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 Health and Human Services Commission (HHSC) and the Office of the Attorney General (OAG) continue to build upon the success of their efforts in detecting and preventing fraud, waste, and abuse in the Medicaid program. Reinforced by 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 HHSC Office of Inspector General (OIG) and the OAG Medicaid Fraud Control Unit (MFCU) recognize the importance of partnership and regular communication in the coordinated effort to fight fraud and abuse in the Medicaid program. 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:

- OIG finalized a process whereby the MFCU is notified of providers under investigation who apply to the Medicaid program to enroll as providers in additional Medicaid programs.
- OIG and MFCU staff worked jointly to finalize a process for making provider payment hold requests.
- Joint training across the two agencies continued with basic Medicaid fraud training sponsored by the MFCU in May 2006.
- 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.
- Working through a signed agreement between the OAG and OIG, the MFCU used the mobile dental unit 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.

OTHER DEVELOPMENTS

The 79th Texas Legislature approved an increase in staffing for the Health and Human Services Commission (HHSC) Office of Inspector General (OIG) for SFY 2006. Sixteen new FTE's were allocated to the OIG's Medicaid Provider Integrity (MPI) section. The MPI staff is 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, the 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 August 2006 (2nd – 4th quarters, SFY 2006), MPI has conducted 10,166 criminal history checks on Medicaid provider applicants and those under investigation. Of the criminal history checks conducted, 368 were either denied, or are pending receipt of return information.

In October 2006, the MPI Section will begin conducting criminal history background checks on ***ALL*** Medicaid providers currently enrolled through TMHP, the state's claims administrator for the Medicaid Program.

For SFY 2006, the number of provider complaints increased significantly from SFY 2005. In SFY 2005, MPI opened 545 cases. In SFY 2006, MPI opened 800 cases. This reflects a 47% increase in complaints. As a result of increased complaints, MPI referred 256 cases to the MFCU for SFY 2006. This reflects a 66% increase in cases referred to the MFCU from SFY 2005.

In accordance with section 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 for approval. For SFY 2006, OIG saw a 330 % increase in complaint referrals from MCO's based on their mandated Special Investigative Units (SIU's).

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 three years 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 MFCU is beginning to see the benefits of its expansion. The number of criminal cases opened has increased 42% since FY 2004, the year the expansion began. The number of cases presented for prosecution has increased nearly 50% during the same time period. Convictions have increased 42%. The Medicaid Fraud Control Unit pending caseload jumped from 453 in FY 2004 to over 1,000 in FY 2006. Another benefit of increased staff resources focused on Medicaid fraud has been the amount of overpayments identified: from $24.9 million in 2004 to over $67.8 million in FY 2006.

MEMORANDUM OF UNDERSTANDING

As required by HB 2292 of the 78th Texas Legislature, 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.

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 outside agencies; 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

HHSC-OIG Waste, Abuse, & Fraud Referrals FY2006 (3rd & 4th Quarters) Received From:

Referral Source	Received
Anonymous	27
Attorney General's Medicaid Fraud Control Unit (AGMFCU)	3
Department of Aging & Disability Services (DADS)	28
Department of Assistive & Rehabilitative Services (DARS)	1
Department of Family & Protective Services (DFPS)	1
Department of State Health Services (DSHS)	1
HHSC Office of the Ombudsman	1
HHSC - Vendor Drug Program	2
Managed Care Organization/Special Investigative Unit (MCO/SIU)	17
OIG MPI Self-initiated	52
OIG State Investigative Unit	1
OIG Utilization Review Division	3
Parent/Guardian	29
Provider	16
Provider Self Reported	6
Public	98
Recipient	58
Texas Health STEPS	5
Texas Medicaid Healthcare Partnership (TMHP)	9
U.S. Health & Human Service, Office of Inspector General (HHS-OIG)	1
U.S. Department of Justice (DOJ)	1
Total Cases Received:	**360**

HHSC-OIG Waste, Abuse & Fraud Referrals FY2006 (3rd & 4th Quarters) Referred To:

Referral Source	Referred
Attorney General's Medicaid Fraud Control Unit	167[1]
Board of Dental Examiners	15
Board of Licensed Vocational Nurse Examiners	1
Board of Medical Examiners	5
Board of Nurse Examiners	1
Board of Optometry	1
Board of Pharmacy	2
Department of Aging & Disability (DADS)	18
Department of Protective & Rehabilitative Services (DPRS)	1
Department of State Health Services (DSHS)	1
HHSC OIG Audit	1
HHSC OIG State Investigative Unit	1
HHSC - Vendor Drug Program	3
Medicare Part A & B	26
OIG – General Investigations (Recipient Fraud)	1
OIG - Research, Analysis & Detection Section (RADS)	1
Palmetto GBA	2
Texas Department of Transportation (TX DOT)	5
Texas Medicaid & Healthcare Partnership (TMHP) - Educational Contact	35
U.S. Department of Labor	1
U.S. Health & Human Service, Office of Inspector General	1
Total:	**289**

[1] This number reflects 1 referral from 2nd quarter of FY 2006 inadvertently omitted from the previous report.

Medicaid Fraud, Abuse, and Waste Workload Statistics and Recoupments:

Action	3rd Quarter FY2006	4th Quarter FY2006	Total FY2006
Medicaid Provider Integrity			
• Cases Opened	210	152	800
• Cases Closed	80	79	304
• Referrals to MFCU	108	58	255
• Criminal History (CH) Checks Conducted	3,534	2,542	10,166[2]
Medicaid Fraud & Abuse Detection System [3]			
• Cases Opened	453	1,120	3,199
• Cases Closed	607	695	3,002
Sanctions Recoupments [4]	$4,984,828	$2,123,778	$15,801,240[5]
Providers Excluded	252	115	499

[2] Numbers previously reported reflected new provider applicants only; the quarterly numbers now also include those currently under investigation. (The 2nd quarter number should reflect 4,090.)

[3] MFADS is a detection source and as such the numbers are duplicated within sections that work or take action on MFADS generated cases.

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

[5] In the Joint Semi-Annual Report for September 1, 2005 through February 28, 2006, the Sanctions' recoupment amount for the 2nd quarter was incorrectly stated as $6,042,488. This mistake was due to a data entry error. The correct recoupment amount for the 2nd quarter is $5,262,123. The "Total FY 2006" recoupment amount of $15,801,240 in this Joint Semi-Annual Report is correct.

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 spending. The legislature 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 879 in the last reporting period to 1078 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 investigated. The MFCU also strives for a blend of cases that are representative of Medicaid provider types. The following chart provides a breakdown of referral sources for this reporting period.

Referral Source	Received
Department of Aging and Disability Services	135
Federal Bureau of Investigation	9
Health and Human Services Commission	146
Law Enforcement	11
Medicaid Fraud Control Unit Self-Initiated	68
National Association of Medicaid Fraud Control Units	8
Public	75
OAG Antitrust and Civil Medicaid	5
U.S. Department of Health and Human Services, Office of Inspector General	12
Other Agencies and Boards	4
Other	20
TOTAL	**493**

Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the third and fourth quarters of fiscal year 2006 are as follows.

Action	3rd & 4th Quarters FY2006
Cases Opened	463
Cases Closed	264
Cases Presented	184
Criminal Charges Obtained	47
Convictions	45
Potential Overpayments Identified	$43,579,458.14
Misappropriations Identified	$589,506.22
Settlements	$16,680,396.02
Cases Pending	1078

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	3rd & 4th Quarters FY2006
Pending Cases/Investigations	151
Cases Closed	0
Cases Opened	30

During this reporting period, the case against Baxter Healthcare Corporation settled for $8,500,000. The settled claims were originally part of a lawsuit filed in May 2004 against Abbott Laboratories, B. Braun Medical and Baxter, which involved a scheme of false price reporting to the Vendor Drug Program. CMF continues to pursue the case against Abbott Laboratories and B. Braun.

CMF is also continuing to pursue a case against Caremark for failure to reimburse Medicaid for pharmacy benefits paid on behalf of dual eligible Medicaid recipients and a case against Merck & Co. for misrepresentations to Texas Medicaid about the safety and efficacy of Vioxx.

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