Texas Enacts Additional Laws to Address Medicaid Fraud, Waste and Abuse

As part of *Lawyer Monthly*'s Legal Focus on Fraud and Financial Crime, we benefit from an exclusive article from Philip H. Hilder from Hilder & Associates, P.C. in Houston, Texas, on Medicaid fraud, waste and abuse.

Medicaid emerged as a leading law enforcement issue in the 83rd Texas legislative session after recent investigations conducted by the Office of Inspector General (OIG) indentified $6 billion in Medicaid fraud, waste and abuse from 2004 to 2011. The Legislature passed four new laws, which take effect on September 1, 2013, that enhance state enforcement and investigation into fraudulent practices in the healthcare field and provide Medicaid providers accused of wrongdoing with additional protections when under investigation.

Senate Bill 746 expands the definition of an 'unlawful act' to include conspiracy to engage in conduct that constitutes a violation of the Texas Medicaid Fraud Prevention Act and also includes the receipt of unlawfully obtained funds and the failure to repay Medicaid overpayment owned the state.

Whistleblowers may recover unlawfully obtained funds for up to six years before the suit was filed if the state declined to intervene, or when the state is involved, three years from the date the state knew or should have known facts material to the unlawful act. The potential amount of recovery that may be awarded to a whistleblower is increased from seven percent to ten percent in addition to reasonable attorney's fees and expenses. 'Original source' is redefined as a person who 'voluntarily disclosed to the state the information on which allegations or transactions in a claim based or has knowledge that is independent of and materially adds to the publicly disclosed allegation or transactions'. Whistleblowers are protected from retaliation and have three years from the date of retaliation to file a lawsuit for discrimination experienced because of actions taken to report Medicaid fraud.

Senate Bill 1803 affords Medicaid providers under investigation with new protections. The OIG is required to conduct preliminary investigations of Medicaid fraud and abuse to determine whether a sufficient basis of the fraud exists to warrant a full investigation. Furthermore, the OIG will be required to give providers notice of payment hold relaying the specific basis for the hold, including the claims supporting the allegation at that point in the investigation. Before a payment hold may be imposed, the OIG must employ a licensed physician medical director and a licensed dentist dental director to ensure investigative findings have been reviewed by a qualified expert. Providers under investigation may request an expedited administrative hearing or seek an informal resolution meeting within thirty days of receiving notice of payment hold. The law makes the OIG and the provider equally responsible for all costs associated with the hearing. Following an expedited administrative hearing, a provider subject to an OIG payment hold may appeal a final administrative order by filing a petition for judicial review in a district court of Travis County.

Senate Bill 8 requires the Health and Human Services Commission to establish a data analysis unit intended to improve contract management and detect anomalies and trends that could indicate Medicaid fraud. It also codifies the OIG's authority to investigate fraud, waste and abuse within all health and human services programs and strengthens limitations on how providers can market their services and prohibits improper soliciting of Medicaid clients. Changes were made regarding how the state will regulate non-emergency transportation companies and emergency medical services providers to decrease the use of emergency services for non-emergency needs. Providers found guilty of Medicaid fraud in Texas or any other state will be excluded from participating in a state or federally funded health care program.

House Bill 658 pertains to litigation involving Medicare fraud. Pursuant to this new law, post-judgment interest on an unpaid balance of damages subject to Medicare subrogation does not accrue until the defendant receives a recovery demand letter from the Centers for Medicare and Medicaid Services. Furthermore, post-judgment interest will not accrue if a defendant appeals.

Although providers now have additional safeguards while under investigation, these bills essentially enhance the state's capabilities for cracking down on healthcare fraud and detecting red flags that could indicate wrongdoing. The broadened definition of unlawful acts and the new restrictions and limitations placed on providers will likely lead to an increasing number of prosecutions relating to Medicaid fraud. **LM**

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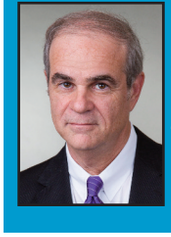

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