SUBJECT: Medicaid and welfare fraud

COMMITTEE: Public Health — committee substitute recommended

VOTE: 6 ayes — Berlanga, Hirschi, Coleman, Davila, Glaze, Maxey

0 nays

2 absent — Delisi, Janek

SENATE VOTE: On final passage, April 17 — 31-0

WITNESSES: (*On House companion, HB 2127*)

For — Mary Jo May, Rebecca L. Solis, El Centro de Corazon

Against — None

On — Robin Herskowitz, Office of the Comptroller; George Noelke, Beth Taylor, Office of the Attorney General; Joe Brown; Robert Kamm, Texas Association of Business/Chambers of Commerce

BACKGROUND: Medicaid, the state/federal health benefits program, assists about two million low-income, uninsured Texans with health care services, and pays for about 66,000 nursing home residents each month. It helps fund programs in at least 12 state agencies, and contributes toward graduate medical education costs.

Last year Texas provided about $504 million in financial assistance to about 223,214 low-income families through the Temporary Assistance to Needy Families (TANF) program, and about 823,297 low-income Texans received about $1.8 billion worth of federal food stamp benefits.

Chapter 36 of the Human Resource Code governs Medicaid fraud prevention. Under sec. 36.002 a person commits an unlawful act by knowingly or intentionally making a false statement; failing to disclose an event; applying for a benefit or payment that is not authorized or is greater than the benefit authorized; or soliciting money as a condition for providing

services to a Medicaid recipient.

DIGEST:

CSSB 30 would direct state agency activities to identify and prosecute cases of Medicaid, food stamp and welfare fraudulent practices, waste and abuse, and recoup claim overpayments. The bill would generally take effect September 1, 1997.

CSSB 30 also would transfer certain Department of Human Services (DHS) and Department of Health (TDH) Medicaid staff to the Health and Human Services Commission; authorize private causes of action — known as*qui tam* — for Medicaid fraud and false claims to a governmental entity; authorize the suspension of driver's and recreational licenses for failure to reimburse food stamp or welfare overpayments; enact administrative and criminal penalties for Medicaid fraud; and establish a pilot program and a health care study to detect fraud.

The bill would take effect September 1, 1997, and would authorize a state agency to delay implementation of the bill's provisions if authorization from the federal government was necessary for implementation.

Welfare payments made in error

The Department of Human Services would have to reduce the time it takes to determine an overpaid food stamp claim or direct assistance benefit and conduct specified studies on fraud. It would have to enact a telephone-based overpayment collection system by January 1, 1998. The department would have to participate in the Federal Tax Refund Offset Program to attempt to recover food stamp benefits granted by the department in error. The department could encourage the creation of a special welfare fraud unit in each district attorney's office that serves a municipality with a population of more than 250,000. The department would also have to use private collection agents to collect benefit reimbursements.

DHS would have to use a computerized matching system to make sure immigrants and U.S. visitors did not receive benefits illegally, comparing department information to that of the U.S. Department of State and the U.S. Department of Justice.

The Health and Human Services Commission would have to set goals for the recovery of payment errors, based on recovery rates reported in other states. The department could use the recovered federal funds to fund activities related to preventing fraud. The Lottery Commission director would have to deduct from an individual's winnings an amount equal to any delinquent reimbursements for food stamp or financial assistance overpayments.

The department could issue an order suspending a driver's or recreational activity license if a person, after notice and opportunity for repayment, failed to reimburse the department for an amount in excess of $250 granted in error to the person under the food stamp or financial assistance programs. Proceedings to revoke and stay the revocation of such licenses would be specified.

Medicaid

Claims. The department would have to implement activities to ensure that Medicaid claims were paid by the appropriate responsible party, such as Medicare or the Veterans Administration, for recipients who were eligible for assistance under more than one benefit program. Each state agency that administers the Medicaid program would have to maintain statistics on the number, type and disposition of fraudulent claims.

Services. DHS would have to develop a procedure for ensuring that the state seeks the highest level of federal reimbursement available for each Medicaid service and seek enhanced reimbursement for services provided since December 31, 1989.

Fraud investigations. The commission would be responsible for fraud investigation and enforcement and could require employees of other health and human services agencies to provide assistance. The commission would have to enter into a memorandum of understanding with the Office of the Attorney General to develop and implement joint written procedures for processing suspected cases of fraud, waste or abuse. If the attorney general failed to act on a referred case within 30 days, the commission would have to refer the suspected case to the appropriate district attorney, county attorney, city attorney, or private collection agency. Local public attorneys

or private collection agencies could collect costs associated with the case and 20 percent of the penalty or reimbursement.

CSSB 30 would establish a Medicaid and Public Assistance Fraud Oversight Task Force to advise and assist the commission, which would be composed of representatives from the Attorney General's Office, the Comptroller's Office, the Department of Public Safety, the State Auditor's Office, the commission, DHS and the Texas Department of Insurance. The comptroller's designee would serve as the presiding officer. Task force duties and reporting would be specified.

The commission could reward individuals who reported activities that constituted fraud or abuse, and the award would have to be equal to not less than 10 percent of the savings to the state that resulted from the disclosure. The award would be paid out of funds appropriated to the commission, but funds could not be appropriated for that purpose.

The commission would have to annually train Medicaid claims processing contractors and appropriate TDH and DHS staff in identifying potential cases of fraud, waste or abuse. The commission also would have to use learning or neural network technology to identify and deter fraud and to award the contract for the technology by January 1, 1998, or enable the comptroller to perform the duties.

Staff transfer. The bill would transfer to the commission by September 1, 1997, staff and related property, records and program rules from DHS' Medicaid hospital utilization assessment and billing review functions and from TDH's Medicaid claims payment review and policy and data groups.

Managed care organizations. Managed care organizations (MCOs) that contract to provide services to Medicaid recipients would have to report all information required by commission rule, including information regarding ratesetting, quality of care, plans to detect and prevent fraud and abuse, service subcontracts, financial condition, and ownership. Contracting MCOs would be audited once every three years by the state and would be responsible for the cost of the audit. Audit procedures would be specified.

An Medicaid-contracted MCO would commit an unlawful act if it failed to provide required services or report required information to the commission, fraudulently enrolled individuals, or obstructed AG investigations.

Other providers. Health care providers would be required to obtain authorization from TDH to transport a Medicaid recipient in an ambulance in nonemergency cases. Providers also would have to ensure for children who were Medicaid recipients and required durable medical equipment that the equipment fit properly. Providers who have shown significant potential for fraud or abuse could be required to file a surety bond with TDH.

New provider contract provisions would have to be developed, state review of provider billing practices would have to be implemented, and rules governing improper vendor drug claims would have to be promulgated. The commission would have to establish criteria for revoking a provider's enrollment based on the results of a criminal history check.

Administrative penalties. A violation subject to administrative penalties would established for the act of submitting a false Medicaid claim or for MCOs that failed to provide health care benefits to a Medicaid enrollee, engaged in fraudulent marketing activity, failed to provide required information to the department, or engaged in actions that showed a pattern of wrongful service denial or delays.

The administrative penalty could not exceed twice the amount paid, if any, by the Medicaid program, plus not less than $5,000 or more than $15,000 for each violation that resulted in injury to an elderly or disabled person or a child, or not more than $10,000 for all other violations.

The commissioners of the appropriate state agencies would have to revoke or suspend a provider agreement or a permit or license of an entity other than a nursing home found liable for harm to a child or elderly or disabled individual. A person, except for nursing home operators, found liable for injury to an elderly or disabled person or a child could not provide health care services under Medicaid for at least 10 years or if found liable for any other violation under this section, could not be a Medicaid provider for at least three years. The agencies would be allowed but not required to suspend or revoke nursing facility or nursing facility personnel licenses or

provider agreements in such cases.

Criminal penalties. Criminal penalties could also be imposed for committing an unlawful act under sec. 36.002, ranging from a Class C misdemeanor, punishable by a maximum fine of $500 for unlawful acts that resulted in benefits or payments less than $50, to a felony of the first degree punishable by a maximum penalty of life in prison and an optional $10,000 fine, if the value of the unlawful act was $200,000 or more. A licensing authority would have to revoke a license issued to a person convicted of a felony under this act.

Private action (*Qui tam*). CSSB 30 would implement new provisions to authorize an individual to file a private civil suit on behalf of the state for a fraudulent Medicaid act. The state would have 60 days to intervene on the action, and if intervening would have the primary responsibility for prosecuting the action.

The state could dismiss the action notwithstanding the objections of the person bringing the action if the attorney general notified the person that the state had filed a motion to dismiss and the court provided the person with an opportunity for a hearing on the motion. The state also could settle the action or, under certain conditions, limit the participation of the person who brought the civil action. The state also could pursue a claim through any alternate remedy, including administrative proceedings.

If the state proceeded with an action, the person bringing the action would be entitled to up to 25 percent of the proceeds of the action, depending on the extent to which the person contributed to the prosecution of the action. If the state did not proceed with an action, the person would be entitled to an amount the court decided was reasonable for civil penalties and damages, which would have to be between 25 and 30 percent of the action's proceeds, unless the court found the person helped plan and initiate the violation. A person convicted of criminal conduct in the violation would be dismissed from the action and could not receive any proceeds.

Defendants who prevailed because the court found the claim to be frivolous, vexatious or harassing would be entitled to reasonable attorney's fees and expenses if the state did not proceed with the action, and to reasonable

attorney fees and other expenses as governed under state agency frivolous claims laws, chapter 105 of the Civil Practice and Remedies Code, in actions in which the state intervened.

A person who brought the suit who was discharged, demoted, suspended, threatened or harassed by the employer because of the action or investigations would be entitled to reinstatement and other compensation.

Pilot program. The commission would have to establish a pilot program in three to five urban counties to reduce fraud by conducting random on-site reviews of persons who applied to provide Medicaid services, and at a minimum would include durable medical equipment providers, therapists and laboratories.

Health care fraud study

The comptroller would have to conduct a biennial study to determine the number and type of fraudulent claims for health care benefits submitted under the state Medicaid program; the Employees Retirement System group health insurance programs; and by or on behalf of state employees under the Workers' Compensation Act (chpt. 501, Labor Code). The comptroller would have to report the results of the study to each affected state agency so that the agency could modify its fraud control procedures.

False Claims

CSSB 30 would amend the Government Code to make illegal the submission to a governmental entity of a false claim or a false record for payment or approval or to decrease or avoid a financial obligation; the delivery of less property than the amount of the receipt; or buying or accepting public property that cannot be sold. A governmental entity would be defined as the state and state boards and agencies, the Legislature and legislative agencies, the Supreme Court and other judicial agencies, and local governments.

A person who knowingly violated these provisions would have to award the affected governmental entity actual damages, exemplary damages up to two times the amount of actual damages, and attorney's fees and costs. The

court could also award to the governmental entity a civil penalty of up to $10,000 for each false claim. Liability would be joint a several for a violation committed by more than one person.

Roles of the attorney general and local prosecuting authorities would be specified. A person could also bring a private cause of action for false claim violations in the name of the state or local government or both. The state or local government would have 60 days to intervene and become the primary prosecuting authority. Under certain circumstances they could dismiss the case or limit the participation of the person who commenced the action. The person could be granted an award of up to 25 percent of the settlement or judgment, or up to 30 percent if the state or local prosecuting attorney did not intervene. Provisions regarding frivolous lawsuits would be specified.

Employers could not retaliate against or deter an employee from exercising private cause of action rights.

SUPPORTERS SAY:

CSSB 30 would help improve oversight and enforcement of state and federal Medicaid, food stamp and welfare standards, ensure that public funds are spent on authorized purposes and for authorized individuals only, save the state money and make its programs more cost-effective. CSSB 30 is based on the Texas Performance Review recommendations FR-1 through 11 and FR-16 in *Disturbing the Peace*, published by the Comptroller's Office, and would result in a net gain to the state of $11.448 million for fiscal 1998-99.

Fraud by its nature is a hidden crime; there are few "dead bodies" or artifacts pointing toward its occurrence. The size and volume of the Texas Medicaid and welfare programs make fraudulent activities difficult to detect. Texas spends nearly $10 billion a year on Medicaid and processes more than 550,000 claims per week from about 121,000 providers. In AFDC and federal food stamp programs, as much as $222.4 million has been estimated to have been spent in error in 1995, and more than 36 percent of the erroneous spending was attributable to recipient fraud.

This bill would ensure state agencies are employing emerging communications and data technologies and making coordinated efforts to detect and investigate fraud. For example, neural network technologies have

been successfully used by private businesses to detect fraud, such as Visa International to detect credit card fraud. Consolidating state agency Medicaid billings and claims review personnel into the commission would place fraud detection activities in one central location and help separate the conflict of interest that comes when enforcement activities, which focus on penalizing fraudulent providers, are located in the same agency as program activities, which tend to encourage provider participation for patient access to care. This bill would lay the groundwork for adding welfare fraud detection efforts to the commission's activities, once Medicaid consolidation efforts have been proven successful.

This bill would also establish needed controls to prevent fraud and limit "after the fact" detection efforts. For example, the Attorney General's Office has detected inappropriate billings for nonemergency transportation and durable medical equipment, which would be prevented in the future by SB 30 provisions requiring prior authorization and provider certification. Other preventive and accountability controls include state auditing, improved provider contracting provisions, and surety bond requirements. Measuring fraud and abuse as a continuing state agency activity also would help detect fraud and document successful fraud detection, prevention, and penalty efforts.

CSSB 30 would enact in the Medicaid program and in the Government Code *qui tam* provisions used by other states and the federal government under the False Claims Act (31 U.S.C. 3729-3733), which allows individuals to file suit against wrongdoers on behalf of the government; the name is drawn from the Latin phrase for "he who brings an action for the king as well as for himself." *Qui tam* essentially broadens a government's investigative powers by privatizing a part of them, and federal*qui tam* recoveries have run in the hundreds of millions of dollars against several leading health care providers. States that have enacted*qui tam* statutes similar to the federal law include Florida, Illinois, California and Tennessee.

Other states have found private *qui tam* actions to be the most effective and inexpensive means of bringing fraud out in the open that otherwise would have gone undetected. This bill would encourage private citizens to come forward with information that could improve fraud detection and prosecution at no cost to the state. Citizens who filed an action against a

provider or individual would be entitled to part of the recovered funds, and citizens who reported suspected fraudulent activity to the commission could receive an award.

CSSB 30 would not increase the number of frivolous or unsubstantiated lawsuits because it would include three important safeguards: 1) the state or local prosecuting attorney would have a 60-day period in which to review and analyze the merits of the case, 2) the case could be dismissed if the lawsuit was baseless, regardless of the individual's objections, and 3) the defendant would be liable for attorney and other fees if the court found the lawsuit frivolous. The possibility of frivolous lawsuits would be further reduced by a floor amendment that Rep. Maxey plans to offer that would require *qui tam* actions to be dismissed entirely if the state refused to intervene.

CSSB 30 would give the state better tools to deter and more appropriately penalize fraud and abuse by enacting criminal penalty provisions and by authorizing the use of higher administrative penalties on fraudulent providers who take advantage of vulnerable Medicaid recipients: children, the elderly, or the disabled. Existing statutes authorize the assessment of monetary penalties against fraudulent providers and their removal from the Medicaid program, but they do not distinguish between vulnerable victims of fraud and other adults, even though the consequences of medical malfeasance can be far more harmful.

Nursing homes would be exempt from mandates that they lose their license due to violations subject to Medicaid administrative penalties, because shutting down a nursing home can result in the loss of institutional care services to current residents and to surrounding communities. Nursing homes would remain under strict enforcement measures and sanctions, however, due to extensive nursing home reform legislation being developed this session and because the department would still retain the option to revoke or suspend a license if considered an appropriate penalty.

The authority to suspend a person's driver's license or hunting or fishing license would be an effective "hammer" to ensure that overpayments in food stamp or financial assistance benefits were reimbursed to the state. Such an action would only take place in cases of wilful fraud, because licenses would

not be revoked without providing the individual with an opportunity to make repayments or to contest the measure through a hearing process.

OPPONENTS SAY:

CSSB 30 *qui tam* provisions would increase the number of frivolous or unsubstantiated actions, cause a lot of providers to settle unsupported claims to avoid negative publicity or huge court costs, and increase costs to nursing homes, hospitals, and other Medicaid providers. CSSB 30 could encourage frivolous lawsuits because of the possibility of a large payoff to the person filing the suit. In the rush to be the first to file suit, individuals could easily fail to fully investigate a claim.

The false claims amendment to the Government Code could distract government employees from their jobs by encouraging them to scrutinize and investigate any large transactions in the hope of winning a payoff for discovering a false claim. Employees should not be made an enforcement arm of the state; they are not trained to investigate claims. If there is a problem in this state with filing false claims against the government, investigators from the Attorney General's Office or local authorities should be solely responsible for investigating such cases.

Private individuals already have sufficient authorization and incentives to bring information of suspected Medicaid fraud to the Department of Human Services, Texas Department of Health or the AG, and the regulatory bodies already have sufficient remedies on hand to investigate and penalize fraudulent providers.

Loss of driver's license could mean loss of livelihood or potential livelihood for some individuals struggling to get off welfare; they should not be so severely punished for what usually is the state's overpayment error.

Punishments should be structured to fit the offense regardless of the type of victim involved. Carving out higher penalty levels for fraud that results in injury to disabled or elderly individuals or children could open the door for other groups asking for special treatment, such as individuals who are vulnerable due to medically complex conditions or life-threatening diseases.

The Legislature should wait for sunset commission review of all health care agencies next session before shifting personnel from one agency to another.

OTHER OPPONENTS SAY:

The reward incentive intended to increase reporting of suspected fraudulent activities to the Health and Human Services Commission would be too small. Awards could only be granted to the extent funds were already available in the commission's budget, and the likelihood of the commission having extra funds to provide an award would be minimal.

If the integrity of the enforcement process and the detection of fraud was enhanced by centrally locating Medicaid billings and claims payment review functions, then the same should be true for the oversight of welfare and food stamp payments. Such functions should also be moved out of DHS to the commission. the Texas Performance Review in *Disturbing the Peace*, recommendation FR-1, proposed transferring the DHS Office of Inspector General, which oversees AFDC and food stamp fraud control efforts, to the commission along with the TDH Medicaid personnel to create a new Investigations and Enforcement Office.

NOTES:

The committee substitute added a *qui tam* provision to the new false claims amendments to the Government Code, allowed a person to continue a private cause of action even if the state declined to pursue a *qui tam* action and made other, primarily nonsubstantive, changes.

This bill would enact several provisions that are substantially the same as provisions that have already passed by the House in HB 820 by Cuellar, concerning reduction of Medicaid fraud, HB 1637 by Alvarado, concerning increased penalties for Medicaid fraud resulting in injury to a child, and HB 494 by Alvarado, which would allow private actions against false claims. HB 820 was reported favorably by the Senate Jurisprudence Committee on May 18, HB 1637 passed the Senate on May 20, and HB 494 died in the Senate Jurisprudence Committee when no action was taken before the bill reporting deadline.