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 12 health and human services agencies into a single office under the HHSC.

This legislation contained 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 Office of the Attorney General (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 OAG Medicaid Fraud Control Unit (MFCU) and the OIG. This has enhanced the timely investigation of potentially fraudulent providers.

House Bill 2292 appropriated increased funding to the MFCU. The U.S. Department of Health and Human Services Office of Inspector General approved matching federal grant funds to expand the MFCU to as many as 208 staff by the end of federal fiscal year 2005. To date, the MFCU has increased its staff to 118. In addition to the field offices opened during the first six months of FY 04 (Dallas, Houston, Lubbock, Tyler), offices have now been opened in Corpus Christi, El Paso, McAllen, and San Antonio. The MFCU also has joint federal task force offices in Houston, Dallas and San Antonio.

Pursuant to the legislative mandate as described in House Bill 2292, HHSC-OIG referred 257 cases to the MFCU for fiscal year 2004, a 147% increase from the 104 cases for fiscal year 2003. House Bill 2292 and the joint MOU require that HHSC-OIG must:

- Begin an integrity review on complaints not later than the 30th day after the date the HHSC-OIG receives a complaint or has reason to believe that fraud or abuse has occurred.
- Complete an integrity review on complaints not later than the 90th day after the integrity review began.

- Take the appropriate action not later than the 30th day after the completion of the integrity review if HHSC-OIG has reason to believe that an incident of fraud or abuse has occurred in the Medicaid program.
- Refer the case to the MFCU if the provider is suspected of fraud or abuse involving possible criminal conduct. This does not preclude the HHSC-OIG from continuing its investigation of the provider, which may lead to the imposition of administrative or civil sanctions.
- Within 30 days of the receipt of a referral from the HHSC-OIG, the MFCU will advise the HHSC-OIG of the action that has been taken.

MEMORANDUM OF UNDERSTANDING

The MOU between the MFCU and the HHSC-OIG was updated and expanded in November 2003 in accordance with House Bill 2292, which required the HHSC-OIG and the MFCU to enter into a new MOU no later than December 1, 2003. The MOU continues to ensure the cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases arising in the state and has proven beneficial to both agencies.

INTERAGENCY COORDINATION EFFORT

The Governor's Executive Order RP-36, dated July 12, 2004, directed all state agencies to establish wide-ranging efforts to detect and eliminate fraud in government programs. The MFCU and the HHSC-OIG continue their coordinated efforts to execute the Governor's directive.

HHSC-OIG and the MFCU 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 the MFCU staff in order to conduct joint investigations.
- Constant communication on cases throughout all staff levels, ensuring all case resources and knowledge are shared and efforts are not duplicated.
- Joint training across the two agencies included invitations to the MFCU staff for the National White Collar Crime Summit in Dallas, and specialized NW3C training this summer in Austin. The HHSC-OIG invited members of the MFCU staff to attend the first annual OIG Summit. In addition, the MFCU staff have extended an invitation to the HHSC-OIG staff to attend an Introduction to Medicaid Fraud training in San Antonio this fall.

The following is presented to illustrate the two agencies' joint efforts. The HHSC-OIG and the MFCU participated in the investigation and testimony in the 177th Harris County District Court regarding one of Texas' more egregious criminal cases involving Medicaid fraud. A husband and wife operated D & H Christian Case Management, which allegedly provided mental-health care

counseling to children. Instead, the couple billed Medicaid for services that were never provided, often using the provider number of contracted counselors who were no longer working for the couple. Both individuals were convicted of Medicaid fraud and received a combined 98 years in prison for $630,000 of inappropriate Medicaid billings. HHSC-OIG and MFCU staff were in Houston when the guilty verdict was read and sentencing took place.

THE HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

Senate Bill 30, enacted by the 75th Texas 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 12 health and human services (HHS) agencies. The OIG will provide oversight of HHS activities, providers, and recipients through compliance and enforcement activities designed to identify and reduce waste, abuse, and fraud; and improve efficiency and effectiveness within the HHS system.

The OIG 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 OIG consists of numerous divisions and has Deputy Inspector Generals for Operations, Compliance, Enforcement, and The Office of the Chief Counsel. The functions of the Deputy Inspector General for Enforcement and The Office of the Chief Counsel as it relates to this report are as follows.

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 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 OAG and Comptroller. The Enforcement Division is comprised of three sections: Medicaid Provider Integrity (MPI), General Investigations (GI), and Internal Affairs (IA).

- MPI 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 OAG MFCU; 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.
- GI investigates allegations of waste, fraud, and abuse involving Medicaid recipients, and other health and human service programs.
- IA tracks and coordinates two computer data matches designed to locate wanted felons and missing children/missing persons; 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.

The Office of the Chief Counsel offers general legal advice to the Office of the Inspector General. The Office of the Chief Counsel is comprised of two subdivisions: Sanctions and Third Party Recovery.

- The Sanctions section imposes administrative enforcement interventions, 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, provide expert testimony and support at administrative hearings, and other legal proceedings against Medicaid providers.
- 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.

Medicaid Fraud and Abuse Referrals Statistics

HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INSPECTOR GENERAL

WASTE, ABUSE, AND FRAUD REFERRALS RECEIVED FY2004 (3rd & 4th Quarters)

Referral Source	Received
Anonymous	11
Assistant U.S. Attorney	1
Center for Medicare Service (CMS)	9
Health and Human Services – Office of Inspector General (HHS-OIG)	43
United States Department of Justice	1
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	52
Office of the Attorney General's Elder Law	1
Board of Dental Examiners	9
Board of Nurse Examiners	105
Board of Pharmacy	2
Board of Psychologist	1
Board of Medical Examiners	40
Texas Department of Human Services (DHS)	11
Texas Department of Human Services (DHS) Long Term Care	8
HHSC Commissioner's Office	1
HHSC Compliance Division	1
HHSC Internal Audit	2
HHSC Medicaid/Chip Division	3
HHSC-MPI-OIG Self-initiated (MPI)	9
HHSC-Hot-line	26
HHSC Limited Program	2
HHSC Research, Analysis and Detection (RAD)	1
Mental Health Mental Retardation (MHMR)	22
Out of State Human Services Department	1
Parkland Community Health Plan	1
Parent/Guardian	1
Provider	17
Public	29
Recipient	3
State Dental Director	1
State Medicaid Office	2
Surveillance, Utilization, Review System (SURS)	30
Texas Commission on Alcohol & Drug Abuse (TCADA)	1
Texas Department of Health	2
Texas Department of Protective & Regulatory Services	1
Texas Health Steps	1
Texas Medicaid Healthcare Partnership (TMHP)	6
Vendor Drug	2
Total Cases Received	**459**

WASTE, ABUSE, AND FRAUD REFERRALS SENT FY2004 (3rd & 4th Quarters)

Referral Source	Referred
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	144
Office of the Attorney General's Elder Law	2
United States Attorneys Office	1
Board of Pharmacy	1
Medicare Part A& B	7
Texas Department of Mental Health and Mental Retardation (MHMR)	7
Department of Family and Protective Services	1
Federal Bureau of Investigation	12
Board of Social Workers	1
HHSC – Medicaid Limited Program	4
SSI Administration	1
Texas Department of Transportation	91
HHSC – Rate Analysis – LTC	4
Texas Department of State Health Services/EMS Enforcement and Education	1
Board of Dental Examiners	2
Board of Medical Examiners	13
Board of Nurse Examiners	1
Board of Optometry	3
Community Care Waiver Program	1
Long Term Care	1
Managed Care	1
HHSC – RAD	4
Claims Administrator – Records Review	5
Claims Administrator – Educational Contract	23
HHSC – General Investigation	16
Surveillance, Utilization, Review System (SURS)	2
TOTAL	**349**

Medicaid Fraud, Abuse, and Waste Recoupments

Recoupments for the third and fourth quarters of fiscal year 2004 are as follows.

RECOUPMENTS BY OIG PROGRAMS FOR FY2004 (3rd & 4th Quarters)

Office of Inspector General	3rd Quarter FY2004	4th Quarter FY2004	TOTAL FY2004
Medicaid Program Integrity	$337,201	1,797,902	*** $23,358,098**
Civil Monetary Penalties	$115,556	$104,193	**$14,184,150**
Surveillance and Utilization Review Subsystems (SURS)	$248,136	$284,313	**$1,529,597**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$480,995	$1,163,271	**$2,470,200**
TOTAL	**$1,181,888**	**$3,349,679**	**$41,542,045**

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

*May include OAG identified amounts and Medicaid global settlements. Amounts listed in OAG's statistics may also include potential overpayments identified by OIG.

Medicaid Fraud, Abuse, and Waste Workload Statistics

OIG Workload statistics for the third and fourth quarters of fiscal year 2004 are as follows.

Action	3rd Quarter FY2004	4th Quarter FY2004	Total FY2004
Medicaid Provider Integrity			
• Cases Opened	299	211	**1,149**
• Cases Closed	270	348	**1,190**
• Providers Excluded	159	102	**625**
Medicaid Fraud & Abuse Detection System			
• Cases Opened	143	795	**1,742**
• Cases Closed	235	465	**1,674**

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 prior 36 employees to up to 236 employees. Over the past six months, the unit has grown to 118 staff and new field offices have been opened in Corpus Christi, El Paso, McAllen and San Antonio. Offices were previously established in Dallas, Houston, Lubbock and Tyler. Cross-designated Assistant U.S. Attorneys (AUSAs) have been hired to work within three of the four federal judicial districts. Other AUSAs are expected to be brought on during next fiscal year.

During this period of rapid expansion, the MFCU was recognized for its efforts in fighting fraud and abuse in the Medicaid program. The U.S. Department of Health and Human Services awarded the MFCU the Inspector General's State Fraud Award. This award was presented to the MFCU for its effectiveness and efficiency in combating fraud, patient abuse and neglect in the Medicaid program.

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 has allowed the unit to open and conduct more investigations and use a risk-based approach to examine a larger cross-section of providers' claims histories. This 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. 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 HHSC-OIG, 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 prosecution and because of limited investigative resources. The current addition of staff and the creation of regional offices throughout the state have 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
Board of Dental Examiners	1
U.S. Drug Enforcement Agency	1
Federal Bureau of Investigations	7
Health and Human Services Commission	99
U.S. Department of Health and Human Services, Office of Inspector General	6
Department of Human Services	262
Licensed Vocation Nurse	1
Local Law Enforcement	2
Medicaid Fraud Control Unit Self-Initiated	14
Board of Medical Examiners	1
National Association of Medicaid Fraud Control Units	5
Director of Nursing	1
Nursing Home Employee	3
Board of Pharmacy	1
Public	130
Other	23
TOTAL	**557**

Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the third and fourth quarters of fiscal year 2004 are as follows.

Action	3rd & 4th Quarters FY2004
Cases Opened	214
Cases Closed	116
Cases Presented	80
Criminal Charges Obtained	64
Convictions	26
Potential Overpayments and Misappropriations Identified	$13,339,593.41
Cases Pending	453

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	3rd & 4th Quarters FY2004
Pending Cases/Investigations	68
Cases Closed	0
Cases Opened	30

Although CMF now has over 68 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.

As set forth above, no cases were closed during this reporting period; however, a significant settlement was reached with a second defendant and its parent companies in *State of Texas ex rel. Ven-A-Care of the Florida Keys, Inc. v. Warrick, et al*., a case involving false price reporting by pharmaceutical manufacturers to the Medicaid Vendor Drug Program. The first settlement of $18.5 million with Defendant, Dey Laboratories, Inc. and its parent was reached in June 2003. A total recovery of $27 million for the federal and state governments was agreed upon with Warrick

Pharmaceuticals and its parents, Schering and Schering-Plough. The State's share of the settlement consists of the following:

Case	Restitution	Multiples/ Penalties	Relator's Award	Attorney's Fees	Total Texas Recovery
Warrick	$3,800,000	$1,938,000	$1,862,000	$3,500,000	$11,100,000

All of the restitution and multiples/penalties are returned to the Medicaid program and the attorney's fees are reported by the OAG to the Legislative Budget Board as part of the biennial appropriation that funds the OAG's legal strategy. The relator's share is not reported as income to the state.

CMF is continuing to litigate a claim against Roxane Laboratories, its parent, Boehringer Ingelheim Corporation, and its sister companies, Ben Venue Laboratories, Inc., and Boehringer Ingelheim Pharmaceuticals, Inc. This case is set for trial in November 2005. In addition, CMF has filed a new case against Abbott Laboratories, Baxter, and B. Braun for false price reporting. Since the inception of CMF, a majority of its resources have been consumed by prosecution of pharmaceutical manufacturers for false price reporting, and this reality will continue for the foreseeable future.

Resources

CMF has again increased its attorney staffing. CMF hired a new senior attorney in April. In addition, the division has initiated some cross-utilization of resources between CMF and the Antitrust Section. Also, due to increased investigator staffing of MFCU, the unit has been able to begin providing more investigative assistance to CMF on civil cases.