(A) that the State health agency, or other appropriate State medical agency, shall be responsible for establishing a plan, consistent with regulations prescribed by the Secretary, for the review by appropriate professional health personnel of the appropriateness and quality of care and services furnished to recipients of medical assistance under the plan in

order to provide guidance with respect thereto in the administration of the plan to the State agency established or designated pursuant to paragraph (5) and, where applicable, to the State agency described in the second sentence of this subsection; and

- (B) that, except as provided in section 1396r(g) of this title, the State or local agency utilized by the Secretary for the purpose specified in the first sentence of section 1395aa(a) of this title, or, if such agency is not the State agency which is responsible for licensing health institutions, the State agency responsible for such licensing, will perform for the State agency administering or supervising the administration of the plan approved under this subchapter the function of determining whether institutions and agencies meet the requirements for participation in the program under such plan, except that, if the Secretary has cause to question the adequacy of such determinations, the Secretary is authorized to validate State determinations and, on that basis, make independent and binding determinations concerning the extent to which individual institutions and agencies meet the requirements for participation;
- (34) provide that in the case of any individual who has been determined to be eligible for medical assistance under the plan, such assistance will be made available to him for care and services included under the plan and furnished in or after the third month before the month in which he made application (or application was made on his behalf in the case of a deceased individual) for such assistance if such individual was (or upon application would have been) eligible for such assistance at the time such care and services were furnished;
- (35) provide that any disclosing entity (as defined in section 1320a-3(a)(2) of this title) receiving payments under such plan complies with the requirements of section 1320a-3 of this title:
- (36) provide that within 90 days following the completion of each survey of any health care facility, laboratory, agency, clinic, or organization, by the appropriate State agency described in paragraph (9), such agency shall (in accordance with regulations of the Secretary) make public in readily available form and place the pertinent findings of each such survey relating to the compliance of each such health care facility, laboratory, clinic, agency, or organization with (A) the statutory conditions of participation imposed under this subchapter, and (B) the major additional conditions which the Secretary finds necessary in the interest of health and safety of individuals who are furnished care or services by any such facility, laboratory, clinic, agency, or organization;
- (37) provide for claims payment procedures which (A) ensure that 90 per centum of claims for payment (for which no further written information or substantiation is required in order to make payment) made for services covered under the plan and furnished by health care practitioners through individual or group practices or through shared health facilities are paid within 30 days of the date of receipt of such claims and that 99 per centum of such

claims are paid within 90 days of the date of receipt of such claims, and (B) provide for procedures of prepayment and postpayment claims review, including review of appropriate data with respect to the recipient and provider of a service and the nature of the service for which payment is claimed, to ensure the proper and efficient payment of claims and management of the program;

- (38) require that an entity (other than an individual practitioner or a group of practitioners) that furnishes, or arranges for the furnishing of, items or services under the plan, shall supply (within such period as may be specified in regulations by the Secretary or by the single State agency which administers or supervises the administration of the plan) upon request specifically addressed to such entity by the Secretary or such State agency, the information described in section 1320a-7(b)(9) of this title;
- (39) provide that the State agency shall exclude any specified individual or entity from participation in the program under the State plan for the period specified by the Secretary, when required by him to do so pursuant to section 1320a-7 or section 1320a-7a of this title, terminate the participation of any individual or entity in such program if (subject to such exceptions as are permitted with respect to exclusion under sections 1320a-7(c)(3)(B) and 1320a-7(d)(3)(B) of this title) participation of such individual or entity is terminated under subchapter XVIII of this chapter or any other State plan under this subchapter, and provide that no payment may be made under the plan with respect to any item or service furnished by such individual or entity during such period;
- (40) require each health services facility or organization which receives payments under the plan and of a type for which a uniform reporting system has been established under section 1320a(a) of this title to make reports to the Secretary of information described in such section in accordance with the uniform reporting system (established under such section) for that type of facility or organization;
- (41) provide that whenever a provider of services or any other person is terminated, suspended, or otherwise sanctioned or prohibited from participating under the State plan, the State agency shall promptly notify the Secretary and, in the case of a physician and notwithstanding paragraph (7), the State medical licensing board of such action;
- (42) provide that--
 - (A) the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan; and
 - (B) not later than December 31, 2010, the State shall--

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Effective:[See Text Amendments]

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Vernon's Texas Statutes and Codes Annotated Currentness
Government Code (Refs & Annos)

Title 4. Executive Branch (Refs & Annos)

Subtitle A. Executive Officers (Refs & Annos)

¬□ Chapter 402. Attorney General

¬□ Subchapter A. General Provisions (Refs & Annos)

→ § 402.004. Admission, Agreement, or Waiver
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An admission, agreement, or waiver made by the attorney general in an action or suit to which the state is a party does not prejudice the rights of the state.

CREDIT(S)

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Acts 1987, 70th Leg., ch. 147, § 1, eff. Sept. 1, 1987.
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Effective: September 1, 2013

Vernon's Texas Statutes and Codes Annotated Currentness

Government Code (Refs & Annos)

Title 4. Executive Branch (Refs & Annos)

Subtitle I. Health and Human Services

ra Chapter 531. Health and Human Services Commission (Refs & Annos)

Subchapter C. Medicaid and Other Health and Human Services Fraud, Abuse, or Overcharges (Refs & Annos)

→→ § 531.102. Office of Inspector General

- (a) The commission's office of inspector general is responsible for the prevention, detection, audit, inspection, review, and investigation of fraud, waste, and abuse in the provision and delivery of all health and human services in the state, including services through any state-administered health or human services program that is wholly or partly federally funded, and the enforcement of state law relating to the provision of those services. The commission may obtain any information or technology necessary to enable the office to meet its responsibilities under this subchapter or other law.
- (a-1) The governor shall appoint an inspector general to serve as director of the office. The inspector general serves a one-year term that expires on February 1.
- (b) The commission, in consultation with the inspector general, shall set clear objectives, priorities, and performance standards for the office that emphasize:
 - (1) coordinating investigative efforts to aggressively recover money;
 - (2) allocating resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and
 - (3) maximizing opportunities for referral of cases to the office of the attorney general in accordance with Section 531.103.
- (c) The commission shall train office staff to enable the staff to pursue priority Medicaid and other health and human services fraud and abuse cases as necessary.
- (d) The commission may require employees of health and human services agencies to provide

assistance to the office in connection with the office's duties relating to the investigation of fraud and abuse in the provision of health and human services. The office is entitled to access to any information maintained by a health and human services agency, including internal records, relevant to the functions of the office.

- (e) The commission, in consultation with the inspector general, by rule shall set specific claims criteria that, when met, require the office to begin an investigation.
- (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) 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 a complaint or allegation or has reason to believe that fraud or abuse has occurred. A preliminary investigation shall be completed not later than the 90th day after it began.
 - (2) If the findings of a preliminary investigation 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:
 - (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 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. The office must notify the provider of the payment hold 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 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 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 shall adopt rules that allow a provider subject to a 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 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 until the informal resolution process is completed.

- (7) The office shall, in consultation with the state's Medicaid fraud control unit, establish guidelines under which payment holds or program exclusions:
 - (A) may permissively be imposed on a provider; or
 - (B) shall automatically be imposed on a provider.
- (h) In addition to performing functions and duties otherwise provided by law, the office may:
 - (1) assess administrative penalties otherwise authorized by law on behalf of the commission or a health and human services agency;
 - (2) request that the attorney general obtain an injunction to prevent a person from disposing of an asset identified by the office as potentially subject to recovery by the office due to the person's fraud or abuse;
 - (3) provide for coordination between the office and special investigative units formed by managed care organizations under Section 531.113 or entities with which managed care or-

ganizations contract under that section;

- (4) audit the use and effectiveness of state or federal funds, including contract and grant funds, administered by a person or state agency receiving the funds from a health and human services agency;
- (5) conduct investigations relating to the funds described by Subdivision (4); and
- (6) recommend policies promoting economical and efficient administration of the funds described by Subdivision (4) and the prevention and detection of fraud and abuse in administration of those funds.
- (i) Notwithstanding any other provision of law, a reference in law or rule to the commission's office of investigations and enforcement means the office of inspector general established under this section.
- (j) The office shall prepare a final report on each audit or investigation conducted under this section. The final report must include:
 - (1) a summary of the activities performed by the office in conducting the audit or investigation;
 - (2) a statement regarding whether the audit or investigation resulted in a finding of any wrongdoing; and
 - (3) a description of any findings of wrongdoing.
- (k) A final report on an audit or investigation is subject to required disclosure under Chapter 552. All information and materials compiled during the audit or investigation remain confidential and not subject to required disclosure in accordance with Section 531.1021(g).

<Text of subsec. (1), as added by Acts 2013, 83rd Leg., ch. 622 (S.B. 1803), § 2>

(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.

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<Text of subsec. (1), as added by Acts 2013, 83rd Leg., ch. 1311 (S.B. 8), § 5>
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- (l) Nothing in this section limits the authority of any other state agency or governmental entity.
- (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.

CREDIT(S)

Added by Acts 1997, 75th Leg., ch. 1153, § 1.06(a), eff. June 20, 1997. Amended by Acts 1999, 76th Leg., ch. 1289, § 3, eff. Sept. 1, 1999; Acts 2003, 78th Leg., ch. 198, § 2.19(a), eff. Sept. 1, 2003; Acts 2005, 79th Leg., ch. 349, § 18(a), eff. Sept. 1, 2005; Acts 2011, 82nd Leg., ch. 879 (S.B. 223), § 3.11, eff. Sept. 1, 2011; Acts 2011, 82nd Leg., ch. 980 (H.B. 1720), § 3, eff. Sept. 1, 2011; Acts 2013, 83rd Leg., ch. 622 (S.B. 1803), § 2, eff. Sept. 1, 2013; Acts 2013, 83rd Leg., ch. 1311 (S.B. 8), § 5, eff. Sept. 1, 2013.

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Government Code (Refs & Annos)
Title 4. Executive Branch (Refs & Annos)
Subtitle I. Health and Human Services

¬□ Chapter 531. Health and Human Services Commission (Refs & Annos)

¬□ Subchapter A. General Provisions; Organization of Commission

→→ § 531.0055. Executive Commissioner: General Responsibility for Health and Human Services Agencies

- (a) In this section and in Section 531.0056, "agency director" means the commissioner of a health and human services agency.
- (b) The commission shall:
 - (1) supervise the administration and operation of the Medicaid program, including the administration and operation of the Medicaid managed care system in accordance with Section 531.021;
 - (2) perform information systems planning and management for health and human services agencies under Section 531.0273, with:
 - (A) the provision of information technology services at health and human services agencies considered to be a centralized administrative support service either performed by commission personnel or performed under a contract with the commission; and
 - (B) an emphasis on research and implementation on a demonstration or pilot basis of appropriate and efficient uses of new and existing technology to improve the operation of health and human services agencies and delivery of health and human services;
 - (3) monitor and ensure the effective use of all federal funds received by a health and human services agency in accordance with Section 531.028 and the General Appropriations Act;
 - (4) implement Texas Integrated Enrollment Services as required by Subchapter F, [FN1] except that notwithstanding Subchapter F, determining eligibility for benefits under the following programs is the responsibility of and must be centralized by the commission:

- (A) the child health plan program;
- (B) the financial assistance program under Chapter 31, Human Resources Code;
- (C) the medical assistance program under Chapter 32, Human Resources Code;
- (D) the nutritional assistance programs under Chapter 33, Human Resources Code;
- (E) long-term care services, as defined by Section 22.0011, Human Resources Code;
- (F) community-based support services identified or provided in accordance with Section 531.02481; and
- (G) other health and human services programs, as appropriate; and
- (5) implement programs intended to prevent family violence and provide services to victims of family violence.
- (c) The commission shall implement the powers and duties given to the commission under Sections 531.0246, 531.0247, 2155.144, and 2167.004.
- (d) After implementation of the commission's duties under Subsections (b) and (c), the commission shall implement the powers and duties given to the commission under Section 531.0248. Nothing in the priorities established by this section is intended to limit the authority of the commission to work simultaneously to achieve the multiple tasks assigned to the commission in this section, when such an approach is beneficial in the judgment of the commission. The commission shall plan and implement an efficient and effective centralized system of administrative support services for health and human services agencies. The performance of administrative support services for health and human services agencies is the responsibility of the commission. The term "administrative support services" includes, but is not limited to, strategic planning and evaluation, audit, legal, human resources, information resources, purchasing, contract management, financial management, and accounting services.
- (e) Notwithstanding any other law, the executive commissioner shall adopt rules and policies for the operation of and provision of health and human services by the health and human services agencies. In addition, the executive commissioner, as necessary to perform the functions described by Subsections (b), (c), and (d) in implementation of applicable policies established for an agency by the executive commissioner, shall:

- (1) manage and direct the operations of each health and human services agency;
- (2) supervise and direct the activities of each agency director; and
- (3) be responsible for the administrative supervision of the internal audit program for all health and human services agencies, including:
 - (A) selecting the director of internal audit;
 - (B) ensuring that the director of internal audit reports directly to the executive commissioner; and
 - (C) ensuring the independence of the internal audit function.
- (f) The operational authority and responsibility of the executive commissioner for purposes of Subsection (e) at each health and human services agency includes authority over and responsibility for the:
 - (1) management of the daily operations of the agency, including the organization and management of the agency and agency operating procedures;
 - (2) allocation of resources within the agency, including use of federal funds received by the agency;
 - (3) personnel and employment policies;
 - (4) contracting, purchasing, and related policies, subject to this chapter and other laws relating to contracting and purchasing by a state agency;
 - (5) information resources systems used by the agency;
 - (6) location of agency facilities; and
 - (7) coordination of agency activities with activities of other state agencies, including other health and human services agencies.
- (g) Notwithstanding any other law, the operational authority and responsibility of the executive commissioner for purposes of Subsection (e) at each health and human services agency in-

cludes the authority and responsibility to adopt or approve, subject to applicable limitations, any rate of payment or similar provision required by law to be adopted or approved by the agency.

- (h) For each health and human services agency, the executive commissioner shall implement a program to evaluate and supervise the daily operations of the agency. The program must include measurable performance objectives for each agency director and adequate reporting requirements to permit the executive commissioner to perform the duties assigned to the executive commissioner under this section.
- (i) To facilitate the operations of a health and human services agency in accordance with this section, the executive commissioner may delegate a specific power or duty given under Subsection (f) or (g) to an agency director. The agency director shall, at the request of the executive commissioner, assist in the development of rules and policies for the operation and provision of health and human services by the agency. The agency director acts on behalf of the executive commissioner in performing the delegated function and reports to the executive commissioner regarding the delegated function and any matter affecting agency programs and operations.
- (j) The executive commissioner shall adopt rules to implement the executive commissioner's authority under this section.
- (k) The executive commissioner and each agency director shall enter into a memorandum of understanding in the manner prescribed by Section 531.0163 that:
 - (1) clearly defines the responsibilities of the agency director and the executive commissioner, including:
 - (A) the responsibility of the agency director to report to the governor and to report to and implement policies of the executive commissioner; and
 - (B) the extent to which the agency director acts as a liaison between the agency and the commission;
 - (2) establishes the program of evaluation and supervision of daily operations required by Subsection (h); and
 - (3) describes each delegation of a power or duty made under Subsection (i) or other law.
- (l) Notwithstanding any other law, the executive commissioner has the authority to adopt

policies and rules governing the delivery of services to persons who are served by each health and human services agency and the rights and duties of persons who are served or regulated by each agency.

(m) The executive commissioner shall establish standards for the use of electronic signatures in accordance with the Uniform Electronic Transactions Act (Chapter 322, Business & Commerce Code), with respect to any transaction, as defined by Section 322.002, Business & Commerce Code, in connection with the administration of health and human services programs.

CREDIT(S)

Added by Acts 1999, 76th Leg., ch. 1460, § 2.01, eff. Sept. 1, 1999. Amended by Acts 2003, 78th Leg., ch. 198, § 1.03, eff. Sept. 1, 2003; Acts 2007, 80th Leg., ch. 755, § 2, eff. Sept. 1, 2007; Acts 2009, 81st Leg., ch. 87, § 11.009, eff. Sept. 1, 2009.

[FN1] V.T.C.A., Government Code § 531.191 et seq.

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Effective:[See Text Amendments]

Vernon's Texas Statutes and Codes Annotated Currentness
Government Code (Refs & Annos)
Title 10. General Government (Refs & Annos)
Subtitle A. Administrative Procedure and Practice

¬□ Chapter 2001. Administrative Procedure (Refs & Annos)

¬□ Subchapter B. Rulemaking

→ § 2001.038. Declaratory Judgment

- (a) The validity or applicability of a rule, including an emergency rule adopted under Section 2001.034, may be determined in an action for declaratory judgment if it is alleged that the rule or its threatened application interferes with or impairs, or threatens to interfere with or impair, a legal right or privilege of the plaintiff.
- (b) The action may be brought only in a Travis County district court.
- (c) The state agency must be made a party to the action.
- (d) A court may render a declaratory judgment without regard to whether the plaintiff requested the state agency to rule on the validity or applicability of the rule in question.
- (e) An action brought under this section may not be used to delay or stay a hearing in which a suspension, revocation, or cancellation of a license by a state agency is at issue before the agency after notice of the hearing has been given.
- (f) A Travis County district court in which an action is brought under this section, on its own motion or the motion of any party, may request transfer of the action to the Court of Appeals for the Third Court of Appeals District if the district court finds that the public interest requires a prompt, authoritative determination of the validity or applicability of the rule in question and the case would ordinarily be appealed. After filing of the district court's request with the court of appeals, transfer of the action may be granted by the court of appeals if it agrees with the findings of the district court concerning the application of the statutory standards to the action. On entry of an order by the court of appeals granting transfer, the action is transferred to the court of appeals for decision, and the validity or applicability of the rule in question is subject to judicial review by the court of appeals. The administrative record and the district court record shall be filed by the district clerk with the clerk of the court of appeals. The court of appeals may direct the district court to conduct any necessary evidentiary hear-

ings in connection with the action.

CREDIT(S)

Added by Acts 1993, 73rd Leg., ch. 268, § 1, eff. Sept. 1, 1993. Amended by Acts 1999, 76th Leg., ch. 894, § 1, eff. Sept. 1, 1999.

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Vernon's Texas Statutes and Codes Annotated Currentness

Human Resources Code (Refs & Annos)

Title 2. Department of Human Services and Department of Protective and Regulatory Services (Refs & Annos)

Subtitle C. Assistance Programs

r Chapter 32. Medical Assistance Program (Refs & Annos)

Subchapter B. Administrative Provisions

→→ § 32.0291. Prepayment Reviews and Payment Holds

- (a) Notwithstanding any other law, the department may:
 - (1) perform a prepayment review of a claim for reimbursement under the medical assistance program to determine whether the claim involves fraud or abuse; and
 - (2) 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.
- (b) Subject to Section 531.102, Government Code, and notwithstanding any other law, the department may impose a payment hold on future claims submitted by a provider.
- (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.
- (d) Repealed by Acts 2013, 83rd Leg., ch. 622 (S.B. 1803), § 6.

CREDIT(S)

Added by Acts 2003, 78th Leg., ch. 198, § 2.103, eff. Sept. 1, 2003. Amended by Acts 2013, 83rd Leg., ch. 622 (S.B. 1803), §§ 4 to 6, eff. Sept. 1, 2013.

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Iowa Administrative Code Currentness

Agency 441 Human Services Department

Title VIII Medical Assistance [chs. 74 to 92]

Sea Chapter 79 Other Policies Relating to Providers of Medical and Remedial Care (Refs & Annos)

→ → 441-79.2(249A) Sanctions.

79.2(1)*Definitions*.

"Affiliates" means persons having an overt or covert relationship such that any one of them directly or indirectly controls or influences or has the power to control or influence another.

"Iowa Medicaid enterprise" means the entity comprised of department staff and contractors responsible for the management and reimbursement of Medicaid services for the benefit of Medicaid members.

"Person" means any individual human being or any company, firm, association, corporation, institution, or other legal entity. "Person" includes but is not limited to a provider and any affiliate of a provider.

"Probation" means a specified period of conditional participation in the medical assistance program.

"Provider" means an individual human being, firm, corporation, association, institution, or other legal entity, which is providing or has been approved to provide medical assistance to a member pursuant to the state medical assistance program.

"Suspension from participation" means an exclusion from participation for a specified period of time.

"Suspension of payments" means the temporary cessation of payments due a person until the resolution of a matter in dispute between a person and the department.

"Termination from participation" means a permanent exclusion from participation in the medical assistance program.

- "Withholding of payments" means a reduction or adjustment of the amounts paid to a person on pending and subsequently submitted bills for purposes of offsetting payments made to, received by, or in the possession of a person.
- **79.2(2)** *Grounds for sanctions*. The department may impose sanctions against any person when appropriate. Appropriate grounds for the department to impose sanctions include, but are not limited to, the following:
 - a. Presenting or causing to be presented for payment any false, intentionally misleading, or fraudulent claim for services or merchandise.
 - b. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of obtaining greater compensation than that to which the person is legally entitled, including charges in excess of usual and customary charges.
 - c. Submitting or causing to be submitted false, intentionally misleading, or fraudulent information for the purpose of meeting prior authorization or level of care requirements.
 - d. Upon lawful demand, failing to disclose or make available to the department, the department's authorized agent, any law enforcement or peace officer, any agent of the department of inspections and appeals' Medicaid fraud control unit, any agent of the auditor of state, the Iowa department of justice, any false claims investigator as defined under Iowa Code chapter 685, or any other duly authorized federal or state agent or agency records of services provided to medical assistance members or records of payments made for those services.
 - e. Failing to provide or maintain quality services, or a requisite assurance of a framework of quality services to medical assistance recipients within accepted medical community standards as adjudged by professional peers if applicable. For purposes of this subrule, "quality services" means services provided in accordance with the applicable rules and regulations governing the services.
 - f. Engaging in a course of conduct or performing an act which is in violation of any federal, state, or local statute, rule, regulation, or ordinance, or an applicable contractual provision, that relates to, or arises out of, any publicly or privately funded health care program, including but not limited to any state medical assistance program.
 - g. Submitting a false, intentionally misleading, or fraudulent certification or statement, whether the certification or statement is explicit or implied, to the department or the department's representative or to any other publicly or privately funded health care program.

- h. Overutilization of the medical assistance program by inducing, furnishing or otherwise causing a member to receive services or merchandise not required or requested.
- *i.* Violating any provision of Iowa Code chapter 249A, or any rule promulgated pursuant thereto, or violating any federal or state false claims Act, including but not limited to Iowa Code chapter 685.
- *j.* Submitting or causing to be submitted false, intentionally misleading, or fraudulent information in an application for provider status under the medical assistance program or any quality review or other submission required to maintain good standing in the program.
- k. Violating any law, regulation, or code of ethics governing the conduct of an occupation, profession, or other regulated business activity, when the violation relates to, or arises out of, the delivery of services under the state medical assistance program.
- *l*. Breaching any settlement or similar agreement with the department, or failing to abide by the terms of any agreement with any other entity relating to, or arising out of, the state medical assistance program.
- m. Failing to meet standards required by state or federal law for participation, including but not limited to licensure.
- n. Exclusion from Medicare or any other state or federally funded medical assistance program.
- o. Except as authorized by law, charging a person for covered services over and above what the department paid or would pay or soliciting, offering, or receiving a kickback, bribe, or rebate, or accepting or rebating a fee or a charge for medical assistance or patient referral, or a portion thereof. This ground does not include the collection of a copayment or deductible if otherwise allowed by law.
- p. Failing to correct a deficiency in provider operations after receiving notice of the deficiency from the department or other federal or state agency.
- q. Formal reprimand or censure by an association of the provider's peers or similar entity related to professional conduct.
- r. Suspension or termination for cause from participation in another program, including but not limited to workers' compensation or any publicly or privately funded health care program.

- s. Indictment or other institution of criminal charges for, or plea of guilty or nolo contendere to, or conviction of, any crime punishable by a term of imprisonment greater than one year, any crime of violence, any controlled substance offense, or any crime involving an allegation of dishonesty or negligent practice resulting in death or injury to a provider's patient.
- t. Violation of a condition of probation, suspension of payments, or other sanction.
- u. Loss, restriction, or lack of hospital privileges for cause.
- v. Negligent, reckless, or intentional endangerment of the health, welfare, or safety of a person.
- w. Billing for services provided by an excluded, nonenrolled, terminated, suspended, or otherwise ineligible provider or person.
- x. Failing to submit a self-assessment, corrective action plan, or other requirement for continued participation in the medical assistance program, or failing to repay an overpayment of medical assistance funds, in a timely manner, as set forth in a rule or other order.
- y. Attempting, aiding or abetting, conspiring, or knowingly advising or encouraging another person in the commission of one or more of the grounds specified herein.

79.2(3) *Sanctions*.

- a. The department may impose any of the following sanctions on any person:
 - (1) A term of probation for participation in the medical assistance program.
 - (2) Termination from participation in the medical assistance program.
 - (3) Suspension from participation in the medical assistance program.
 - (4) Suspension of payments in whole or in part.
 - (5) Prior authorization of services.
 - (6) Review of claims prior to payment.

- b. The withholding of a payment or a recoupment of medical assistance funds is not, in itself, a sanction. Overpayments, civil monetary penalties, and interest may also be withheld from payments without imposition of a sanction.
- c. Mandatory suspensions and terminations.
 - (1) Suspension or termination from participation in the medical assistance program is mandatory when a person is suspended or terminated from participation in the Medicare program, another state's medical assistance program, or by any licensing body. The suspension or termination from participation in the medical assistance program shall be retroactive to the date established by the Centers for Medicare and Medicaid Services or other state or body and, in the case of a suspension, must continue until at least such time as the Medicare or other state's or body's suspension ends.
 - (2) Termination is mandatory upon entry of final judgment, in the Iowa district court or a federal district court of the United States, of liability of the person in a false claims action.
 - (3) Suspension from participation is mandatory whenever a person, or an affiliate of the person, has an outstanding overpayment of medical assistance funds, as defined in Iowa Code chapter 249A.
 - (4) Upon notification from the U.S. Department of Justice, the Iowa department of justice, the department of inspections and appeals, or a similar agency, that a person has failed to respond to a civil investigative demand or other subpoena in a timely manner as set forth in governing law and the demand or other subpoena itself, the department shall immediately suspend the person from participation and suspend all payments to the person. The suspension and payment suspension shall end upon notification that the person has responded to the demand in full.
- **79.2(4)***Imposition and extent of sanction.* The department shall consider the totality of the circumstances in determining the sanctions to be imposed. The factors the department may consider include, but are not limited to:
 - a. Seriousness of the offense.
 - b. Extent of violations.
 - c. History of prior violations.

- d. Prior imposition of sanctions.
- e. Prior provision of provider education (technical assistance).
- f. Provider willingness to obey program rules.
- g. Whether a lesser sanction will be sufficient to remedy the problem.
- h. Actions taken or recommended by peer review groups or licensing boards.

79.2(5)*Scope of sanction.*

- a. Suspension or termination from participation shall preclude the person from submitting claims for payment, whether personally or through claims submitted by any other person or affiliate, for any services or supplies except for those services provided before the suspension or termination.
- b. No person may submit claims for payment for any services or supplies provided by a person or affiliate who has been suspended or terminated from participation in the medical assistance program except for those services provided before the suspension or termination.
- c. When the provisions of this subrule are violated, the department may sanction any person responsible for the violation.
- **79.2(6)***Notice to third parties.* When a sanction is imposed, the department may notify third parties of the findings made and the sanction imposed, including but not limited to law enforcement or peace officers and federal or state agencies. The imposition of a sanction is not required before the department may notify third parties of a person's conduct. In accordance with 42 CFR § 1002.212, the department must notify other state agencies, applicable licensing boards, the public, and Medicaid members, as provided in 42 CFR §§ 1001.2005 and 1001.2006, whenever the department initiates an exclusion under 42 CFR § 1002.210.

79.2(7)*Notice of violation.*

a. Any order of sanction shall be in writing and include the name of the person subject to sanction, identify the ground for the sanction and its effective date, and be sent to the person's last-known address. If the department sanctions a provider, the order of sanction shall also include the national provider identification number of the provider and be sent to the provider's last address on file within the medical assistance program. Proof of mailing to such address shall be conclusive evidence of proper service of the sanction upon the

provider. The department of inspections and appeals is not required to comply with the additional notification provisions of 441—paragraph 7.10(7) "c" for appeals certified for hearing under this chapter.

b. In the case of a currently enrolled provider otherwise in good standing with all program requirements, the provider shall have 15 days subsequent to the date of the notice prior to the department action to show cause why the action should not be taken. If the provider fails to do so, the sanction shall remain effective pending any subsequent appeal under 441—Chapter 7. If the provider attempts to show cause but the department determines the sanction should remain effective pending any subsequent appeal under 441—Chapter 7, the provider may seek a temporary stay of the department's action from the director or the director's designee by filing an application for stay with the appeals section. The director or the director's designee shall consider the factors listed in Iowa Code section 17A.19(5) "c."

79.2(8)Suspension or withholding of payments. The department may withhold payments on pending and subsequently received claims in an amount reasonably calculated to approximate the amounts in question due to a sanction, incorrect payment, civil monetary penalty, or other adverse action and may also suspend payment or participation pending a final determination. If the department withholds or suspends payments, it shall notify the person in writing within the time frames prescribed by federal law for cases related to a credible allegation of fraud, and within ten days for all other cases.

79.2(9)*Civil monetary penalties and interest*. Civil monetary penalties and interest assessed in accordance with 2013 Iowa Acts, Senate File 357, section 5 or section 11, are not allowable costs for any aspect of determining payment to a person within the medical assistance program. Under no circumstance shall the department reimburse a person for such civil monetary penalties or interest.

79.2(10)*Report and return of identified overpayment.*

- a. If a person has identified an overpayment, the person must report and return the overpayment in the form and manner set forth in this subrule.
- b. A person has identified an overpayment if the person has actual knowledge of the existence of the overpayment or acts in reckless disregard or deliberate ignorance of the existence of the overpayment.
- c. An overpayment required to be reported under 2013 Iowa Acts, Senate File 357, section 3, must be made in writing, addressed to the Program Integrity Unit of the Iowa Medicaid Enterprise, and contain all of the following:

- (1) Person's name.
- (2) Person's tax identification number.
- (3) How the error was discovered.
- (4) The reason for the overpayment.
- (5) Claim number(s), as appropriate.
- (6) Date(s) of service.
- (7) Member identification number(s).
- (8) National provider identification (NPI) number.
- (9) Description of the corrective action plan to ensure the error does not occur again, if applicable.
- (10) Whether the person has a corporate integrity agreement with the Office of the Inspector General (OIG) or is under the OIG Self-Disclosure Protocol or is presently under sanction by the department.
- (11) The time frame and the total amount of refund for the period during which the problem existed that caused the refund.
- (12) If a statistical sample was used to determine the overpayment amount, a description of the statistically valid methodology used to determine the overpayment.
- (13) A refund in the amount of the overpayment.

This rule is intended to implement Iowa Code section 249A.4.

[ARC 1155C, IAB 10/30/13, effective 1/1/14; ARC 1695C, IAB 10/29/14, effective 1/1/15]

[Filed March 11, 1970]





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N.Y. Comp. Codes R. & Regs. tit. 18, § 515.2

Compilation of Codes, Rules and Regulations of the State of New York Currentness

Title 18. Department of Social Services

Chapter II. Regulations of the Department of Social Services

Subchapter E. Medical Care

Article 3. Policies and Standards Governing Provision of Medical and Dental Care Part 515. Provider Sanctions (Refs & Annos)

→ Section 515.2. Unacceptable practices under the medical assistance program

- (a) General. An unacceptable practice is conduct by a person which is contrary to:
 - (1) the official rules and regulations of the department;
 - (2) the published fees, rates, claiming instructions or procedures of the department;
 - (3) the official rules and regulations of the Departments of Health, Education and Mental Hygiene, including the latter department's offices and divisions, relating to standards for medical care and services under the program; or
 - (4) the regulations of the Federal Department of Health and Human Services promulgated under title XIX of the Federal Social Security Act.
- (b) *Conduct included*. An *unacceptable practice* is conduct which constitutes fraud or abuse and includes the practices specifically enumerated in this subdivision.
 - (1) False claims.
 - (i) Submitting, or causing to be submitted, a claim or claims for:
- (a) unfurnished medical care, services or supplies;
- (b) an amount in excess of established rates or fees;
- (c) medical care, services or supplies provided at a frequency or in an amount not medically necessary; or

- (d) amounts substantially in excess of the customary charges or costs to the general public.
 - (ii) Inducing, or seeking to induce, any person to submit a false claim under this subdivision.
 - (2) False statements.
 - (i) Making, or causing to be made any false, fictitious or fraudulent statement or misrepresentation of material fact in claiming a medical assistance payment, or for use in determining the right to payment.
 - (ii) Inducing or seeking to induce the making of any false, fictitious or fraudulent statement or a misrepresentation of material fact.
 - (3) Failure to disclose. Having knowledge of any event affecting the right to payment of any person and concealing or failing to disclose the event with the intention that a payment be made when not authorized or in a greater amount than due.
 - (4) Conversion. Converting a medical assistance payment, or any part of such payment, to a use or benefit other than for the use and benefit intended by the medical assistance program.
 - (5) Bribes and kickbacks. Unless the discount or reduction in price is disclosed to the client and the department and reflected in a claim, or a payment is made pursuant to a valid employer-employee relationship, the following activities are unacceptable practices:
 - (i) soliciting or receiving either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed under the program;
 - (ii) soliciting or receiving either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program;
 - (iii) offering or paying either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for referring a client to a person for any medical care, services or supplies for which payment is claimed

under the program; or

- (iv) offering or paying either directly or indirectly any payment (including any kickback, bribe, referral fee, rebate or discount), whether in cash or in kind, in return for purchasing, leasing, ordering or recommending any medical care, services or supplies for which payment is claimed under the program.
 - (6) Unacceptable recordkeeping. Failing to maintain or to make available for purposes of audit or investigation records necessary to fully disclose the medical necessity for and the nature and extent of the medical care, services or supplies furnished, or to comply with other requirements of this Title.
 - (7) Employment of sanctioned persons. Submitting claims or accepting payment for medical care, services or supplies furnished by a person suspended, disqualified or otherwise terminated from participation in the program or furnished in violation of any condition of participation in the program.
 - (8) Receiving additional payments. Seeking or accepting any gift, money, donation or other consideration in addition to the amount paid or payable under the program for any medical care, services or supplies for which a claim is made.
 - (9) Client deception. Deceiving, misleading or threatening a client, or charging or agreeing to charge or collect any fee in excess of the maximum fee, rate or schedule amount from a client.
 - (10) Conspiracy. Making any agreement, combination or conspiracy to defraud the program by obtaining, or aiding anyone to obtain, payment of any false, fictitious or fraudulent claim.
 - (11) Excessive services. Furnishing or ordering medical care, services or supplies that are substantially in excess of the client's needs.
 - (12) Failure to meet recognized standards. Furnishing medical care, services or supplies that fail to meet professionally recognized standards for health care or which are beyond the scope of the person's professional qualifications or licensure.
 - (13) Unlawful discrimination. Illegally discriminating in the furnishing of medical care, services or supplies based upon the client's race, color, national origin, religion, sex, age or handicapping condition.

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- (14) Factoring. Assigning payments under the program to a factor, either directly or by power of attorney; or receiving payment through any person whose compensation is not related to the cost of processing the claim, is related to the amount collected or is dependent upon collection of the payment.
- (15) Solicitation of clients. Offering or providing any premium or inducement to a client in return for the client's patronage of the provider or other person to receive care, services or supplies under the program.
- (16) Verification of MA eligibility:
- (i) failing to use the Medicaid Eligibility Terminal (MET) verification procedure, as required by Part 514 of this Title, in a significant number of cases and such failure is unjustified;
- (ii) failing to use the card swipe capability of the MET, as required by Part 514 of this Title, in a significant number of cases and such failure is unjustified;
- (iii) failing to post orders for medical care, services or supplies in the electronic Medicaid eligibility verification system (EMEVS), as required by Part 514 of this Title, in a significant number of cases and such failure is unjustified; or
- (iv) failing to clear prescription or fiscal orders which are required to be posted to EMEVS, as required by Part 514 of this Title, in a significant number of cases and such failure is unjustified.
 - (17) Denial of services. Denying services to a recipient based in whole or in part upon the recipient's inability to pay a co-payment for medical care, services or supplies.
 - (18) Other prohibited acts. With respect to any person not a provider, committing any act which would result in the termination of a provider's enrollment in the program pursuant to section 504.7 of this Title.

Sec. filed Jan. 21, 1976; repealed, new filed: Aug. 31, 1976; Aug. 27, 1979; amds. filed: March 30, 1982; Oct. 13, 1983; repealed, new filed May 16, 1988; amds. filed: July 31, 1990; Sept. 29, 1992 eff. Oct. 14, 1992.

18 NYCRR 515.2, 18 NY ADC 515.2

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N.Y. Comp. Codes R. & Regs. tit. 18, § 515.2

Current with amendments included in the New York State Register, Volume XXXVII, Issue 10, dated March 11, 2015.

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N.Y. Comp. Codes R. & Regs. tit. 18, § 518.7

Compilation of Codes, Rules and Regulations of the State of New York Currentness Title 18. Department of Social Services

Chapter II. Regulations of the Department of Social Services Subchapter E. Medical Care

Article 3. Policies and Standards Governing Provision of Medical and Dental Care Part 518. Recovery and Withholding of Payments or Overpayments (Refs & Annos)

 $\rightarrow \rightarrow$ Section 518.7. Withholding of payments

(a) Basis for withholding.

- (1) The department may withhold payments under the program, in whole or in part, when it has determined that a provider has abused the program or has committed an unacceptable practice. The department's determination that a provider has abused the program, or has committed an unacceptable practice may consist of preliminary findings by the department's audit or utilization review staff of unacceptable practices or significant overpayments, information from a State professional licensing or certifying agency of an ongoing investigation of a provider involving fraud, abuse, professional misconduct or unprofessional conduct, or information from a State investigating or prosecutorial agency or other law enforcement organization of an ongoing investigation of a provider for fraud or criminal conduct involving the program. The department may withhold payment of current and future claims to the provider and any affiliate.
- (2) The department must withhold payments under the program, in whole or in part, when it has determined or has been notified that a provider is the subject of a pending investigation of a credible allegation of fraud unless the department finds good cause not to withhold payments in accordance with 42 C.F.R. 455.23. A credible allegation of fraud is an allegation that has indicia of reliability and has been verified by the department, or the Medicaid fraud control unit, or another State agency, or law enforcement organization.
 - (i) Whenever the department initiates a withholding, in whole or in part, in relation to a pending investigation of a credible allegation of fraud, the department must make a fraud referral to the Medicaid fraud control unit. If the Medicaid fraud control unit does not accept the referral, then the department may refer the matter to another law enforcement organization.
 - (ii) The fraud referral made under this paragraph must be in writing and provided to the Medicaid fraud control unit or other law enforcement organization not later than the next business day after the withhold is enacted.

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- (b) Notice of the withholding will be given within five days of taking such action unless requested in writing by a law enforcement organization to delay such notice. The notice will describe the reasons for the action, but need not include specific information concerning an ongoing investigation.
- (c) The notice of withholding must:

(1)

- (i) state that the payments are being withheld in accordance with this section; and
- (ii) in cases where there is a pending investigation of a credible allegation of fraud state that the payments are being withheld in accordance with 42 CFR 455.23;
- (2) state that the withholding is for a temporary period only and recite the circumstances under which the withholding will be terminated;
- (3) specify whether the withholding applies to all or only some claims and identify which claims if not all claims are involved; and
- (4) advise of the right to submit written arguments and documentation in opposition to the withholding and how to submit them in accordance with subdivision (e) of this section.
- (d) The withholding may continue only temporarily.
 - (1) When initiated by the department prior to issuance of a draft audit report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written draft audit report or notice of proposed agency action is sent to the provider. Issuance of the draft report or notice of proposed action may extend the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.
 - (2) When initiated by the department after issuance of a draft audit report or notice of proposed agency action, the withholding will not continue for more than 90 days unless a written final audit report or notice of agency action is sent to the provider. Issuance of the report or notice of action may extend the withholding until an amount reasonably calculated to satisfy the overpayment is withheld, pending a final determination on the matter.
 - (3) When initiated by another State agency or law enforcement organization, the withhold-

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ing may continue until the agency or prosecuting authority determines that there is insufficient evidence to support an action against the provider or its affiliate, or until the agency or criminal proceedings are completed.

- (4) When initiated by the department when it has determined or has been notified that a provider is the subject of a pending investigation of a credible allegation of fraud all withholding actions will be temporary and will not continue after either of the following:
 - (i) The department, or the Medicaid fraud control unit, or other law enforcement organization determines that there is insufficient evidence of fraud by the provider.
 - (ii) Legal proceedings related to the provider's alleged fraud are completed.

(e) Appeals.

- (1) A provider or its affiliate that is the subject of the withholding is not entitled to an administrative hearing, but may, within 30 days of the date of the notice, submit written arguments and documentation that the withhold should be removed.
- (2) Within 60 days of receiving written arguments or documentation in response to a withhold, the department will review the determination and notify the provider or its affiliate of the results of that review. After the review, the determination to impose a withhold may be affirmed, reversed or modified, in whole or in part.
- (3) A decision by the department to affirm, reverse or modify a withhold on appeal shall not be a determination of the merits of any investigation initiated by another State agency, the Medicaid fraud control unit, or other law enforcement organization.

Sec. filed May 16, 1988 eff. June 6, 1988; amds. filed Apr. 22, 2010 eff. May 12, 2010; amd. filed Aug. 6, 2012 eff. Aug. 22, 2012.

18 NYCRR 518.7, 18 NY ADC 518.7

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Wyoming Rules and Regulations Currentness

Department of Health

Medicaid

Section 15. Suspension of Payments.

The Department may suspend payments to the provider under the following conditions:

- (a) Suspected fraud, theft, or abuse of services;
- (b) Failure to comply with the provisions of the provider agreement;
- (c) Lack of requested documentation; or
- (d) Violation of Medicaid, Department, or other state or federal statute, rule, or law relating to provisions of services.

11/07/2011

WY Rules and Regulations HLTH MDCD Ch. 16 s 15, WY ADC HLTH MDCD Ch. 16 s 15

Current through February 28, 2015