BILL ANALYSIS

Senate Research Center
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S.B. 1587
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Human Services
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As Filed

DIGEST

Currently, the comptroller and the state auditor's office report possible overpayment of approximately $162 million for Medicaid acute services. The comptroller's Fraud Measurement Study makes recommendations for improvements via random audits, data matches and investigations of possible fraud by dishonest providers and recipients. This bill would set forth procedures for detecting fraud, waste, and abuse in the state Medicaid program.

PURPOSE

As proposed, S.B. 1587 sets forth procedures for detecting fraud, waste, and abuse in the state Medicaid program.

RULEMAKING AUTHORITY

Rulemaking authority is granted to the Health and Human Services Commission in SECTIONS 3 and 4 (Sections 531.102 and 531.110, Government Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Chapter 32B, Human Resources Code, by adding Sections 32.0242 and 32.0243, as follows:

> Sec. 32.0242. VERIFICATION OF CERTAIN INFORMATION. Requires the Health and Human Services Commission or an agency operating part of the medical assistance program, as appropriate (department) to verify an applicant's residential address on determination that an applicant is eligible for medical assistance. Prohibits the department from accepting a post office box unless an applicant provides an alternative address, that can be verified, at which the applicant can be contacted.
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> Sec. 32.0243. PERIODIC REVIEW OF ELIGIBILITY FOR CERTAIN RECIPIENTS. Requires the department in cooperation with the United States Social Security Administration to review the eligibility of a recipient of medical assistance based on eligibility to receive benefits under 42 U.S.C. Section 1381 et seq. as amended (SSI benefits). Requires the department to ensure that only recipients who reside in this state and who continue to be eligible for SSI benefits remain eligible for medical assistance.

SECTION 2. Amends Section 403.026(a), Government Code, as added by Chapter 1153, Acts of the 75th Legislature, Regular Session, 1997, to require the comptroller to conduct a study to determine the need for changes to the eligibility system used under the state Medicaid program. Makes conforming changes.

SECTION 3. Amends Section 531.102, Government Code, by adding Subsections (e) and (f), to require the Health and Human Services Commission (HHSC) to assign the highest priority for investigation of potential fraud to claims submitted for reimbursement for certain services. Requires HHSC to set, by rule, specific claims criteria, required to be based on a total dollar amount or a total number of claims submitted for services to a particular recipient during a specified amount of time that indicates a high potential for fraud, that require an investigation to begin.

SECTION 4. Amends Chapter 531C, Government Code, by adding Sections 531.109, 531.110, and 531.111, as follows:

Sec. 531.109. SELECTION AND REVIEW OF CLAIMS. Requires the HHSC to review a sample of all claims for reimbursement under the state Medicaid program, including the vendor drug program, for potential cases of fraud, waste, or abuse. Requires the HHSC to directly contact a recipient by a certain manner to verify that services claimed for reimbursement were actually provided. Requires the HHSC to determine the types of claims at which HHSC resources for fraud and detection should be primarily directed.

Sec. 531.110. ELECTRONIC DATA MATCHING PROGRAM. Requires the HHSC to conduct electronic data matches for a recipient of assistance under the state Medicaid program at least quarterly to verify certain factors that affect the eligibility of the recipient. Requires the electronic data matching to match information provided by the recipient with information contained in databases maintained by certain governmental entities and neighboring states. Requires the Texas Department of Human Service (TDHS) to provide data or any other assistance necessary to conduct the electronic data matches to the HHSC. Authorizes the HHSC to contract with a public or private entity to conduct the electronic data matches. Requires the HHSC to establish, by rule, procedures to verify the electronic data matches. Requires the TDHS to remove recipients ineligible for assistance under the state Medicaid program, within 20 days of an electronic data matches' verification. Requires the HHSC to report biennially to the legislature on the results of the electronic data matching program, and must include a summary of the number of recipients removed from eligibility.

Sec. 531.111. FRAUD DETECTION TECHNOLOGY. Authorizes the HHSC to contract with a contractor who specializes in developing technology to implement fraud detection technology to determine if a pattern of fraud by Medicaid recipients is present.

SECTION 5. Requires the HHSC to study and consider for implementation fraud detection technology.

SECTION 6. Requires the Texas Department of Health (TDH) to contract with a contractor who specializes in Medicaid claims payment systems to perform tests on the system considered for implementation by the TDH and a contractor to conduct tests at certain times.

SECTION 7. Requires the TDHS to develop an eligibility confirmation letter, not easily duplicated, before January 1, 2000, to be used to replace the Medicaid eligibility letter used on the effective date of this Act. Requires TDHS to identify and consider other methods, including electronic methods, for proving eligibility. Requires the TDHS to implement a permanent system for Medicaid eligibility confirmation by September 1, 2000.

SECTION 8. Requires an agency affected by a need for a waiver or authorization to implement a provision of this Act, to request a waiver or authorization and authorizes the agency to delay implementation until the request is granted.

SECTION 9. Effective date: September 1, 1999.

SECTION 10. Emergency clause.