

SUBJECT: Preventing fraud and abuse in the Medicaid program

COMMITTEE: State Health Care Expenditures — favorable, without amendment

VOTE: 8 ayes — Delisi, Gutierrez, Berman, Crownover, Deshotel, Harper-Brown, Truitt, Uresti

0 nays

3 absent — Capelo, Miller, Wohlgemuth

WITNESSES: None

BACKGROUND: **Office of investigations and enforcement.** The Health and Human Services Commission (HHSC) has an office of investigations and enforcement responsible for the investigating fraud in health and human services and enforcing state law relating to those services. HHSC and the Attorney General's Office have a memorandum of understanding under which they jointly investigate fraud and enforce relevant state laws. Two departments in the Attorney General's Office — the Medicaid fraud control unit and the civil Medicaid fraud section — work on fraud in health and human services.

Medicaid fraud. Sec. 32.039 of the Human Resources Code defines Medicaid fraud as:

- the presentation of a claim that contains a statement the person knows or should know is false;
- a managed care organization's failure to provide a service that the organization is required to provide under contract;
- a managed care organization's failure to provide information required by law; or
- a managed care organization's fraudulent activity in connection with enrollment or payment.

A provider who commits a violation is liable for the amount paid with interest, an administrative penalty not to exceed twice the amount paid, plus an additional penalty between \$5,000 and \$15,000 for injuring a child, an elderly person, or a disabled person.

When a provider is found guilty of a violation that injured a child, an elderly person, or a disabled person, the provider is barred from Medicaid for at least 10 years. Violations that do not result in an injury to these groups require in at least a three-year ban. This ban does not apply to a person who operates a nursing facility or an intermediate care facility for people with mental retardation (ICF-MR).

Medicaid and Public Assistance Fraud Oversight Task Force. Sec. 531.107 of the Government Code directs the Medicaid and Public Assistance Fraud Oversight Task Force to advise HHSC in improving the efficiency of fraud investigations and collections. It is composed of representatives from HHSC, the Attorney General's Office, Comptroller's Office, Department of Public Safety, State Auditor's Office, Texas Department of Human Services, and Texas Department of Insurance.

Third-party billing. Third-party billing vendors are companies that process claims for physicians or other health professionals billing Medicaid, Medicare, and private health insurers. These companies receive the documentation from the provider and put it into a claim format, then send it to the appropriate payor. Because people may be enrolled in more than one health program, the third-party billing company can handle sending portions of a claim to separate payors.

DIGEST: HB 1743 would add "abuse" to the provisions regarding fraud prevention and detection activities at HHSC.

Office of investigations and enforcement. HHSC's office of investigations and enforcement would be considered a law enforcement office for the purposes of obtaining information and would have the authority to obtain information in the same manner as other law enforcement agencies. Information obtained this way would be exempt from public information disclosure. The office would be authorized to issue a subpoena to compel testimony or the production of documents. It also would be authorized to seize assets if they had been used to commit fraud and were integral to recovery of damages or other penalties. HHSC would be prohibited from disposing of the assets until the seizure was confirmed appropriate.

HHSC would be required to refer each suspected case of fraud, waste, or abuse to the office of the attorney general within 10 days of discovery. By November 1 each year, the Attorney General's Office would report expenditures, caseloads, length of time required to complete a case, recoveries and penalties, and any other relevant information to the governor and the Legislature.

The bill would require HHSC and the Attorney General's Office to amend the memorandum of understanding to include circumstances when HHSC should refer a case directly to the appropriate U.S. district attorney, other attorney, or collection agency. The amendments would be required by December 1, 2003.

Medicaid fraud. The definition of fraud would be broadened to include offering to pay remuneration for soliciting a patient or patronage from a health care provider. This would include kickbacks or bribes for referrals of Medicaid patients or influencing the decision about selection of a provider. Violations of this nature that occurred on or after the effective date of this bill would be state-jail felonies (180 days to two years in a state jail and an optional fine of up to \$10,000). The prohibition on kickbacks and bribes would not include marketing campaigns or giving away token items for advertising purposes, refreshments at informational meetings, or other acts specifically authorized by law.

HHSC's office of investigations and enforcement would be authorized to hold a claim for five days to review it before payment and determine if it involved fraud or abuse. HHSC also would be authorized to impose a hold on future payments to a provider if it had reliable evidence that the provider engaged in fraud or wilful misrepresentation, but would have to notify the provider by the fifth working day after the hold. The commission also would have the authority to require a reasonable surety bond from a provider if HHSC found irregularities in the provider's services that indicated the need for protection against future fraud or abuse.

HHSC would be authorized to lift the three- or 10-year ban on a provider found guilty of a violation under certain circumstances. Criteria for waiving the ban would include the person's knowledge of the violation and the likelihood that education would prevent future violations, potential impact on

access to services in the area, or other factors. The bans would apply to a person who operated a nursing facility or ICF-MR.

Medicaid and Public Assistance Fraud Oversight Task Force. CSHB 2292 would expand the task force's membership to include representation from the Texas Department of Health. With participation from the department's Bureau of Vital Statistics, the task force would be directed to study the documentation requirements and procedures used by the state to confirm a person's identity for medical, cash, or other forms of assistance. The results of this study would be reported to the Legislature by December 1, 2004.

Third-party billing. Third-party billing vendors would be required to enter into a contract with HHSC authorizing the submission of Medicaid claims. The contract would include similar provisions to those between HHSC and health plan providers, especially in the areas of fraud or abuse. The contract would be required to include documentation of the billing agency's authority to process a provider's claims, a way for HHSC to identify and verify the provider submitting the claim, and access to records it may need to verify the data in the claim. If HHSC received a claim from a contracted third-party vendor, the commission would be required to send notice to the provider, which the provider would review for accuracy. These changes would take effect January 1, 2004.

The bill would take effect September 1, 2003.

**SUPPORTERS
SAY:**

HB 1743 appropriately would add the term "abuse" to HHSC's fraud prevention and detection activities. Federal regulations require the agency to investigate both fraud and abuse, while state law speaks only to fraud in the Medicaid program. The language should be clarified to authorize HHSC to go after activities that abuse the system, but that do not fit the technical definition of fraud.

Office of investigations and enforcement. HHSC should have the same powers as other law enforcement agencies when investigating Medicaid fraud and abuse. The commission should be able to subpoena records and documents within the same parameters as federal fraud investigators. The commission also should have the authority to seize assets because illegally obtained cash tends to be spent quickly. Federal investigators and law

enforcement are able to seize some assets to recover funds, but HHSC currently can recover seized assets only when federal authorities become involved. The bill would allow HHSC to go after assets quickly, before they were spent, to recover as much as possible.

The commission works with many different law enforcement entities in detecting fraud, including the Texas Department of Public Safety, local prosecutors, police and sheriffs' offices, the Federal Bureau of Investigation and the U.S. Attorney General's Office. Because HHSC currently does not have formal law enforcement status, some of these law enforcement agencies may not be able to share important information. HHSC should have access to all the information it needs to conduct Medicaid fraud investigations.

HHSC should have the authority to work directly with local or federal prosecutors. Under current law, all cases must be referred through the Civil Medicaid Fraud Section at the Office of the Attorney General. That office is overworked with the number of cases HHSC sends for prosecution, let alone referral cases. It would be more efficient for HHSC to work directly with local or federal prosecutors.

Medicaid fraud. The HHSC office of investigations and enforcement has found cases where a doctor has bribed Medicaid recipients with cash or gifts such as lottery or sporting event tickets to participate in unnecessary screening and treatments. There is no state law against this practice, even though it is clearly wrong and a waste of Medicaid dollars.

Federal law allows states to review and hold payments without cause, but state law requires immediate notification, which generates administrative complexity and makes the holds less effective. HB 1743 would grant HHSC the flexibility of a five-day hold without notification, as allowed under federal law, so that it could prevent overpayments.

HHSC also should have the authority to require a surety bond to protect the state against provider fraud. If the state held a surety bond, taxpayer dollars would be protected in cases where the provider's claims turned out to be fraudulent. Also, by authorizing HHSC to require bonds only when the commission suspected fraud, rather than requiring them of all new providers,

this bill would allow small businesses that might not have the money for a surety bond to continue contracting with the state.

Third-party billing. Federal auditors report that Texas does not have adequate safeguards against fraudulent electronic claims filed by third-party billing vendors. HHSC currently does not require third-party billing vendors to complete Medicaid provider agreements or report who is using their services. A recent investigation uncovered \$9 million in fraudulent claims made by a Houston therapist acting as a third-party billing vendor for other Medicaid providers. The providers who were using the service did not know that fraudulent claims were made on their behalf, a situation that HB 1743 would remedy.

OPPONENTS
SAY:

The prevention and investigation of Medicaid fraud and abuse is a good idea, but this bill fails to define certain terms and processes well enough to ensure that legitimate providers would not get thrown in with the bad. The bill should better define “irregularities” because simple errors or legitimate prescribing patterns could appear erratic enough for HHSC to require a surety bond. The due process for seizure of assets also should be better defined. The state should make sure that there were plenty of opportunities to clear things up before HHSC began seizing a doctor’s practice.

NOTES:

The fiscal note for HB 1743 estimates that the bill would save the state \$21.4 million in general revenue and \$56.3 million in all funds for fiscal 2004-05. It would require an additional 18 FTEs.

Many of the proposals in HB 1743 are included in the comptroller’s E-Texas report, *Limited Government, Unlimited Opportunity*. All of the proposals in the bill also are part of HB 2292 by Wohlgemuth, which is pending in the House Appropriations Committee.