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

RECENT DEVELOPMENTS

Among its several accomplishments, the 78th Texas Legislature, Regular Session, 2003, enacted sweeping changes to the composition, structure, and delivery of health and human services in Texas. The 78th Legislature also strengthened Health and Human Services Commission's (HHSC) authority to combat fraud, abuse, or waste in health and human services programs. These mandates were enacted, for the most part, through House Bill 2292. A major focus of the bill is the consolidation and streamlining of services currently provided by 12 health and human services agencies into five, under the direction of the HHSC. House Bill 2292 also creates the Office of Inspector General within the HHSC, consolidating compliance and enforcement functions now within 12 agencies into one office under the Executive Commissioner, HHSC.

Within the same legislation, the Office of the Attorney General (OAG) Medicaid Fraud Control Unit (MFCU) was appropriated funding that, when matched with federal grant funds, could expand from its current level of 36 staff to up to 236 staff.

The 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 will establish guidelines under which provider payment holds and exclusions from the Medicaid program are implemented. Timelines have been established for the HHSC Office of Investigations and Enforcement for making referrals to the MFCU. 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 initially executed in April 1998, between the HHSC's Medicaid Program Integrity Department (MPI) and the MFCU. The MOU was most recently updated and expanded in October 2001 to include the Elder Law and Public Health Division (ELD) of the OAG. This change was necessary in that the OAG has designated ELD to investigate and prosecute civil Medicaid fraud and *qui tam* actions relating to Title XIX of the Social Security Act.

House Bill 2292 requires HHSC and the OAG to enter into a new MOU, no later than December 1, 2003. The revisions required by HB 2292 further delineate the roles and expectations of the respective agencies. The MOU facilitates the development and implementation of joint written procedures for processing cases of suspected fraud, abuse, or waste under the state Medicaid program. The MOU also 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 have long recognized the importance of partnership and regular communication in the coordinated effort to fight fraud and abuse in the Medicaid program. Scheduled quarterly meetings are held to focus on major initiatives to identify new trends, increase accountability and further improve the working relationship between the two agencies. In addition to formal meetings, daily informal communication to discuss specific case progress and referrals is ongoing.

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 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; several continue to be investigated. Meetings are held on an as needed basis to share information about this project.

THE HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INVESTIGATIONS AND ENFORCEMENT

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). Established to investigate fraud and abuse in the provision of health and human services and enforce state law relating to the provision of those services, the OIE 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.

Medicaid Program Integrity (MPI) is responsible for investigating allegations or complaints of Medicaid fraud, abuse, or misuse. This department investigates allegations, imposes sanctions, processes provider exclusions, and coordinates provider education. The MPI has primary responsibility for activities relating to investigation and administrative sanction of Medicaid provider fraud, abuse, and waste across all Texas state agency lines, regardless of where the provider contract is administered. MPI refers cases involving fraud or abuse of a criminal nature to the MFCU.

Utilization Review (UR) is responsible for monitoring utilization review activities in Medicaid contract hospitals. UR is also responsible for developing and implementing a statewide effective and efficient nursing home case mix assessment review program. As part of the reorganization of programs within the health and human services system, UR transferred to the Deputy Commissioner for Health Services within HHSC effective September 1, 2003.

Systems Resources (SR) provides systems analysis support to OIE and its operating functions. SR serves as OIE's liaison with all health and human services agencies as it relates to the development, implementation, and operation of automated systems that support health and human services programs. SR manages the contract for the Medicaid Fraud and Abuse Detection System (MFADS) and is the project manager for the Medicare-Medicaid data match project.

Medicaid Fraud and Abuse Referrals Statistics

THE HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INVESTIGATIONS AND ENFORCEMENT

Medicaid Fraud, Abuse, and Waste Recoupments

Recoupments for the third and fourth quarters of fiscal year 2003 are as follows.

RECOUPMENTS BY OIE FOR FISCAL YEAR 2003 (3rd and 4th Quarters)[1]

Office of Investigations and Enforcement Divisions	3rd Quarter FY2003	4th Quarter FY2003	TOTAL
Medicaid Program Integrity	$1,083,901	$8,838,453	**$9,922,354**
Civil Monetary Penalties	$114,596	$6,497,074	**$6,611,670**
Utilization Review (DRG-hospitals)	$3,187,512	$1,597,085	**$4,784,597**
TEFRA Claims – Children's Summary	$188	$0	**$188**
TEFRA Claims – Psychiatric Summary	$1,994	$3,206	**$5,200**
Case Mix Review (Nursing Homes)	$3,342,646	$3,402,213	**$6,744,859**
Surveillance and Utilization Review Subsystems (SURS)*	$49,689	*	**$49,689**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$1,117,783	$288,801	**$1,406,584**
TOTAL	**$8,898,309**	**$20,626,832**	**$29,525,141**

Note: Total recoupment dollars reflect all active cases within OIE.

*SURS Recoveries in the 4tth quarter of FY2003 are included in the MPI recovery amount.

[1] As part of the reorganization and consolidation of functions within the Health and Human Services system, the Utilization Review (UR) department and its functions transferred to the Deputy Commissioner for Health Services effective September 1, 2003. This is the last report that will include information on UR activities or recoveries.

THIRD PARTY RECOVERIES FOR FISCAL YEAR 2003 (3rd and 4th Quarters)[2]

Office of Investigations and Enforcement Divisions	3rd Quarter FY2003	4th Quarter FY2003	TOTAL
Third Party Liability and Recovery:			
Recoveries (Provider)			
• Other Insurance Credits*	$77,961,917	$70,973,488	**$148,935,405**
• Provider Refunds	$1,160,212	$1,785,309	**$2,945,521**
• Texas Automated Recovery System (TARS)	$4,805,409	$3,778,675	**$8,584,084**
• Recipient Refunds	$0	$0	**$0**
• Pharmacy	$1,183,718	$1,741,190	**$2,924,908**
Recoveries (Recipient)			
• Credit Balance Audit	$3,522,282	$5,441,024	**$8,963,306**
• Amnesty Letter	$0	$0	**$0**
• Tort	$4,226,173	$5,528,883	**$9,755,056**
TOTAL	**$92,859,711**	**$89,248,569**	**$182,108,280**

* Other insurance credits are estimated pending the completion of a data repair project.

RECOUPMENTS FOR FISCAL YEAR 2003 (3rd and 4th Quarters) BY OTHER HHSC DIVISIONS

Health and Human Services Divisions	3rd Quarter FY2003	4th Quarter FY2003	TOTAL
Medicaid Audits (cost settlement based on cost reimbursement methodology)*	$5,946,819*	$15,036,791*	**$20,983,610***
Vendor Drug			
• Recoveries	$21,990,566	$19,843,906	**$41,834,472**
• Manufacturer Rebates	$101,655,198	$101,352,840	**$203,008,038**
Customer Services/Provider Resolutions	$37,792	$26,788	**$64,580**
TOTAL	**$129,630,375**	**$136,260,325**	**$265,890,700**

* Overpayments for Medicaid Audits are reported as net based on Cost Settlements. Managed care payment settlements are excluded from the calculation. Overpayments are calculated based on the difference in total interim payments and cost, less any previous settlements completed during the period.

[2] As part of the reorganization and consolidation of functions within the Health and Human Services system, the Third Party Recovery programs transferred to the State Medicaid-CHIP division of HHSC effective September 1, 2003. This is the last issue of the joint report that will include information on Third Party Recovery activities.

Medicaid Fraud, Abuse, and Waste Workload Statistics

OIE Workload statistics for the third and fourth quarters of fiscal year 2003 are as follows.

Action	3rd Quarter FY2003	4th Quarter FY2003	Total
Medicaid Program Integrity			
• Cases Opened	246	191	**437**
• Cases Closed	325	156	**481**
• Providers Excluded	233	69	**302**
Utilization Review			
• Case Mix (Nursing Homes) - Cases Closed	334	310	**644**
• Case Mix (Nursing Homes) - # of Reviews	7,005	6,895	**13,900**
• Hospitals - Cases Closed	45	203	**248**
• Hospitals - # of Reviews	1,737	1,119	**2,856**
Medicaid Fraud & Abuse Detection System			
• # of Cases Opened	532	593	**1,125**

Action	3rd Quarter FY2003			4th Quarter FY2003		
LOCK-IN*	03/03	04/03	05/03	06/03	07/03	08/03
• Fee-for-Service (FFS)	510	530	527	522	521	489
• STAR	299	297	295	292	289	282
• STAR+PLUS	74	71	67	62	61	39
TOTAL	**883**	**898**	**889**	**876**	**871**	**810**

***LOCK-IN:** CFR, Title 43, Volume 3, Section 431.54 (e) requires "Lock-in of recipients who over-utilize Medicaid services. If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only." The Texas Administrative Code, Title 45, Part I, Chapter 43 outlines the Texas Utilization Control Methods. Fee-for-Service clients can be limited to a doctor and/or pharmacy. Managed Care Organization members can be limited to a pharmacy. STAR+PLUS members were added to the Lock-in process on September 1, 2001.*

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 also 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 has 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 unit has established its first regional office in Dallas, and is preparing to open offices in Houston, Lubbock, and Tyler. Areas have been selected based upon analysis of the number of Medicaid providers, recipients and dollars spent statewide. The regions selected represent 53% of the Medicaid providers and 41.5% of Medicaid dollars in Texas. Additional legal services staff will work within each of the four federal judicial districts.

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 HB2292, 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.

Referral Sources

The MFCU receives referrals from a wide range of sources including concerned citizens, Medicaid recipients, current and former provider employees, 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 third and fourth quarters of fiscal year 2003 are as follows.

Action	3rd and 4th Quarters FY2003
Cases Opened	91
Cases Closed	111
Cases Presented	45
Criminal Charges Obtained	24
Convictions	20
Overpayments and Misappropriations Identified	$8,934,184.21
Cases Pending	309

OFFICE OF THE ATTORNEY GENERAL, ELDER LAW AND PUBLIC HEALTH 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). Under the 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 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 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	3rd & 4th Quarters FY2003
Pending Cases/Investigations	24
Cases Closed	4

Although there are 24 total cases/investigations listed on the docket, as a practical matter, that number is approximately double 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: Two cases were declined for civil prosecution due to no Medicaid utilization. A settlement in the *qui tam* action entitled, *United States ex rel. John David Foster v. Pfizer, Inc., successor-in-interest to Warner-Lambert Co.,* was collected during the third quarter of 2003. (See table below). A settlement was also collected during the third quarter of 2003 in *United States v. Primary CareNet of Texas d/b/a Christus Primary CareNet of Texas, Health Texas Medical Group of*

San Antonio, Texas and Solomon Anthony Clinic, et al., which was a referral from MFCU. (See table below and MFCU statistics above). A settlement with Dey, Inc., was collected in the fourth quarter of 2003, but was not reflected as a closed case because it was obtained with one of three defendants in the heavily litigated *State of Texas ex rel. Ven-A-Care of the Florida Keys, Inc. v. Dey, Inc. et al.* lawsuit that is ongoing. (See table below).

	Dey		***Pfizer***		***Primary***	
Fed'l Share	$9,207,000		$1,638,872		$1,132,623	
TX Total	$9,293,000		$ 985,442		$ 227,377	$ 43,194
Relator		$2.537,500		$109,491		$ 227,337
Attorney's Fees		$1,311,500		$412,000		$ 6,805
Restitution		$2,774,000		$463,931		$113,150
Multiples/ Penalties		$2,850,000				$ 64,221
Totals	$18.5M		$2,624,294		$1,360,000	

A grand total of $20,124,294 was collected through civil Medicaid fraud prosecutions during FY 2003.