Texas Medicaid Fraud and Prevention Act ("TMFPA")

The State of Texas passed its own version of the federal False Claims Act ("FCA") in 1995, the Texas Medicaid Fraud Prevention Act ("TMFPA"). Whereas the FCA involves many categories of fraud, the TMFPA is specifically geared toward combatting fraud against the Texas Medicaid Program. The Texas Medicaid Program provides healthcare and prescription drug coverage to low-income individuals.

Under the TMFPA, Petitions initially remain sealed for 180 days (this time period is extended in most every case), as opposed to 60 days under the FCA, in order for the State of Texas to decide if it wants to intervene in the case. If it does so, the Whistleblower/Relator is entitled to 15-25% of the recovery by the government, plus attorneys' fees, expenses and costs.

Similar to the FCA, however, in the event the Government declines to intervene in the case (which is most often the case), the TMFPA contains a provision that allows private individuals who have knowledge about fraud involving the Texas Medicaid Program to bring an action on behalf of the State of Texas for violations of the TMFPA. In the event of a recovery, the Whistleblower is entitled to 25-30% of the recovery, plus attorneys' fees, expenses and costs.

Comparison of the TMFPA and Federal False Claims Act

While the federal FCA applies to all false claims for payment or reimbursement (other than claims under the Internal Revenue Code), the TMFPA specifically targets Medicaid fraud, as discussed above. The TMFPA also provides for enhanced penalties, ranging from $5,500 to $11,000 for Unlawful Acts in most cases, and up to $15,000 for Unlawful Acts that result in injuries to elderly, disabled, or minor persons. The TMFPA does not require that a false claim be submitted to Texas Medicaid, and only 2 of the 13 Unlawful Acts set forth below require the presentment of any claim. Instead, the TMFPA prohibits Unlawful Acts, which are generally false statements and misrepresentations affecting the Medicaid program.

The available remedies are also different under the TMFPA. Damages are not an element of a TMFPA claim. Rather, a defendant who violates the TMFPA is liable to the State for the entire amount of the payment or benefit provided under the Medicaid Program, plus two times that amount. The State has no obligation to show that the payment or benefit is an overpayment or damages.

Do You Have Knowledge of Medicaid Fraud by Your Employer?

Do you suspect your employer is participating in a scheme to profit financially from Texas Medicaid? Do you have original first-hand knowledge that a person or company is committing Medicaid Fraud? The TMFPA provides whistleblowers with powerful protections and potentially large cash rewards for reporting information. **You may be eligible for a significant cash award**

as Whistleblowers who report fraud are entitled to 15-30% of the government's recovery, plus attorneys' fees and expenses. Contact Attorney Rusty Tucker at 214-505-0097 or **contact us** today for a free case evaluation.

TMFPA Unlawful Acts

The 13 enumerated Unlawful Acts set forth in Chapter 36 the TMFPA, which are as follows:

> Sec. 36.002. UNLAWFUL ACTS. A person commits an unlawful act if the person:
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> (1) knowingly makes or causes to be made a false statement or misrepresentation of a material fact to permit a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;
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> (2) knowingly conceals or fails to disclose information that permits a person to receive a benefit or payment under the Medicaid program that is not authorized or that is greater than the benefit or payment that is authorized;
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> (3) knowingly applies for and receives a benefit or payment on behalf of another person under the Medicaid program and converts any part of the benefit or payment to a use other than for the benefit of the person on whose behalf it was received;
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> (4) knowingly makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning:
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> (A) the conditions or operation of a facility in order that the facility may qualify for certification or recertification required by the Medicaid program, including certification or recertification as:
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> (i) a hospital;
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> (ii) a nursing facility or skilled nursing facility;
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> (iii) a hospice;
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> (iv) an ICF-IID;
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> (v) an assisted living facility; or
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> (vi) a home health agency; or
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> (B) information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program;
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> (5) except as authorized under the Medicaid program, knowingly pays, charges, solicits, accepts, or receives, in addition to an amount paid under the Medicaid program, a gift, money, a donation, or other consideration as a condition to the provision of a service or product or the continued provision of a service or product if the cost of the service or product is paid for, in whole or in part, under the Medicaid program;

(6) knowingly presents or causes to be presented a claim for payment under the Medicaid program for a product provided or a service rendered by a person who:

(A) is not licensed to provide the product or render the service, if a license is required; or

(B) is not licensed in the manner claimed;

(7) knowingly makes or causes to be made a claim under the Medicaid program for:

(A) a service or product that has not been approved or acquiesced in by a treating physician or health care practitioner;

(B) a service or product that is substantially inadequate or inappropriate when compared to generally recognized standards within the particular discipline or within the health care industry; or

(C) a product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate;

(8) makes a claim under the Medicaid program and knowingly fails to indicate the type of license and the identification number of the licensed health care provider who actually provided the service;

(9) conspires to commit a violation of Subdivision (1), (2), (3), (4), (5), (6), (7), (8), (10), (11), (12), or (13);

(10) is a managed care organization that contracts with the commission or other state agency to provide or arrange to provide health care benefits or services to individuals eligible under the Medicaid program and knowingly:

(A) fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract;

(B) fails to provide to the commission or appropriate state agency information required to be provided by law, commission or agency rule, or contractual provision; or

(C) engages in a fraudulent activity in connection with the enrollment of an individual eligible under the Medicaid program in the organization's managed care plan or in connection with marketing the organization's services to an individual eligible under the Medicaid program;

(11) knowingly obstructs an investigation by the attorney general of an alleged unlawful act under this section;

(12) knowingly makes, uses, or causes the making or use of a false record or statement material to an obligation to pay or transmit money or property to this state under the Medicaid program, or knowingly conceals or knowingly and improperly avoids or

decreases an obligation to pay or transmit money or property to this state under the Medicaid program; or

(13) knowingly engages in conduct that constitutes a violation under Section 32.039(b).