Activities of the Health and Human Services Commission, Office of the Inspector General and the Office of the Attorney General in Detecting and Preventing Fraud, Waste, and Abuse in the State Medicaid Program

RECENT DEVELOPMENTS

The 78th Texas Legislature, enacted sweeping changes to the composition, structure, and delivery of health and human services in Texas. It also strengthened the Health and Human Services Commission's (HHSC) authority to combat fraud, abuse, and waste in health and human services programs. These mandates were enacted, for the most part, through House Bill 2292 as well as House Bill 1743. A major focus of House Bill 2292 is the consolidation and streamlining of services currently provided by twelve health and human services agencies into five, under the direction of the HHSC. It created the Office of Inspector General (OIG) within the HHSC, by consolidating compliance and enforcement functions from the twelve health and human services agencies into a single office under the HHSC.

In addition, HB 2292 appropriated funding to the Office of the Attorney General (OAG) Medicaid Fraud Control Unit (MFCU). The U.S. Department of Health & Human Services Office of Inspector General approved matching federal grant funds, to expand the OAG MFCU from its current level of 36 staff to up to 236 staff. The MFCU has increased its staff and has opened field offices in Dallas, Houston, Lubbock, and Tyler.

This legislation contains provisions to improve the detection and prevention of fraud, waste and abuse by providers, recipients, contractors, and employees who participate in the delivery and receipt of health and human services programs, including the state Medicaid program. The HHSC and the OAG have established guidelines under which provider payment holds and exclusions from the Medicaid program are implemented. Timelines and minimum standards have been established by the HHSC OIG for making referrals between the MFCU and OIG . This will enhance the timely investigation of potentially fraudulent providers.

MEMORANDUM OF UNDERSTANDING

Pursuant to the requirements of Senate Bill 30 of the 75th Legislature, a memorandum of understanding (MOU) was executed in April 1998 between the HHSC's Medicaid Program Integrity Department (MPI) and the MFCU. The MOU was updated and expanded in November 2003 in accordance with House Bill 2292 which required HHSC and the OAG to enter into a new MOU no later than December 1, 2003. The revisions to delineate the roles and expectations of the respective agencies, which were required by HB 2292, were

accomplished. The MOU facilitates the development and implementation of joint written procedures for processing cases of suspected fraud, abuse, and/or waste under the state Medicaid program. The MOU ensures cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases arising in the state and has proved to be beneficial to both agencies.

INTERAGENCY COORDINATION EFFORT

HHSC and the OAG recognize the importance of partnership and regular communication in the coordinated effort to fight fraud and abuse in the Medicaid program. This latest biannual reporting period has seen more progress and success in this area than in many prior periods, thanks to a renewed cooperative spirit and the efforts of both agencies. For example, the following has occurred in the last six months:

- An increased commitment by both agencies to promptly send and/or act upon referrals, accomplished by improving turnaround time in addressing recent referrals and systematically revisiting older referrals.

- Regular case presentation meetings initiated by HHSC OIG to introduce critical cases to MFCU staff in order to conduct joint investigations.

- Constant communication on cases throughout all staff levels, ensuring all case resources and knowledge is shared and efforts are not duplicated.

- Joint training across the two agencies - HHSC OIG staff attended MFCU training sessions in this reporting period and HHSC OIG management has planned two orientation sessions for MFCU staff attendance during this upcoming reporting period.

Periodic planning sessions have occurred to coordinate case methodology guidelines that apply to all cases, regardless of type.

MFCU and MPI currently continue to move forward on a joint case management program project. Both agencies have selected cases to investigate, performed statistically valid random samples and have exchanged data with the Texas Department of Health to determine the Medicaid overpayments. One MFCU case management investigation is complete and will be presented for prosecution while several continue to be investigated. Meetings are held on an as-needed basis to share information and several joint investigation projects have been initiated.

THE HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INSPECTOR GENERAL

Senate Bill 30, enacted by the 75th Legislature, directed the Texas Health and Human Services Commission (HHSC) to create the Office of Investigations and Enforcement (OIE). The 78th Legislature created the new Office of Inspector General (OIG). The OIG assumed all the duties of HHSC's Office of Investigation and Enforcement and all fraud and abuse functions of the other twelve health and human services (HHS) agencies. It is responsible for investigation of fraud and abuse in health and human services programs. The OIG will provide oversight of HHS activities, providers, and recipients through compliance and enforcement activities designed to identify and reduce waste, abuse, or fraud; and improve efficiency and effectiveness within the HHS system.

It was established to expand the previous mission to investigate fraud and abuse in the provision of health and human services and to enforce state law relating to the provision of those services. The OIG is required to set clear objectives, priorities, and performance standards for the office that emphasize:

- Coordinating investigative efforts to aggressively recover Medicaid overpayments;
- Allocating resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and
- Maximizing the opportunities for referral of cases to the Office of the Attorney General.

The Office of the Deputy Inspector General for Operations provides direction and guidance in strategic operations and planning of administrative and financial services functions of the Office of the Inspector General (OIG). Work involves establishing objectives, priorities, and performance standards; recommending and developing policies, guidelines, and procedures for OIG operations, administration, compliance, and enforcement functions; coordinating these functions with other health and human services agencies, the Office of the Attorney General, and the Comptroller.

The Office of the Deputy Inspector General for Compliance is responsible for providing direction and guidance in strategic operations and planning of compliance functions of the OIG. Work involves establishing objectives, priorities, and performance standards; recommending and developing policies, guidelines, and procedures for OIG Compliance functions; coordinating compliance functions with other health and human services agencies, the Office of the Attorney General, and the Comptroller. Compliance is comprised of three divisions, which includes: Quality Control, Information Technology, and Audit. Information Technology provides systems analysis support to OIG and its operating functions through development, implementation, and operation of automated systems that support the health and human services programs. Quality Review provides direction and guidance in strategic operations and planning for the Quality Review programs. Work involves establishing the Quality Review programs strategic plans, goals, and objectives;

developing policies; reviewing guidelines, procedures, rules, and regulations; establishing priorities, standards, and measurement tools for determining progress in meeting goals. Work includes coordinating Quality Review activities, including developing standards for quality control. The position also provides technical assistance and training to agency staff; and conducts periodic reviews or evaluations. This division has two units/sections: WIC Monitoring and Utilization Review.

The Office of the Chief Counsel within OIG is comprised of two subdivisions – Sanctions and Third-Party Recovery. The Chief Counsel also offers general legal advice to the Office of the Inspector General. Sanctions imposes administrative sanctions, damages and penalties as warranted by investigation or as directed by state and federal statutes, regulations, rules or directives; to monitor recoupment of Medicaid overpayments, damages, penalties, and imposition of other administrative sanctions; to negotiate settlements and/or conduct informal reviews on administrative cases involving overpayments and/or penalties; to pursue bad debts or ensure collection of overpayments, damages, and penalties through seizure of assets, referral to credit bureaus or collection agencies, or through payment hold by the State Comptroller, recoupment by Medicare, or referral to Office of the Attorney General to file suit; to prepare agency cases, provide expert testimony, and support to administrative hearings and other legal proceedings; and to monitor Claims Administrator functions as they relate to financial and administrative systems involving OIG accounts receivable, payment hold, provider enrollment, and provider education. Third-Party Recovery is to minimize program expenditures by shifting claims to third-party payers other than Medicaid or the recipient. By law, all other available third-party resources must meet their legal obligation to pay claims before Medicaid pays for eligible patient care. Third-party resources can be any of various public, group, or individual health insurance plans; automobile, casualty insurance, or workers compensation; long-term care insurance plans; court-ordered health insurance programs, tort cases; and other federal and state programs.

The Deputy Inspector General for Enforcement is responsible for providing direction and guidance in strategic operations and planning of enforcement and investigative functions of the Office of the Inspector General (OIG). Work involves establishing objectives, priorities, and performance standards; recommending and developing policies, guidelines, and procedures for OIG Enforcement functions; coordinating enforcement functions with other health and human services agencies, the Office of the Attorney General, and the Comptroller. The Deputyship is comprised of three subdivisions: Medicaid Provider Integrity, General Investigations, and Internal Affairs. Medicaid Provider Integrity (MPI) investigates allegations of waste, fraud, and abuse involving Medicaid, providers and other health and human service programs; refers cases and leads to law enforcement agencies, licensure boards and regulatory agencies; refers complaints to the Attorney General's, Medicaid Fraud Control Unit; provides investigative support and technical assistance to other OIG divisions, and some outside agencies; monitors recoupment of Medicaid overpayments, civil monetary penalties, damages, and other administrative sanctions. General Investigations (GI) investigates allegations of waste, fraud, and abuse involving

Medicaid recipients, and other health and human service programs. Internal Affairs (IA) tracks and coordinates three computer datamatches designed to locate wanted felons and missing children; investigates traditional internal affairs cases involving allegations of theft, worker's compensation, misuse of state property**,** and policy and procedure violations; investigates all issues of fraud, waste, abuse and neglect in state hospitals and state schools.

Medicaid Fraud and Abuse Referrals Statistics

THE HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INSPECTOR GENERAL

WASTE, ABUSE, AND FRAUD REFERRAL STATISTICS, RECEIVED:

Referral Source	Received
Affiliated Computer Services (CHIP)	8
Anonymous	15
Office of the Attorney General's Medicaid Fraud Control Unit	28
Board of Dental Examiners	13
Board of Licensed Vocational Nurse Examiners	88
Board of Medical Examiners	34
Board of Nurse Examiners	107
Texas Department of Human Services	10
Texas Department of Human Services Long Term Care	9
Texas Department of Human Services Office of Inspector General	3
Federal Qui Tam	2
Health and Human Services/Office Inspector General	19
HHSC Commissioner's Office	1
HHSC Internal Audit	3
HHSC Medicaid/Chip Division	5
HHSC-MPI-OIG Self-initiated	16
HHSC Rate Setting & Actuarial Services Department	1
HHSC OIG Research and Development	1
HHSC-Hot-line	64
Medically Dependent Children's Program	1
Mental Health Mental Retardation	49
Parent of Guardian	3
Provider	6
Public	17
Recipient	6
State Dental Director	4
State Medicaid Office	2
State Legislator	2
Surveillance, Utilization, Review System	100
Texas Commission on Alcohol & Drug Abuse	3
Texas Department of Health	1
Texas Health Network, Birch & Davis	1
Texas Medicaid Healthcare Partnership	5
United Concordia Companies SIU	4

U.S. Department of Justice	3
Texas Department of Protective and Regulatory Services	1
Total Cases Received:	**635**

WASTE, ABUSE, AND FRAUD REFERRAL STATISTICS, SENT:

Referral Source	Referred
Office of the Attorney General's Medicaid Fraud Control Unit	111
Assistant US Attorney	1
Board of Dental Examiners	4
Board of Medical Examiners	2
Board of Podiatry Examiners	1
Drug Enforcement Agency	1
Federal Bureau of Investigations	4
HHSC Office of Inspector General:	
Limited Program	1
General Investigations	35
Medicare Part A&B	1
Texas Medicaid & Healthcare Partnership-Education Visits	11
Social Security Administration	1
Texas Department of Human Services	4
Total Cases Referred:	**177**

Medicaid Fraud, Abuse, and Waste Recoupments

Recoupments for the first and second quarters of fiscal year 2004 are as follows.

RECOUPMENTS BY OIG PROGRAMS FOR FISCAL YEAR 2004 (1st and 2nd Quarters)

Office of Inspector General	1st Quarter FY2004	2nd Quarter FY2004	TOTAL FY2004
Medicaid Program Integrity	$2,699,051	$18,523,944	**$21,222,995**
Civil Monetary Penalties	$893,237	$13,071,164	**$13,964,401**
Surveillance and Utilization Review Subsystems (SURS)	$388,419	$608,729	**$997,148**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$452,432	$373,502	**$825,934**
TOTAL	**$4,433,140**	**$32,577,341**	**$37,010,478**

Note: Total partial recoupment dollars reflect active cases within OIG.

Medicaid Fraud, Abuse, and Waste Workload Statistics

OIG Workload statistics for the first and second quarters of fiscal year 2004 are as follows.

Action	1st Quarter FY2004	2nd Quarter FY2004	Total FY2004
Medicaid Provider Integrity			
• Cases Opened	354	285	**639**
• Cases Closed	329	243	**572**
• Providers Excluded	240	124	**364**
Medicaid Fraud & Abuse Detection System			
• Cases Opened	451	353	**804**
• Cases Closed	559	415	**974**

OFFICE OF THE ATTORNEY GENERAL, MEDICAID FRAUD CONTROL UNIT

The MFCU has conducted criminal investigations into allegations of wrongdoing by Medicaid providers within the Medicaid arena since 1979. According to federal legislation:

- The unit will conduct a Statewide program for investigating and prosecuting (or referring for prosecution) violations of all applicable State laws pertaining to fraud in the administration of the Medicaid program, the provision of medical assistance, or the activities of providers of medical assistance under the State Medicaid plan. [42 CFR §1007.11(a)]
- The unit is mandated to review, investigate, or refer to an appropriate authority complaints alleging abuse or neglect of patients in health care facilities receiving payments under the State Medicaid plan and may review complaints of the misappropriation of patients' private funds in such facilities. [42 CFR §1007.11(b)]

House Bill 2292 mandated an increase in funding and staffing to address the increased emphasis on detecting, investigating, and prosecuting fraud and abuse in the Medicaid program. The legislation appropriated funding that, when matched with federal grant funds, could expand the unit from its current 36 employees up to 236 employees. Over the past six months, the unit has grown by 55 staff and field offices have been opened in Dallas, Houston, Lubbock and Tyler. Cross-designated Assistant U.S. Attorneys are being hired to work within each of the four federal judicial districts.

The unit anticipates receiving approval from the U.S. Department of Health and Human Services Office of Inspector General to continue its expansion to 140 full time employees before the end of Fiscal Year 2004 and open field offices in Corpus Christi, El Paso, McAllen and San Antonio. It is anticipated that the unit will continue to grow in Fiscal Year 2005 to 208 full time employees.

Criminal Investigations

The MFCU conducts criminal investigations into allegations of fraud, physical abuse, and criminal neglect by Medicaid providers--e.g., physicians, dentists, physical therapists, licensed professional counselors, ambulance companies, laboratories, podiatrists, nursing home administrators and staff, and medical equipment companies. Common investigations include assaults and criminal neglect of patients in a Medicaid facility, fraudulent billings by Medicaid providers, misappropriation of patient trust funds, drug diversions, and filing of false information by Medicaid providers.

The MFCU's investigations are criminal, and the penalties assessed against providers can include imprisonment, fines, and exclusion from the Medicaid program. Increased staff will allow the unit to conduct more investigations and utilize a risk-based approach to examine a larger cross-section of providers' claims histories, which will lead to more cases being filed with prosecutors in state and federal court. Until the passage of House Bill 2292, the MFCU depended upon state and federal authorities for criminal prosecution of its cases. Now having concurrent jurisdiction with the consent of local prosecutors to prosecute certain state felony offenses, the MFCU can apply additional resources and assistance in the trial work. In addition, the Code of Criminal Procedures has been amended to allow the OAG to institute asset forfeiture proceedings in cases that are filed by the OAG or requested by the OIG.

Referral Sources

The MFCU receives referrals from a wide range of sources including concerned citizens, Medicaid recipients, current and former provider employees, the Office of Inspector General other state agencies, and federal agencies. MFCU staff review every referral received. Not all are investigated, however, because statutory mandate restricts investigations to referrals that have substantial potential for criminal investigation and because of limited investigative resources. However, with the current addition of staff and the creation of regional offices throughout the state, the unit will have enhanced capability to respond quickly and efficiently to the referrals, which are investigated. The MFCU also strives for a blend of cases that are representative of Medicaid provider types.

Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the first and second quarters of fiscal year 2004 are as follows.

Action	1st and 2nd Quarters FY2004
Cases Opened	134
Cases Closed	121
Cases Presented	57
Criminal Charges Obtained	21
Convictions	12
Potential Overpayments and Misappropriations Identified	$13,435,901.61
Cases Pending	353

OFFICE OF THE ATTORNEY GENERAL, ANTITRUST & CIVIL MEDICAID FRAUD DIVISION

Background and History

In August of 1999, the Civil Medicaid Fraud Section (CMF) was created within the Elder Law & Public Health Division (ELD) of the Office of the Attorney General (OAG). CMF was instituted to investigate and prosecute civil Medicaid fraud cases under Chapter 36 of the Texas Human Resources Code (the Texas Medicaid Fraud Prevention Act). In February 2004, CMF was merged into the Antitrust Division as part of a reorganization, and the resulting division was renamed the Antitrust & Civil Medicaid Fraud Division.

Under the Texas Medicaid Fraud Prevention Act, the Attorney General has the authority to investigate and prosecute any person who has committed an "unlawful act" as defined in the statute. The OAG, in carrying out this function, is authorized to issue civil investigative demands, require sworn answers to written questions, and obtain sworn testimony through examinations under oath. All of the investigative tools can precede the filing of a lawsuit based on any of the enumerated "unlawful acts." The remedies available under the Act are extensive, and include the automatic suspension or revocation of the Medicaid provider agreement and/or license of certain providers.

The Texas Medicaid Fraud Prevention Act also permits private citizens to bring actions on behalf of the State of Texas for any "unlawful act." In these lawsuits, commonly referred to as *qui tam* actions, the OAG is responsible for determining whether or not to prosecute the action on behalf of the state. If the OAG does not intervene, the lawsuit is dismissed. On the other hand, if the OAG intervenes and prosecutes the matter, the private citizen, known as the "relator," is entitled to a percentage of the total recovery.

Statistics

CMF Docket	1st and 2nd Quarters FY2004
Pending Cases/Investigations	41
Cases Closed	4

Although there are over 40 total cases/investigations listed on the docket, as a practical matter, that number is significantly greater because, in one investigation, there are multiple potential defendants that most likely will be each separately civilly prosecuted.

A breakdown of the four cases closed is as follows: prosecution was declined on two *qui tam* lawsuits (name under court seal); and settlements were reached in *United States of America, ex rel. Tim Ohman v. Primary CareNet of Texas et al.* and *United States of*

America ex rel. Michael C. Qualls v. Warm Springs Rehabilitation Foundation, Inc. Settlement figures for these two cases are set forth in the table that follows.

Case	Restitution	Multiples/ Penalties	Relator's Award	Attorney's Fees	Total Texas Recovery
Primary CareNet	$113,150	$64,221	$43,201	$6,805	**$227,377**
Warm Springs	$25,115	$30,885	$14,000	$70,000	**$140,000**
Total	**$138,265**	**$95,106**	**$57,201**	**$76,805**	**$367,377**

CMF continued to prepare the civil case of *State of Texas ex rel. Ven-A-Care of the Florida Keys, Inc. v. Warrick, et al.* for an April 12, 2004 trial date. Due to the extensive preparations needed for trial and the very heavy defensive activity from defendants Warrick Pharmaceuticals and its parents, Schering and Schering-Plough, that single case consumed the majority of CMF's resources.

CMF has increased its staffing resources. Two senior attorneys from other OAG divisions who had been assisting with the *Ven-A-Care* litigation were transferred to CMF to prosecute civil Medicaid fraud full-time--one to fill a vacated position and another to fill a new position. Also, CMF has posted another new senior attorney position.