SUBJECT: Revising statutes governing Medicaid fraud

COMMITTEE: Public Health — committee substitute recommended

VOTE: 7 ayes — Delisi, Laubenberg, Truitt, Coleman, Dawson, Jackson, Solis

0 nays

2 absent — McReynolds, Zedler

SENATE VOTE: On final passage, March 31 — 30-0, on Local and Uncontested Calendar

WITNESSES: For — None

Against — None

On — Rick Copeland, Patrick O'Connell, Office of the Attorney General

BACKGROUND: Medicaid, the state-federal health insurance program for low-income families, children, the elderly, and disabled persons, is administered by the Health and Human Services Commission (HHSC). Fraud by providers or beneficiaries is investigated and prosecuted by the Office of the Attorney General.

DIGEST: CSSB 563 would add Medicaid fraud provisions to the Penal Code and make changes to the statutes governing investigations and offenses.

It would expand the definition of "provider" to include manufacturers and distributors of products that are reimbursed by Medicaid. The bill would define the circumstances under which a person "knowingly" acted in relation to Medicaid fraud to include having knowledge of certain information or acting with conscious indifference or reckless disregard of the truth or falsity of that information. It also would broaden the list of unlawful acts to include fraud involving products and fraud involving false records or statements made or used to avoid paying money owed to the state under the Medicaid program.

CSSB 563 would permit the Office of the Attorney General to disclose

information obtained during a fraud investigation to political subdivisions and others authorized by the attorney general to receive the information and would clarify and reconcile existing disclosure restrictions. It also would permit the attorney general to file a petition to order a person to comply with that office's efforts to gather information in a fraud investigation. In cases where an action was brought by a private person, the attorney general could elect to intervene within 180 days, rather than 60 days.

CSSB 563 would exempt acts of Medicaid fraud from the limitations on the award of exemplary damages in the Civil Practice and Remedies Code. It also would permit HHSC to exempt from ineligibility for a license Medicaid providers found liable for fraud if the full 10-year ineligibility would cause harm to the program or to a Medicaid beneficiary.

The bill would take effect September 1, 2005.

SUPPORTERS SAY:

CSSB 563 would settle matters of interpretation that are debated by the Office of the Attorney General and defendants in cases involving Medicaid fraud. Definitions, location of the offenses in code, and other clarifications would establish more precisely the laws governing investigation and prosecution of Medicaid fraud. The bill also would make changes to align Texas law with the Federal False Claims Act.

The bill would exempt cases involving Medicaid fraud from the caps on exemplary damages in place since HB 4 by Nixon was enacted by the 78th Legislature in 2003. Those limits were designed to protect providers and others from excessively high damage awards but not providers committing fraud against the state.

OPPONENTS SAY:

CSSB 563 could cause personal identifying information to fall into the wrong hands. Under the current statute, employees of the Office of the Attorney General must be authorized to gain access to information collected from a provider during an investigation. However, CSSB 563 would allow any employee of that office to have access, and additional entities would be eligible to receive the information.

NOTES:

The committee substitute differs from the Senate-passed bill by making knowingly acting to avoid paying money owed to the state under the

Medicaid program an unlawful act and extending the deadline for the attorney general to intervene in a private action to 180 days.