BILL ANALYSIS

C.S.S.B. 563
By: Janek
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

The Texas Medicaid Fraud Prevention Act (TMFPA), provides a mechanism for private person plaintiffs who have knowledge of actions taken by companies or individuals to defraud the Texas Medicaid program to file against the wrongdoer under seal and turn over evidence to the Attorney General. The Attorney General may investigate, and, if he finds the allegations are meritorious, may intervene in the lawsuit.

The substitute amends the Aunlawful acts@ provisions of the statute, and codifies that the cap on exemplary damages in Civil Practice & Remedies Code Chapter 41 does not apply to actions under the TMFPA. It adds several definitions to the TMFPA to make it read more clearly and to assist the OAG in the enforcement of its provisions. Furthermore, a number of sections in the TMFPA are amended to clarify ambiguities.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 6 of this bill.

ANALYSIS

The substitute clarifies that a "provider" includes a manufacturer or distributor of any product that is reimbursed by the Medicaid program. The substitute adds a section on "culpable mental state," so that a person acts "knowingly" if he or she has knowledge of the information and acts with indifference or reckless disregard of the information. Proof of specific intent to defraud is not required in a civil or administrative proceeding to show that a person acted "knowingly."

The substitute clarifies unlawful acts relating to Medicaid payments and benefits. It adds that an unlawful act includes making or using false records that affect obligations to pay or transmit money or property to the state under the Medicaid program. The substitute also cleans up and simplifies language.

The substitute includes political subdivisions of the state and a person authorized by the attorney general in the list of those who are authorized to receive documentary material from the attorney general. It also includes political subdivisions of the state and a person authorized by the attorney general in the list of those to whom documentary material may be provided without the provider being held liable.

The substitute provides that a health and human services agency is required to suspend or revoke a provider agreement, permit or license for persons found liable who do not operate a nursing facility or ICF-MR facility, and is authorized to suspend or revoke an agreement or license for a person found liable who does operate one of these types of facilities. The substitute clarifies that a provider found liable for an unlawful act may not provide or arrange to provide health care services under the Medicaid program or supply or sell, directly or indirectly, a product to or under the Medicaid program for a period of ten years. The executive commissioner of the Health and Human Services Commission (HHSC) is given rulemaking authority to grant a full or partial exemption from the period of ineligibility if enforcement of the full period of ineligibility is harmful to the Medicaid program or a beneficiary of the program.

The substitute clarifies the remedies available to the state.

The substitute adds guidelines for the attorney general's disclosure of documentary material and adds procedures for the attorney general to compel a person to submit to examinations under oath. The substitute prohibits the office of the attorney general from releasing or disclosing information that is obtained when a person files on a prescribed form a statement in writing, under oath or affirmation, as to all the facts and circumstances concerning the alleged unlawful act and other information considered necessary by the attorney general, or when the attorney general has examined under oath a person in connection with the alleged unlawful act or any documentary material or other record except under certain circumstances. The substitute authorizes the attorney general to use documentary material or copies of that material, as necessary in the enforcement of the Medicaid Fraud Prevention, including presentation before a court. The substitute authorizes the attorney general, if a person fails to meet certain requirements, to file in a district court of Travis County a petition for an order to compel the person to meet the requirements. Provides that failure to comply with an order is punishable as contempt. The substitute provides that an order issued by a district court is subject to appeal to the supreme court.

The substitute changes the deadline for filing petitions to the 180th day after the petition is filed or on the date the state elects to intervene. The attorney general is authorized to request that petitions remain under seal. The substitute makes technical and conforming changes throughout the legislation.

The substitute allows a court to determine expenses, fees, and costs to be awarded after the defendant has been found liable.

The substitute adds a Medicaid Fraud chapter to the Penal Code. The substitute provides definitions under this chapter. The substitute defines an offense of Medicaid Fraud if:

- a person knowingly makes or causes to be made a false statement or misrepresentation of a material fact;
- a person knowingly conceals or fails to disclose information that permits a person to receive a Medicaid benefit;
- a person knowingly applies for and receives a benefit or payment on behalf of another person and converts the benefit or payment to a use other than what it was intended for.
- a person knowingly makes, causes to be made, induces, or seeks to induce a false statement or misrepresentation of material fact concerning the conditions or operation of a facility so that the facility may qualify for certification or recertification as a hospital, nursing facility, skilled nursing facility, hospice, intermediate care facility for the mentally retarded, assisted living facility, or a home health agency;
- a person knowingly makes, causes to be made, induces, or seeks to induce a false statement or misrepresentation of material fact concerning information that is required to be provided as stipulated by federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program;
- except as allowed by Medicaid, a person knowingly pays, charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or product under the Medicaid program;
- a person knowingly presents or causes to be presented a claim for payment or a service by a person who is not licensed to provide the product or render the service, if a license is needed;
- a person knowingly makes a claim for a service or product that has not been approved or acquiesced; a service or product that is substantially inadequate or inappropriate when compared to generally recognized standards; a product that has been adulterated, debased, or mislabeled;
- a person makes a claim under the Medicaid program and knowingly fails to indicate the type of license and the identification number of the licensed provider that provided the services;
- a person knowingly enters into an agreement, combination, or conspiracy to defraud the state by aiding another person in obtaining an unauthorized payment or benefit;
- the entity is a managed care organization that contracts with the HHSC or other state agency to provide health care benefits or services and fails to provide to an individual a benefit that is required under the contract; fails to provide information required by law,

commission or agency rule, or contractual provision; engages in a fraudulent activity in connection with the enrollment of an individual eligible under the program, in the organization's managed care plan, or in connection with marketing to an individual eligible under the Medicaid program;

- a person knowingly obstructs an investigation by the attorney general of an alleged unlawful act under Section 36.002 of the Human Resources Code; or
- knowingly makes, uses, or casues the making or use of, a false record or statement to conceal, avoid or decrease an obligation to pay or transmit money or property to the state.

The substitute specifies punishment for an offense as follows. If the amount of any payment or the value of any monetary or in-kind benefit provided under the Medicaid program, directly or indirectly, as a result of the conduct is: less than $50, it is a Class C misdemeanor; $50 or more, but less than $500, it is a Class B misdemeanor; $500 or more, but less than $1,500, it is a Class A misdemeanor; $1,500 or more, but less than $20,000, it is a state jail felony; $20,000 or more, but less than $100,000, it is a third degree felony; $100,000 or more, but less than $200,000, it is a second degree felony; $200,000 or more, it is a first degree felony.

The substitute provides that if conduct constituting an offense under this section also constitutes an offense under another section of this code or another provision of law, the actor may be prosecuted under either this section or the other section or provision.

The substitute authorizes, when multiple payments or monetary or in-kind benefits are provided under the Medicaid program as a result of one scheme or continuing course of conduct, the conduct to be considered as one offense and the amount of the payments or monetary or in-kind benefits aggregated in determining the grade of the offense.

The substitute amends Section 41 of the Civil Practice and Remedies Code to clarify that the section, which imposes a cap on punitive damage awards, does not apply to Chapter 36 of the Human Resources Code.

This bill repeals Section 36.131 of the Human Resources Code and states that this bill applies only to conduct on or after the effective date, and an offense under the penal law that occurred before the effective date of this Act if any element of the offense occurred before that date.

EFFECTIVE DATE

September 1, 2005.

COMPARISON OF ORIGINAL TO SUBSTITUTE

The substitute modifies the original by adding language to that makes it unlawful for a person to knowingly make, use, or cause the use of false records or statements to conceal, avoid, or decrease an obligation to pay or transmit money or property to this state under the Medicaid program. The substitute removed the list of commissioners of several agencies and replaced them with Aa health and human services agency. The substitute added language to provide more discretion for the executive commissioner of the HHSC in determining exemptions from the period of ineligibility for providers who have violated this Act. The substitute makes conforming changes, technical changes, and renumbers the sections accordingly.