BILL ANALYSIS

Senate Research Center
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C.S.S.B. 1589
By: Zaffirini
Human Services
3/31/1999
Committee Report (Substituted)

DIGEST

Texas expended $7.3 billion in 1997 on its Medicaid program, $3.8 billion of which was spent on acute care services. The 75th Legislature directed the comptroller of public accounts (comptroller) to study the size and nature of fraud and overpayments in the Medicaid program and other state health care programs. The comptroller and the State Auditor's Office reported possible overpayments of approximately $162 million for Medicaid acute services based on 1997 expenditures. The comptroller included recommendations in the Fraud Measurement Study for improving the state's ability to ensure that state health care program funds are properly expended.

PURPOSE

As proposed, C.S.S.B. 1589 sets forth provisions for conducting a study of fraudulent medical or health care benefit claims submitted under certain state programs.

RULEMAKING AUTHORITY

This bill does not grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Redesignates Section 403.026, Government Code, as Section 403.028, which is amended to require the comptroller of public accounts (comptroller), in consultation with the office of the state auditor, to conduct a study each biennium to determine the number and type of fraudulent claims for medical or health care benefits submitted under the state Medicaid program, including the Medicaid managed care program implemented under Chapter 533. Authorizes the comptroller or, at the request of the comptroller, a state agency that administers a program identified by Subsection (a) to make contact with a person identified as receiving services for which benefits are provided under a program to confirm delivery of services to a person. Requires the information to be provided in a certain format agreed to by the comptroller and the state agency. Requires each state agency that administers a program identified by Subsection (a), in consultation with the comptroller and the office of the state auditor, to establish performance measures to be used to evaluate the agency's fraud control procedures. Requires a report to indicate whether the level of fraud in each program included in the study has increased, decreased, or remained constant since the comptroller's last report. Makes conforming changes.

SECTION 2. Emergency clause.
Effective date: upon passage.

SUMMARY OF COMMITTEE CHANGES

SECTION 1.

Redesignates Section 403.026, Government Code, as Section 403.028, which is amended to require the comptroller of public accounts (comptroller), in consultation with the office of the state auditor, to conduct a study each biennium to determine the number and type of fraudulent claims for medical or health care benefits submitted, including the Medicaid managed care program implemented under Chapter 533. Requires the information to be provided in a certain format agreed to by the comptroller and the state agency. Requires each state agency that administers a program identified by Subsection (a), in consultation with the comptroller and the office of the state auditor, to establish performance measures to be used to evaluate the agency's fraud control procedures. Deletes text regarding managed care programs which provide health care benefits as

a part of group coverages offered to active and retired state employees.

SECTION 2.

Deletes existing SECTIONS 2 - 4. Redesignated from existing SECTION 5.