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 Office of Inspector General (OIG) within the Health and Human Services Commission (HHSC) continues to be successful in its efforts to combat fraud, waste and abuse in all health and human service programs following the consolidation mandate of HB 2292 from the 78th Legislature. The OIG's Medicaid Provider Integrity (MPI) section and the Office of the Attorney General's (OAG) Medicaid Fraud Control Unit (MFCU) continue to build upon the success of their efforts that resulted, in part, from legislative action. The two agencies are making timely and relevant referrals to the other, and cooperative efforts have resulted in a number of successful investigations of potentially fraudulent providers.

The 78th Texas Legislature afforded the MFCU a unique opportunity for expansion. With agreement from the United States Department of Health and Human Services, Office of Inspector General, the unit has grown over the past 30 months from 36 staff to nearly 200. Field offices are open in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio and Tyler. Both formal and informal task forces have been formed with the unit's federal and state investigative partners in conducting its criminal investigations.

The 79th Texas Legislature approved an increase in staffing for the Health and Human Services Commission (HHSC) Office of Inspector General (OIG) for SFY2006. Sixteen new FTE's were allocated to the OIG's Medicaid Provider Integrity (MPI) section. The MPI staff are primarily devoted to investigating provider fraud in the Texas Medicaid Program. This staffing increase allowed MPI to place investigators in key areas of the state to more efficiently investigate issues related to Medicaid fraud, waste, and abuse. In addition to its Austin headquarters office, MPI now has field investigators located in Dallas, Houston, San Antonio, and Edinburg.

In December 2005, and in furtherance to combat fraud, waste and abuse, OIG's MPI section initiated a process to conduct criminal history background checks for all potential Medicaid, Medicaid Managed Care, and Children with Special Health Care Needs Services Program providers submitting an enrollment application through the Texas Medicaid and Healthcare Partnership (TMHP). In addition, criminal background checks are now performed for any person or business entity that meets the definition of "indirect ownership interest" as defined in 1 *Texas Administrative Code* (TAC) §371.1601 who are applying to become a Medicaid provider, or who are applying to obtain a new provider number or a performing provider number. Details of these changes were published in the January/February 2006 *Texas Medicaid Bulletin*, No. 192 and the February 2006 *CSHCN Provider Bulletin*, No. 57.

From December 2005 through February 2006 (2nd quarter, FY 2006), MPI conducted nearly 4,000 criminal history checks on Medicaid providers. Of those, 155 were either denied, or are in a pending status based on return information.

For the first two quarters of FY 2006, the number of provider complaints has more than doubled from the same time frame in FY 2005. During the first and second quarters of FY 2005, MPI opened 213 cases. For the same time frame in FY 2006, MPI has opened 438 cases. This reflects a 105% increase in complaints from last fiscal year.

In accordance with §531.113 of the Government Code, all Managed Care Organizations (MCO's) contracting with the State of Texas are required to adopt a plan to prevent and reduce waste, abuse, and fraud and file their plan annually with OIG's approval. For the first two quarters of FY 2006, OIG has seen a 108% increase in complaint referrals from MCO's based on their mandated Special Investigative Units (SIUs).

MEMORANDUM OF UNDERSTANDING

As required by HB 2292, the MOU between the MFCU and HHSC-OIG was updated and expanded in November 2003. It continues to ensure the cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases and has proven beneficial to both agencies.

INTERAGENCY COORDINATION EFFORT

The HHSC-OIG and MFCU recognize the importance of partnership and regular communication in the coordinated effort to fight fraud and abuse in the Medicaid program. The Governor's Executive Order RP-36, dated July 12, 2004, issued to all state agencies served to reinforce the partnership. The governor's order directed all state agencies to establish wide-ranging efforts to detect and eliminate fraud in government programs. Activities in the latest biannual reporting period continue to reflect progress and success in this area. For example, the following has occurred in the last six months:

- Both agencies continued to uphold their commitment to promptly send and/or act upon referrals. The ensuing working relationship between the two agencies is recognized by other states as highly effective.
- Monthly meetings continued between HHSC-OIG and MFCU staff to discuss referrals of cases and to conduct joint investigations.
- Communication on cases remained consistent and ongoing throughout all staff levels, ensuring all case resources and knowledge were shared and efforts not duplicated.
- Joint training across the two agencies continued with basic Medicaid fraud training sponsored by the MFCU in November 2005.
- Following the signed mobile dental unit agreement between the OAG and OIG, the MFCU used this vehicle to conduct clinical examinations during the course of its criminal investigations.
- Both agencies coordinated efforts by using the most geographically appropriate staff within either agency to conduct provider visits prior to enrollment for provider types that have higher rates of anticipated fraud.
- When appropriate, the same professional consultants were used to add consistency and to strengthen cases that require specific expertise.
- OIG continued to work with MFCU staff as they developed a process following provider payment hold requests.

THE HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

The 78th Texas Legislature created the OIG to strengthen HHSC's authority to combat waste, abuse, and fraud in health and human services program. OIG provides program oversight of health and human service (HHS) activities, providers, and recipients through its compliance, chief counsel and enforcement divisions, which are designed to identify and reduce waste, abuse or fraud, and improve HHS system efficiency and effectiveness. Specifically, the chief counsel and enforcement divisions play an intricate role in coordinating with the OAG as it relates to provider investigations and sanction actions.

Within the Enforcement Division, the MPI section investigates allegations of waste, fraud, and abuse involving Medicaid providers and other health and human services programs; refers cases and leads to law enforcement agencies, licensure boards, and regulatory agencies; refers complaints to the MFCU; provides investigative support and technical assistance to other OIG divisions and some outside agencies; and monitors recoupments of Medicaid overpayments, civil monetary penalties, damages, and other administrative sanctions.

Under the Chief Counsel, the Sanctions section imposes administrative enforcement intervention and/or adverse actions on providers of various state health care programs found to have committed Medicaid fraud, waste, or abuse in accordance with state and federal statutes, regulations, rules or directives, and investigative findings. Sanctions monitors the recoupment of Medicaid overpayments, damages, penalties, and may negotiate settlements and/or conduct informal reviews as well as prepare agency cases, and provide expert testimony and support at administrative hearings and other legal proceedings against Medicaid providers.

OIG has clear objectives, priorities, and performance standards that emphasize:

- Coordinating investigative efforts to aggressively recover Medicaid overpayments;
- Allocating resources to cases that have the strongest supporting evidence and the greatest potential for monetary recovery; and
- Maximizing the opportunities for case referrals to the MFCU.

Medicaid Fraud and Abuse Referrals Statistics

HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INSPECTOR GENERAL

WASTE, ABUSE, AND FRAUD REFERRALS RECEIVED FY2006 (1st & 2nd Quarters)

Referral Source	Received
Office of the Attorney General Medicaid Fraud Control Unit	3
United States Department of Treasury	1
Medicare Matching Project	2
Assistant US Attorney's Office	1
Texas Department of Aging and Disability Services (DADS)	22
Texas Health Steps	31
Texas Department of State Health Services (DSHS)	9
Texas Medicaid Healthcare Partnership (TMHP)	5
Texas Department of Family and Protective Services (DFPS)	1
Law Enforcement Agency	1
Managed Care Organizations /SIUs	19
2005 PAM III Study (Comptroller's Office)	1
2005 Year Four Perm Study (Comptroller's Office)	4
TX Health Care Claims Study 2005 (Comptroller's Office)	4
Parent/Guardian	19
Provider	20
Public	66
Recipient	147
Anonymous	44
HHSC – Internal Affairs	3
HHSC – Medicaid/Chip Division	2
HHSC – MPI-OIG Self-initiated (MPI)	16
HHSC – Utilization Review	14
Vendor Drug	3
Total Cases Received:	**438**

WASTE, ABUSE, AND FRAUD REFERRALS SENT FY2006 (1st & 2nd Quarters)

Referral Source	Referred
Office of the Attorney General Medicaid Fraud Control Unit	89
Medicare Part A& B	7
Palmetto GBA	1
Department of Family and Protective Services (DPRS)	2
Texas Department of Aging and Disability Services (DADS)	5
Texas Department of State Health Services	1
Texas Department of Transportation (TXDOT)	2
Board of Dental Examiners	5
Board of Medical Examiners	4
Board of Nurse Examiners	2
Board of Pharmacy	1
Claims Administrator – Educational Contract	30
Claims Administrator – Claims/Record Review	1
HHSC – Audit	1
Vendor Drug	1
TOTAL:	**152**

Medicaid Fraud, Abuse, and Waste Workload Statistics and Recoupments

OIG workload statistics and recoupments for the first and second quarters of fiscal year 2006 are as follows.

Action	1st Quarter FY2006	2nd Quarter FY2006	Total FY2006
Medicaid Provider Integrity			
• Cases Opened	235	203	**438**
• Cases Closed	74	71	**145**
• Criminal History Checks Conducted	0[1]	3,923	**3,923**
Medicaid Fraud & Abuse Detection System [2]			
• Cases Opened	367	1,259	**1,626**
• Cases Closed	621	1,079	**1,700**

Office of Inspector General Recoupments	1st Quarter FY2006	2nd Quarter FY2006	Total FY2006
Sanctions[3]	$ 3,430,511	6,042,488	**$ 9,472,999**
Providers Excluded	55	77	**132**

[1] Criminal history process not initiated during the 1st quarter.
[2] MFADS is a detection source and as such the numbers are duplicated within sections that work or take action on MFADS generated cases.
[3] May include OAG identified amounts and Medicaid global settlements. Amounts listed in OAG's statistics may also include potential overpayments identified by OIG.

OFFICE OF THE ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT

For more than 27 years, the Texas Medicaid Fraud Control Unit (MFCU) has been conducting criminal investigations into allegations of fraud, physical abuse, and criminal neglect by healthcare providers in the Medicaid program. MFCUs are operating in 48 states and Washington, D.C., all with similar goals.

The staff increase mandated by House Bill 2292 helped bring Texas in line with other states with similar numbers of Medicaid recipients and Medicaid budgets. The legislation appropriated funding that, when matched with federal grant funds, has expanded the unit from 36 staff to nearly 200. Of this number, over 50 are commissioned peace officers. Field offices are open in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio and Tyler. Cross-designated Special Assistant U.S. Attorneys (SAUSAs) are working 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 healthcare providers. The providers cover a broad range of disciplines and include physicians, dentists, physical therapists, licensed professional counselors, ambulance companies, case management centers, laboratories, podiatrists, nursing home administrators and staff, and medical equipment companies. Common investigations include assaults and criminal neglect of patients in Medicaid facilities, fraudulent billings by Medicaid providers, misappropriation of patient trust funds, drug diversions, and filing of false information by Medicaid providers. Unit investigators often work cases with other state and federal law enforcement agencies.

Because the MFCU's investigations are criminal, the penalties assessed against providers can include imprisonment, fines, and exclusion from the Medicaid program. The provider is also subject to disciplinary action by his or her professional licensing board. Increased staff has allowed the unit to increase its open investigations from 597 in the 2nd quarter, FY2005, to 879 this reporting period. This, in turn, has led 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. During this reporting period, MFCU state prosecutors have been deputized by various district attorneys to prosecute MFCU cases. As the unit continues to offer its prosecutorial expertise to assist local district attorneys in prosecuting MFCU cases, this trend is expected to continue. In addition, the Code of Criminal Procedure was amended to allow the OAG to institute asset forfeiture proceedings in cases that are filed by the OAG or requested by the OIG. Both federal and state prosecutions are expected to increase.

Referral Sources

The MFCU receives referrals from a wide range of sources including concerned citizens, Medicaid recipients, current and former provider employees, the HHSC-OIG, other state agencies, and federal agencies. MFCU staff review every referral received. Not all are investigated, however, because the statutory mandate restricts investigations to referrals that have a substantial potential

for criminal prosecution. The current addition of staff and field offices has enhanced the unit's 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. The chart which follows provides a breakdown of referral sources for this reporting period.

Referral Source	Received
Department of Aging and Disability Services	172
Department of State Health Services	4
Federal Bureau of Investigation	14
Health and Human Services Commission	84
Law Enforcement	4
Medicaid Fraud Control Unit Self-Initiated	45
National Association of Medicaid Fraud Control Units	1
Public	52
U.S. Department of Health and Human Services, Office of Inspector General	8
Other State Agencies and Boards	5
Other	30
TOTAL	**419**

Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the first and second quarters of fiscal year 2006 are as follows.

Action	1st & 2nd Quarters FY2006
Cases Opened	357
Cases Closed	281
Cases Presented	93
Criminal Charges Obtained	57
Convictions	45
Potential Overpayments and Misappropriations Identified	$34,250,715.29
Settlements	$4,184.698.31
Cases Pending	879

OFFICE OF THE ATTORNEY GENERAL
ANTITRUST & CIVIL MEDICAID FRAUD DIVISION

In August 1999, the Civil Medicaid Fraud Section (CMF) was created within the Elder Law and 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 & 2nd Quarters FY2006
Pending Cases/Investigations	146
Cases Closed	22
Cases Opened	24

During this reporting period the case against Roxane Laboratories, its parent, Boehringer Ingelheim Corporation, and its sister companies, Ben Venue Laboratories, Inc., and Boehringer Ingelheim Pharmaceuticals, Inc., was settled for $10,100,000. The settled claims were originally part of the lawsuit filed in 2000 against Dey, Warrick and Roxane, which involved a scheme of false price reporting to the Vendor Drug Program. With the claims against this final set of defendants settled, a total of $55,600,000 has been collected since 2003 as a result of that original lawsuit.

A settlement was also reached in a case against King Pharmaceuticals, Inc. This case arose from claims that King failed to report deep discounts on its products that caused the company's Best Price to be miscalculated. The result was substantial underpayment of Medicaid rebates by King. The total recovery for Texas was $3,082,019.35 and the federal share attributable to Texas was $4,523,306.23.

An additional settlement occurred in a case against Serano Laboratories, Inc. This was an off-label promotion case, which resulted in a Texas recovery of $1,385,936.19. The federal settlement share attributable to Texas was $2,180,795.11.

CMF continues to pursue a case against Abbott Laboratories, Baxter, and B. Braun for false price reporting and a case against Caremark for failure to reimburse Medicaid for pharmacy benefits paid on behalf of dual eligible Medicaid recipients.

CMF continues its heavy involvement in multi-state cases or investigations against Medicaid providers.