SUBJECT: Civil actions to recover fraudulent Medicaid claims

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Berlanga, Hirschi, Coleman, Davila, Delisi, Glaze, Maxey

0 nays

2 absent — Janek, Rodriguez

WITNESSES: For — None

Against — Michael D. Smith, Texas Health Care Association

On — Robin Herskowitz, Comptroller's Office; George Noelke, Office of the Attorney General

BACKGROUND: Chapter 36 of the Human Resource Code defines a number of offenses related to Medicaid fraud. To commit an offense, a person must knowingly or intentionally engage in actions intended to unlawfully divert Medicaid funds.

DIGEST: CSHB 820 would authorize individuals to file private civil suits on behalf of the state for fraudulent Medicaid acts and share in the proceeds of the action. The bill also would authorize the Health and Human Services Commission to grant awards to individuals reporting incidents of Medicaid fraud.

Private individuals filing a civil action would have to serve a copy of the petition and written disclosure of material evidence to the attorney general. Persons could not bring action for Medicaid fraud based on allegations or transactions that were the subject of a civil suit or administrative penalty proceeding; criminal hearing; legislative or administrative report, hearing audit or investigation; or from the news media, unless the person bringing the action had direct and independent knowledge of the information on which the allegations were based.

The state would have 60 days to intervene on the action. If it intervened, the state would have primary responsibility for prosecuting the action. The

Office of the Attorney General (OAG) could contract with private attorneys to represent the state in such suits. No other party could intervene in the suit. Persons initiating actions would be entitled from seven to 25 percent of the proceeds, depending on the extent to which they substantially contributed to the prosecution.

The state could dismiss any action if the individual bringing the action was notified of the motion to dismiss and provided 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, and could pursue a claim through any alternate remedy, including administrative proceedings.

If the state elected not to proceed with the action, the person bringing the action would have the right to conduct the suit and would be entitled to a reasonable amount for collecting civil penalties and damages. This amount would be between 25 and 30 percent of the action's proceeds, unless the court found the person helped plan and initiate the violation. Persons 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 claims to be frivolous, vexatious or harassing would be entitled to reasonable attorney's fees and expenses.

Persons who were discharged, demoted, suspended, threatened or harassed by their employer because of they had filed actions or assisted with investigations would be entitled to reinstatement with the same seniority status and not less than two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained.

Persons found liable under a private action would also be considered liable for civil remedies or a suit for injunctive relief filed by the OAG. The OAG, or a private attorney chosen by the OAG, also could file a federal lawsuit in connection with federal Medicaid program violations under the federal False Claims Act. The OAG would have to develop strategies to increase state recoveries under the federal act and report the results to the Legislature by September 1, 1998.

The attorney general could also retain a reasonable portion of Medicaid fraud recoveries as specified under the general appropriations act.

The Health and Human Services Commission could grant an award to individuals for reporting Medicaid fraud if they did not file a private cause of action and the commission determined that their reports caused the state to recover an overcharge or put a stop to the fraudulent activity. The award would be equal to at least 10 percent of the resulting savings and would be paid from existing appropriations to the commission.

The commission also would have to assist the attorney general in performing preliminary and ongoing Medicaid fraud investigations, but would not have to provide assistance for more than 100 investigations per fiscal year. This requirement would take effect contingent upon the enactment of SB 741 by Nelson or a similar law transferring to the commission employees of the Texas Department of Human Services and Texas Department of Health.

CSHB 820 would take effect September 1, 1997.

SUPPORTERS SAY:

CSHB 820 would help improve oversight and enforcement of state and federal Medicaid standards, ensure that public funds are spent on authorized purposes and for authorized individuals only, save the state money and make the program more cost-effective. CSHB 820 is based on recommendation FR-8 in the latest Texas Performance Review report *Disturbing the Peace*, published by the Comptroller's Office.

The size and volume of the Texas Medicaid program 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. Fraud by its nature is a hidden crime; there are few smoking guns pointing toward its occurrence.

CSHB 820 would enact a *qui tam* provision used by both the federal government under the False Claims Act and other states. Such provisions allow 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." Other states have found private

qui tam actions to be the most effective and inexpensive means of bringing fraud out in the open that might otherwise would have gone undetected.

Qui tam actions essentially broaden a government's investigative powers by privatizing a part of them; 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.

CSHB 820 would put *qui tam* to work in Texas. The bill would encourage private citizens to come forward with information that could improve fraud detection and prosecution at no cost to the state. Citizens filing an action against a provider or individual would be entitled to part of the recovered funds, while citizens reporting suspected fraudulent activity to the commission could receive an award.

Even though other statutory and regulatory provisions require or authorize the reporting of fraudulent activities, individuals are often inhibited from speaking up for fear of harassment or losing their job or benefits for themselves or their loved ones. For example, many consumer advocates have testified about witnessing nursing homes submitting fraudulent Medicaid claims, such as the reporting of equipment purchases that were never used by the nursing home resident, but were afraid of speaking up and leaving their family member vulnerable to harassment from the staff in the home.

CSHB 820 would not increase the number of frivolous or unsubstantiated lawsuits because it would include three important safeguards: (1) the state would have a 60-day period in which to review and analyze the merits of the case, (2) the state could dismiss the lawsuit if baseless, regardless of the individual's objections, and (3) the defendant would be made liable for attorney and other fees if a court found the lawsuit frivolous.

Also, by specifically authorizing the attorney general to contract with private attorneys to represent Texas under the federal *qui tam* statute, the Legislature would be clearly expressing its intent that Texas maximize its recoveries under the statute.

OPPONENTS SAY:

CSHB 820 would increase the number of frivolous or unsubstantiated actions, cause many providers to settle unsupported claims to avoid negative publicity or huge court costs, and increase costs to nursing homes, hospitals and other Medicaid providers.

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 OAG, and these regulatory bodies already have sufficient remedies on hand to investigate and penalize fraudulent providers.

OTHER OPPONENTS SAY:

The incentive for reward is too small to generate more reporting of suspected fraudulent activities to the Health and Human Services Commission. The awards could only be granted to the extent funds were already available in the commission's budget; the likelihood of the commission having extra funds to provide an award would be very small.

NOTES:

The committee substitute added provisions that specifically authorized the attorney general to contract with private attorneys to represent the state in state *qui tam* proceedings, and directed the commission to assist the attorney general in investigations of Medicaid fraud.

Other bills related to Medicaid fraud this session include SB 30 by Zaffirini, which passed the Senate on April 17 and was reported favorably as substituted by the Public Health Committee on April 25, and HB 494 by Alvarado, allowing private actions against false claims against government entities or contractors, which passed the House on April 16 and has been referred to the Senate Jurisprudence Committee.