1) **ANTI-KICKBACK**

**Texas Occupations Code, Chapter 102 – Solicitation of Patients**

It is unlawful under § 102.001 for a person to knowingly offer to pay or agree to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency. There is a rebuttable presumption that a person violated the statute if (1) the person refers or accepts a referral of a patient to an inpatient mental health facility or chemical dependency treatment facility; (2) before the patient is discharged or furloughed from the facility, the person pays the referring person or accepts payment from the facility for outpatient services to be provided by the referring person after the patient is discharged or furloughed from the facility; and (3) the referring person does not provide the outpatient services for which payment was made and does not return to the facility the payment received for those services.

Section 102.001 does not prohibit any payment, business arrangement, or payment practice permitted by 42 U.S.C. § 1320a-7b(b) or any regulation adopted under that law. In addition, it does not prohibit advertising unless it is false, misleading, deceptive, or not readily subject to verification.

Section 102.001 does not apply to licensed insurers, governmental entities, group hospital service corporations, or health maintenance organizations that reimburse, provide, offer to provide, or administer health-related benefits under a health benefits plan for which it is the payor. The law also does not apply to certain health care information services.

A person who accepts remuneration to secure or solicit a patient or patronage in a manner permitted under Section 102.001 must disclose to the patient the person’s affiliation with the person for whom the patient is secured or solicited and that the
A violation of Section 102.001 or a failure to disclose a permissible referral under Section 102.001 is a Class A misdemeanor. However, a violation can be upgraded to a third degree felony if it is shown at trial that the person has previously been convicted of an offense under this section or was employed by a federal, state, or local government at the time of the offense. An offense is also grounds for disciplinary action by the regulatory agency that issued a license, certification, or registration.

A person who commits a violation of Section 102.001 or fails to disclose a permissible referral under Section 102.001 is also subject to a civil penalty of not more than $10,000 for each day of violation and each act of violation. The Texas Attorney General may institute legal action in a district court for the assessment of civil penalties and injunctive relief. The Attorney General is entitled to attorneys’ fees and costs associated with the investigation and prosecution of the case. The assessment of civil penalties and injunctive relief is in addition to any other civil, administrative, or criminal action provided by law. A violation of Section 102.001 is grounds for disciplinary action by the regulatory agency that issued a license, certification, or registration to the person who committed the violation.

Texas Human Resources Code - Chapter 32

Under § 32.039, Tex. Hum. Res. Code, it is unlawful for a person:

- to offer to pay or agree to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency;
- to solicit or receive, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind for referring an individual to a person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the medical assistance program;
- to solicit or receive, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind for purchasing, leasing, or ordering, or arranging for or recommending the purchasing, leasing, or ordering of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program;
- to offer or pay, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to refer an individual to another person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the medical assistance program;
to offer or pay, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to purchase, lease, or order, or arrange for or recommend the purchase, lease, or order of, any good, facility, service, or item for which payment may be made, in whole or in part, under the medical assistance program; or

• to provide, offer, or receive an inducement in a manner or for the purpose not otherwise prohibited by this section or section 102.001, Texas Occupations Code, to or from a person, including a recipient, provider, or employee or agent of a provider, third party vendor, or public servant for the purpose of influencing or being influenced in a decision regarding selection of a provider or receipt of a good or service under the medical assistance program, the use of goods or services provided under the medical assistance program or the inclusion or exclusion of goods or services available under the medical assistance program.

A person who commits a violation under Chapter 32, TEX. HUM. RES. CODE, is liable for:

• the amount paid as a result of the violation, including interest; administrative penalties not to exceed twice the amount paid, plus an amount not less than $5,000.00 and not more than $15,000.00 for each violation; and

• exclusion from the Medicaid program for 3 to 10 years depending on the violation.

An intentional violation of Chapter 32 could constitute a state jail felony.

A person who knowingly engages in conduct that constitutes a violation of Tex. Hum. Res. Code Chap. 32 constitutes a violation of the Texas Medicaid Fraud Protection Act. Texas Government Code § 531.101 allows the Texas Health and Human Services Commission to grant an award to an individual who reports activity that constitutes fraud or abuse of funds in the state Medicaid program or reports overcharges in the program. The disclosure must result in the recovery of an overcharge or in the termination of the fraudulent activity or abuse of funds.

Texas Human Resources Code - Chapter 36 – Texas Medicaid Fraud Prevention Act

Under § 36.002(5), a person commits a violation of the Texas Medicaid Fraud Prevention Act if the person accepts or charges any gift, money, or other consideration, other than the Medicaid payment, as a condition for the provision of services to a Medicaid recipient.

If a person violates the Act, he or she could be subject to the following:

• Injunctive relief;
• suspension or revocation of the provider agreement, permit, license, or certification;
• exclusion from the Medicaid program for a period of no less than ten (10) years;
• disciplinary action by a state licensing board;
• restitution for the value of any money or benefit received
• two times the value of the unlawful payment or benefit received;
• civil penalty from $5,500.00 to $15,000.00 depending on the unlawful act; and

* If a provider self-reports in a timely manner, penalties are limited to two times the value of the payment or benefit received.

A private citizen may file an action under the Texas Medicaid Fraud Prevention Act, but the Texas Attorney General must be notified and given the opportunity to pursue the case. Tex. Hum. Res. Code § 36.102. If the Attorney General proceeds with an action under this subchapter, the person bringing the action may be entitled to receive a percentage of the proceeds recovered by the State. If the Attorney General declines to pursue the case, the person bringing the action may proceed with the action without state intervention and may be entitled to receive a percentage of the proceeds recovered in an action under the Act.

A person who reports a violation of the Act or otherwise acts in furtherance of an action brought under the Act cannot be discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against. TEX. HUM. RES. CODE § 36.115.

A person who is subject to such retaliation is entitled to:

• reinstatement with the same seniority status the person would have had but for the discrimination;
• not less than two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney’s fees; and
• a person may bring an action in the appropriate district court for relief

In addition, under § 36.132 a state agency authorized to regulate a provider who receives, or is eligible to receive, payment for a health care service under the Medicaid program must revoke a license issued by the authority to a person if the person is convicted of a felony under Section 35A.02, Penal Code (offense of Medicaid Fraud).

**Texas Health and Safety Code, Chapter 164**
Under § 164.006, a mental health or chemical dependency treatment facility or person employed or under contract with a such a facility, if acting on behalf of the treatment facility, may not, in relation to intervention and assessment services, contract with, offer to remunerate, or remunerate a person who operates an intervention and assessment service that makes referrals to a treatment facility for inpatient treatment of mental illness or chemical dependency unless the intervention and assessment service is operated by a community mental health and mental health...
Texas Health and Safety Code, Chapter 242
Under § 242.014, a nursing facility may not receive monetary or other remuneration from a person or agency that furnishes services or materials to the facility or its occupants for a fee. The department may revoke the license of a facility that violates this section.

Texas Health and Safety Code, Chapter 252
Under § 252.011, an intermediate care facility for the mentally retarded may not receive monetary or other remuneration from a person or agency that furnishes services or materials to the facility or its occupants for a fee. The department may revoke the license of a facility that violates this section.

Texas Penal Code, Chapter 35A
Under § 35A.02(5), a person commits the offense of Medicaid Fraud if the person, 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, 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.

An offense under §35A.02(5) is punishable as:
- a Class C misdemeanor if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is less than $100;
- a Class B misdemeanor if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $100 or more but less than $750
- a Class A misdemeanor if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $750 or more but less than $2,500;
- a state jail felony if:
  - the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $2,500 or more but less than $30,000;
  - the offense is committed under Subsection (a)(11); or
• it is shown on the trial of the offense that the amount of the payment or value of the benefit described by this subsection cannot be reasonably ascertained;

• a felony of the third degree if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $30,000 or more but less than $150,000, or it is shown on the trial of the offense that the defendant submitted more than 25 but fewer than 50 fraudulent claims under the Medicaid program;

• a felony of the second degree if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $150,000 or more but less than $300,000, or it is shown on the trial of the offense that the defendant submitted 50 or more fraudulent claims under the Medicaid program;

or

• a felony of the first degree if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $300,000 or more.

The punishment prescribed for an offense is increased to the punishment prescribed for the next highest category of offense if it is shown beyond a reasonable doubt on the trial of the offense that the actor was a provider or high managerial agent at the time of the offense.

If conduct constituting an offense under Texas Penal Code § 35A also constitutes an offense under another section of the Code or another provision of law, the actor may be prosecuted under either this section or the other section or provision. When multiple payments or monetary or in-kind benefits are provided under the Medicaid program as a result of one scheme or continuing course of conduct, the conduct may be considered as one offense and the amounts of the payments or monetary or in-kind benefits aggregated in determining the grade of the offense.


**Title 1, Texas Administrative Code § 371.1669**

A person is subject to administrative actions or sanctions if the person:

• rebates or accepts a fee or a part of a fee or charge for a Medicaid or other HHS program patient referral;

• solicits recipients or causes recipients to be solicited, through offers of transportation or otherwise, for the purpose of claiming payment related to those recipients;
• knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency or HHS agency;
• knowingly offers to pay or agrees to accept, directly or indirectly, overtly or covertly, any remuneration in cash or in kind to or from another for securing or soliciting a patient or patronage for or from a person licensed, certified, or registered by a state health care regulatory agency, subject to the exceptions enumerated in Chapter 102, Occupations Code;
• solicits or receives, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind for referring an individual to a person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the Medicaid or other HHS program, provided that this paragraph does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;
• solicits or receives, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind for purchasing, leasing, or ordering, or arranging for or recommending the purchasing, leasing, or ordering of, any good, facility, service, or item for which payment may be made, in whole or in part, under the Medicaid or other HHS program;
• offers or pays, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to refer an individual to another person for the furnishing of, or for arranging the furnishing of, any item or service for which payment may be made, in whole or in part, under the Medicaid or other HHS program, provided that this paragraph does not prohibit the referral of a patient to another practitioner within a multispecialty group or university medical services research and development plan (practice plan) for medically necessary services;
• offers or pays, directly or indirectly, overtly or covertly, any remuneration, including any kickback, bribe, or rebate, in cash or in kind to induce a person to purchase, lease, or order, or arrange for or recommend the purchase, lease, or order of, any good, facility, service, or item for which payment may be made, in whole or in part, under the Medicaid or other HHS program;
• provides, offers, or receives an inducement in a manner or for a purpose not otherwise prohibited by this section or § 102.001, Occupations Code, to or from a person, including a recipient, provider, employee or agent of a provider, third-party vendor, or public servant, for the purpose of influencing or being influenced in a decision regarding:
  o selection of a provider or receipt of a good or service under the Medicaid or other HHS program;
  o the use of goods or services provided under the Medicaid or other HHS program; or
  o the inclusion or exclusion of goods or services available under the Medicaid program;
• is a physician and refers a Medicaid or other HHS program recipient to an entity with which the physician has a financial relationship for the furnishing of designated health services, payment for which would be denied under Title XVIII (Medicare) pursuant to § 1877 and § 1903(s) of the Social Security Act, codified at 42 U.S.C. § 1395nn, § 1396b(s) (Stark I, II, and III), the federal Anti-Kickback Statute, the Affordable Care Act, or other state or federal law prohibiting self-dealing or self-referral;

• engages in marketing services in violation of § 531.02115 of the Texas Government Code, program rules, or contract and has not received prior authorization from the program for the marketing campaign; or

• fails to disclose documentation of financial relationships necessary to establish compliance with § 1877 and § 1903(s) of the Social Security Act or 42 C.F.R. §§ 411.350-389 (Stark I, II, and III), the federal Anti-Kickback Statute, The Affordable Care Act, or other state or federal law prohibiting self-dealing or self-referral.

Under 1 T.A.C. § 371.1701, the Office of the Inspector General of the Texas Health and Human Services Commission may take any of the following administrative actions, individually or in combination, against a person who commits a program violation or commits an act that amounts to fraud, abuse, overpayment, or waste in relation to Medicaid or an HHS program or service:

• transferring a person to a closed-end contract or agreement for a specified period of time or to a provisional or probationary contract or agreement with modified terms and conditions;

• attendance at education sessions;

• prior authorization of selected services (failure to submit and receive prior authorization prior to the service being rendered or billed would result in denial of the claim);

• prepayment review of all claims or certain specific claims or services of a person;

• conducting post-payment review of all claims or certain specific claims or services of a person after payment;

• attendance at informal or formal person corrective action meetings;

• requiring submission of additional documentation or justification for a claim, as deemed advisable by the OIG, as a condition precedent to payment of the claim;

• oral, written, or personal educational contact with the person;

• requiring a person to post a surety bond or provide a letter of credit, as provided in § 371.23 of this chapter (relating to Surety Bond);

• serving a subpoena to compel the production of a witness or of relevant evidence;

• reinstatement; and

• referral for additional review or investigation of any person suspected of committing fraud, waste, or abuse. Such referrals include the following entities:
  o all cases of suspected Medicaid fraud or patient abuse or neglect to the OAG Medicaid Fraud Control Unit or Civil Medicaid Fraud Division for investigation;
  o peer review outside HHSC or operating agency;
- the appropriate state licensing board;
- the United States Department of Health and Human Services, including for action under the Civil Monetary Penalties Law (the Social Security Act, § 1128);
- other federal or state law enforcement agencies for fraud investigation and criminal fraud prosecution;
- other federal or state agencies for civil fraud prosecution and imposition of civil damages or penalties or recovery of overpayments and administrative penalties and damages through judicial means;
- a collection agency, the OAG, or any other collection authority, for recovery of overpayments, administrative penalties and damages or other debts established by the OIG;
- credit bureaus for failure to pay all imposed recoupments and damages and penalties; and
- any other entity determined to be advisable or necessary by the OIG.

2) PROHIBITIONS ON SELF-REFERRAL

**Texas Occupations Code § 105.002 – Unprofessional Conduct**

A health care provider commits unprofessional conduct if the health care provider, in connection with the provider’s professional activities, knowingly directs or requires a patient to obtain health care goods or services from a niche hospital in which the health care provider or an immediate family member of the provider has a financial interest, unless the provider discloses to the patient, in writing, that the provider or the provider’s family member has a financial interest in the niche hospital and informs the patient that the patient has the option of using an alternative health care facility. A niche hospital is defined as a hospital that classifies at least two-thirds of the hospital’s Medicare patients or, if data is available, in not more than two major diagnosis-related groups or in surgical diagnosis-related groups, specializes in cardiac, orthopedics, surgery, or women’s health and is not a public hospital, a hospital with fewer than 10 claims per bed per year, or a hospital for which the majority of inpatient claims are for major diagnosis-related groups relating to rehabilitation, psychiatry, alcohol and drug treatment, or children or newborns.

This statute does not apply to a financial interest in publicly traded shares of a registered investment company, such as a mutual fund that owns publicly traded equity securities or debt obligations issued by a niche hospital or an entity that owns the niche hospital.

The commission of unprofessional conduct constitutes cause for the revocation or suspension of a provider’s license, permit, registration, certificate, or other authority or other disciplinary action.
Texas Health and Safety Code, Chapter 142
Under § 142.019, a physician may not refer a patient to a home and community support services agency if the referral violates 42 U.S.C. Section 1395nn and its subsequent amendments.

Title 1, Texas Administrative Code § 371.1669(10)
Under 1 T.A.C. § 371.1669, a physician is subject to administrative actions or sanctions if a physician refers a Medicaid or other HHS program recipient to an entity with which the physician has a financial relationship for the furnishing of designated health services, payment for which would be denied under Title XVIII (Medicare) pursuant to § 1877 and § 1903(s) of the Social Security Act, codified at 42 U.S.C. § 1395nn, § 1396b(s) (Stark I, II, and III), the federal Anti-Kickback Statute, the Affordable Care Act, or other state or federal law prohibiting self-dealing or self-referral.

Under 1 T.A.C. § 371.1701, the Office of the Inspector General of the Texas Health and Human Services Commission may take any of the following administrative actions, individually or in combination, against a person who commits a program violation or commits an act that amounts to fraud, abuse, overpayment, or waste in relation to Medicaid or an HHS program or service:

- transferring a person to a closed-end contract or agreement for a specified period of time or to a provisional or probationary contract or agreement with modified terms and conditions;
- attendance at education sessions;
- prior authorization of selected services (failure to submit and receive prior authorization prior to the service being rendered or billed would result in denial of the claim);
- prepayment review of all claims or certain specific claims or services of a person;
- conducting post-payment review of all claims or certain specific claims or services of a person after payment;
- attendance at informal or formal person corrective action meetings;
- requiring submission of additional documentation or justification for a claim, as deemed advisable by the OIG, as a condition precedent to payment of the claim;
- oral, written, or personal educational contact with the person;
- requiring a person to post a surety bond or provide a letter of credit, as provided in § 371.23 of this chapter (relating to Surety Bond);
- serving a subpoena to compel the production of a witness or of relevant evidence;
- reinstatement; and
- referral for additional review or investigation of any person suspected of committing fraud, waste, or abuse. Such referrals include the following entities:
  o all cases of suspected Medicaid fraud or patient abuse or neglect to the OAG Medicaid Fraud Control Unit or Civil Medicaid Fraud Division for investigation;
  o peer review outside HHSC or operating agency;
  o the appropriate state licensing board;
the United States Department of Health and Human Services, including for action under the Civil Monetary Penalties Law (the Social Security Act, § 1128);

- other federal or state law enforcement agencies for fraud investigation and criminal fraud prosecution;

- other federal or state agencies for civil fraud prosecution and imposition of civil damages or penalties or recovery of overpayments and administrative penalties and damages through judicial means;

- a collection agency, the OAG, or any other collection authority, for recovery of overpayments, administrative penalties and damages or other debts established by the OIG;

- credit bureaus for failure to pay all imposed recoupments and damages and penalties; and

- any other entity determined to be advisable or necessary by the OIG.

3) FALSE CLAIMS/FRAUD & ABUSE

**Texas Human Resources Code - Chapter 36 – Texas Medicaid Fraud Prevention Act**

Under § 36.002, a person commits a violation of the Texas Medicaid Fraud Prevention Act if the person:

- knowingly makes a false statement or misrepresents a material fact to obtain a benefit or payment;

- knowingly conceals an event or fact that affects the initial or continued right to a payment or benefit;

- knowingly applies for or receives a benefit or payment on behalf of a recipient and converts some or all of the benefit or payment for use other than on behalf of the recipient;

- knowingly makes, causes to be made, induces or seeks to induce the making of a false statement or misrepresentation regarding the (a) conditions or operation of a facility to obtain certification or recertification or (b) any other information required to be provided to the Medicaid program;

- knowingly pays, charges, solicits, accepts or receives any gift, money or other consideration, other than the Medicaid payment, as a condition for the provision of services to a Medicaid recipient;

- knowingly presents a claim for payment for services rendered by a person who is not licensed;

- knowingly makes or causes to be made a claim for a service that (a) has not been ordered by an appropriate practitioner, (b) is substandard or inadequate, or (c) for a product that has been mislabeled, adulterated, that is otherwise inappropriate;

- makes a claim for payment and knowingly fails to indicate the type of license or identification number of the provider who actually rendered the services;

- knowingly enters into an agreement or conspiracy to defraud the state by obtaining an unauthorized payment or benefit;
is a managed care organization that contracts with a 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;

knowingly obstructs an investigation by the Attorney General of an alleged unlawful act under this section;

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;

knowingly engaging in conduct that constitutes a violation of Tex. Hum. Res. Code, Chapter 32; or

knowingly engaging in conduct that constitutes a violation of Tex. Occ. Code, Chapter 102.

If a person violates the Act, he or she could be subject to the following:

• suspension or revocation of the provider agreement, permit, license, or certification;
• exclusion from the Medicaid program for a period of no less than ten (10) years;
• disciplinary action by a state licensing board;
• restitution for the value of any money or benefit received;
• civil penalty from $5,500.00 to $15,000.00 (or the maximum amount imposed as provided by 31 U.S.C. § 3729(a) if it exceeds $15,000) depending on the unlawful act; and
• penalties of up to two times the value of the unlawful payment or benefit received.

* If a provider self-reports in a timely manner, penalties are limited to two times the value of the payment or benefit received.

A private citizen may file an action under the Texas Medicaid Fraud Prevention Act, but the Texas Attorney General must be notified and given the opportunity to pursue the case. If the Attorney General proceeds with an action under this subchapter, the person bringing the action may be entitled to receive a percentage of the proceeds recovered by the State. If the Attorney General declines to pursue the case, the person bringing the action may proceed with the action without state intervention.
and may recover for an unlawful act for a period of up to six (5) years before the date the lawsuit was filed, or for a period beginning when the unlawful act occurred until up to three (3) years from the date the state knows or reasonably should have known facts material to the unlawful act, whichever of these two periods is longer, regardless of whether the unlawful act occurred more than six (6) years before the date the lawsuit was filed. In no event shall a person recover for an unlawful act that occurred more than 10 years before the date the lawsuit was filed.

A person who reports a violation of the Act or otherwise acts in furtherance of an action brought under the Act cannot be discharged, demoted, suspended, threatened, harassed or in any other manner discriminated against. A person who is subject to such discrimination is entitled to:

- reinstatement with the same seniority status the person would have had but for the discrimination; and
- not less than two times the amount of back pay, interest on the back pay, and compensation for any special damages sustained as a result of the discrimination, including litigation costs and reasonable attorney's fees.
- a person may bring an action in the appropriate district court for relief.

In addition, under § 36.132 a state agency authorized to regulate a provider who receives or is eligible to receive payment for a health care service under the Medicaid program must revoke a license issued by the authority to a person if the person is convicted of a felony under Section 35A.02, Penal Code (offense of Medicaid Fraud).

**Texas Human Resources Code - Chapter 32**

Under Tex. Hum. Res. Code § 32.039(b)(1), it is unlawful for a person to present or cause to be presented a claim that contains a statement or representation the person knew or should have known to be false. A person who commits a violation under Chapter 32, Tex. Hum. Res. Code, is liable for:

- the amount paid as a result of the violation, including interest;
- administrative penalties not to exceed twice the amount paid, plus an amount not less than $5,000.00 and not more than $15,000.00 for each violation; and
- exclusion from the Medicaid program for 3 to 10 years depending on the violation.
- An intentional violation of Chapter 32 could constitute a state jail felony.

A person who knowingly engages in conduct that constitutes a violation of Tex. Hum. Res. Code, Chapter 32 constitutes a violation of the Texas Medicaid Fraud Protection Act, Chapter 36, TEX. HUM. RES. CODE.

**Texas Government Code § 531.101** allows the Texas Health and Human Services Commission to grant an award to an individual who reports activity that constitutes fraud or abuse of funds in the state Medicaid program or reports overcharges in the program. The disclosure must result in the recovery of an overcharge or in the termination of the fraudulent activity or abuse of funds.
Texas Penal Code, Chapter 35A

Under § 35A.02, a person commits the offense of Medicaid Fraud if the person:

- 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;
- 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;
- 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;
- knowingly makes, causes to be made, induces, or seeks to induce the making of a false statement or misrepresentation of material fact concerning:
  - 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:
    - a hospital;
    - a nursing facility or skilled nursing facility;
    - a hospice;
    - an intermediate care facility for the mentally retarded;
    - an assisted living facility; or
    - a home health agency; or
  - information required to be provided by a federal or state law, rule, regulation, or provider agreement pertaining to the Medicaid program;
- 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, 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;
- 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:
  - is not licensed to provide the product or render the service, if a license is required; or
  - is not licensed in the manner claimed;
- knowingly makes or causes to be made a claim under the Medicaid program for:
  - a service or product that has not been approved or acquiesced in by a treating physician or health care practitioner;
  - 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
  - a product that has been adulterated, debased, mislabeled, or that is otherwise inappropriate;
• 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;
• knowingly enters into an agreement, combination, or conspiracy to defraud the state by obtaining or aiding another person in obtaining an unauthorized payment or benefit from the Medicaid program or a fiscal agent;
• is a managed care organization that contracts with the Health and Human Services 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:
  o fails to provide to an individual a health care benefit or service that the organization is required to provide under the contract;
  o 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
  o 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;
• knowingly obstructs an investigation by the attorney general of an alleged unlawful act under this section or under Section 32.039, 32.0391, or 36.002, Human Resources Code; or
• knowingly makes, uses, or causes the making or use of a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to this state under the Medicaid program.

An offense under Tex. Penal Code 35A.02(b) is:
• a Class C misdemeanor if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is less than $100;
• a Class B misdemeanor if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $100 or more but less than $750;
• a Class A misdemeanor if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $750 or more but less than $2,500;
• a state jail felony if:
  o the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $2,500 or more but less than $30,000;
  o the offense is committed under Subsection (a)(11); or
it is shown on the trial of the offense that the amount of the payment or value of the benefit described by this subsection cannot be reasonably ascertained;

- a felony of the third degree if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $30,000 or more but less than $150,000, or it is shown on the trial of the offense that the defendant submitted more than 25 but fewer than 50 fraudulent claims under the Medicaid program;
- a felony of the second degree if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $150,000 or more but less than $300,000, or it is shown on the trial of the offense that the defendant submitted 50 or more fraudulent claims under the Medicaid program; or
- a felony of the first degree if the amount of any payment or the value of any monetary or in-kind benefit provided or claim for payment made under the Medicaid program, directly or indirectly, as a result of the conduct is $300,000 or more.

The punishment prescribed for an offense is increased to the punishment prescribed for the next highest category of offense if it is shown beyond a reasonable doubt on the trial of the offense that the actor was a provider or high managerial agent at the time of the offense.

If conduct constituting an offense under Texas Penal Code § 35A also constitutes an offense under another section of this Code or another provision of law, the actor may be prosecuted under either this section or the other section or provision. When multiple payments or monetary or in-kind benefits are provided under the Medicaid program as a result of one scheme or continuing course of conduct, the conduct may be considered as one offense and the amounts of the payments or monetary or in-kind benefits aggregated in determining the grade of the offense.


**Texas Occupations Code §501.401(4)**

A psychologist is subject to disciplinary action if he/she engages in fraud or deceit in connection with services provided as a psychologist. Disciplinary action includes license revocation or probation or remand of license and imposition of administrative penalties.
Title 1 Texas Administrative Code § 371.1653

A person is subject to administrative actions or sanctions if the person submits, or causes to be submitted, a claim for payment by the Medicaid or other HHS program:

- for an item or service for which the person knew or should have known the claim or cost report was false or fraudulent;
- for an item or service that was not provided as claimed;
- for an item or service that requires prior authorization, prior order, or prescription, where prior authorization, prior order, or prescription was not properly obtained, including where prior authorization, prior order, or prescription requirements were met by misrepresentation or omission;
- for an item or service that requires the name and National Provider Number of the supervising, ordering, or referring person for prior authorization, where the correct name and National Provider Number of the supervising, ordering, or referring person were not provided;
- based on a Code that would result in greater payment than the Code applicable to the item or service that was actually provided;
- for an item or service that was not coded, bundled, or billed in accordance with standards required by statute, regulation, contract, Medicaid or other HHS program policy or provider manual, and that, if used, has the potential of increasing any individual or state provider payment rate or fee;
- for an item or service that was not reimbursable by, permitted by, or associated with Medicaid or other HHS program, including an item or service substituted without authorization by Medicaid or other HHS program and a prescription drug substituted without authorization by an HHS program;
- for any order or prescription in which a false statement, misrepresentation, or omission of pertinent facts was made by the ordering or prescribing person on a claim, attachments to a claim, medical record, documentation used to adjudicate a claim for payment or to support representations on cost reports, used by the provider to show the medical necessity, or on documents used to establish fees, daily payment rates, or vendor payments;
- for an item or service where the charges for that item or service exceed the usual and customary fee the person charges to the public, privately insured persons, or private-pay persons for the same item or service, including a claim submitted under Title XVIII (Medicare);
- for an item or service where the charges or costs for that item or service were discounted for the public, privately insured persons, or private-pay persons for the same item or service, including a claim submitted under Title XVIII (Medicare);
- for an item or service that is furnished, prescribed, or otherwise ordered or presented by a person that is excluded, terminated, or otherwise prohibited from participation in an HHS program or any state or federally funded health care program, except an order or prescription that was:
o written before the exclusion or termination of a physician or other practitioner legally authorized to write a prescription; and
o delivered within 30 days of the effective date of such exclusion or termination;

• for a home health service for which no in-person evaluation of the recipient was performed within the 12-month period preceding the date of the order or other authorization for the home health service;

• for durable medical equipment for which the physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse-midwife that ordered or otherwise authorized the durable medical equipment has failed to certify on the order or authorization that he or she conducted an in-person evaluation of the recipient within the 12-month period preceding the date of the order or other authorization;

• for an item or service for which the provider knowingly made, used, or caused 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 concealed or knowingly and improperly avoided or decreased an obligation to pay or transmit money or property to this state under the Medicaid program;

• for an item or service that constitutes a violation of § 32.039(b) or § 36.002 of the Texas Human Resources Code;

• for an item or service rendered to a child who was not accompanied by an authorized adult or who was accompanied by the provider or its affiliate to treatment; or

• for damages, costs, or penalties collected or assessed by OIG.

Under 1 T.A.C. § 371.1701, the Office of the Inspector General of the Texas Health and Human Services Commission may take any of the following administrative actions, individually or in combination, against a person who commits a program violation or commits an act that amounts to fraud, abuse, overpayment, or waste in relation to Medicaid or an HHS program or service:

• transferring a person to a closed-end contract or agreement for a specified period of time or to a provisional or probationary contract or agreement with modified terms and conditions;
• attendance at education sessions;
• prior authorization of selected services (failure to submit and receive prior authorization prior to the service being rendered or billed would result in denial of the claim);
• prepayment review of all claims or certain specific claims or services of a person;
• conducting post-payment review of all claims or certain specific claims or services of a person after payment;
• attendance at informal or formal person corrective action meetings;
• requiring submission of additional documentation or justification for a claim, as deemed advisable by the OIG, as a condition precedent to payment of the claim;
• oral, written, or personal educational contact with the person;
- requiring a person to post a surety bond or provide a letter of credit, as provided in § 371.23 of this chapter (relating to Surety Bond);
- serving a subpoena to compel the production of a witness or of relevant evidence;
- reinstatement; and
- referral for additional review or investigation of any person suspected of committing fraud, waste, or abuse. Such referrals include the following entities:
  - all cases of suspected Medicaid fraud or patient abuse or neglect to the OAG Medicaid Fraud Control Unit or Civil Medicaid Fraud Division for investigation;
  - peer review outside HHSC or operating agency;
  - the appropriate state licensing board;
  - the United States Department of Health and Human Services, including for action under the Civil Monetary Penalties Law (the Social Security Act, § 1128);
  - other federal or state law enforcement agencies for fraud investigation and criminal fraud prosecution;
  - other federal or state agencies for civil fraud prosecution and imposition of civil damages or penalties or recovery of overpayments and administrative penalties and damages through judicial means;
  - a collection agency, the OAG, or any other collection authority, for recovery of overpayments, administrative penalties and damages or other debts established by the OIG;
  - credit bureaus for failure to pay all imposed recoupments and damages and penalties; and
  - any other entity determined to be advisable or necessary by the OIG.

4) HELPFUL LINKS
- Texas Attorney General (OAG)
- Texas Health and Human Services Commission (HHSC)
- Texas Statutes
- Texas Administrative Code