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 each other, and cooperative efforts have resulted in a number of successful investigations of 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 and MFCU staff worked jointly to improve communication, share resources and information regarding providers under investigation and to ensure parallel criminal and administrative actions result in the most successful case disposition.
- OIG and MFCU are sharing information developed through claims analysis, investigative findings and prosecution analysis to improve deficiencies in Medicaid policy that allow for exploitation and abuse of the Medicaid program.
- Quarterly meetings continued between OIG and MFCU executive management to ensure that collaboration is occurring at all levels of both organizations.
- MFCU and OIG staff continued to participate in joint working groups to enhance provider enrollment, fraud detection, and Medicaid claims system processes.
- Joint training across the two agencies continued, including MFCU Assistant Attorneys General providing witness testimony training to HHSC program experts.
- 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 OIG and MFCU staff to discuss referrals of cases and other mutually beneficial projects that aide investigative activities by both entities.
- MFCU and OIG staff convened a series of meetings with HHSC Medicaid/CHIP to improve understanding of investigating within a managed care environment.
- Communication on cases remained consistent and ongoing throughout all staff levels, ensuring all case resources and knowledge were shared and efforts not duplicated.
- In locations throughout the state where the OIG does not office field investigators, MFCU investigators assisted in conducting on-site provider verifications for provider types that have shown a higher propensity towards potential 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 2007. Eleven new FTE's were allocated to the OIG's Medicaid Provider Integrity (MPI) section. The MPI staff is primarily devoted to investigating provider fraud, waste and abuse in the Texas Medicaid Program. This staffing increase has allowed MPI to place additional investigators and nurse analysts in key areas of the state to more efficiently investigate issues related to Medicaid fraud, waste, and abuse. MPI has field investigators located in Dallas, Houston, San Antonio, and Edinburg.

In accordance with section 531.113 of the Government Code, all managed care organizations (MCOs) 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. OIG has designated staff who review and approve these annual plans. For the first and second quarters of SFY 2008, OIG received 15 complaint referrals from MCOs based on their mandated Special Investigative Units (SIUs). All appropriate cases received from the SIUs were referred to the MFCU.

OIG continues to meet quarterly with the Special Investigative Units (SIU's) to work on enhancements of processes and development of protocols for improved coordination between the two entities. These meetings are intended to allow an exchange of information between the state and the SIU's in order to work in collaboration to address fraud, waste and abuse issues within the managed care environment.

Under the provisions of the Deficit Reduction Act (DRA) of 2005, Congress directed the Center for Medicare and Medicaid Services (CMS) to establish the Medicaid Integrity Program (MIP). In doing so, it dramatically increased the resources available to CMS to combat fraud, waste and abuse in the Medicaid program. The major operational roles of the MIP contractors will be to review provider activities, audit claims, identify overpayments, conduct provider education and provide effective support and assistance to states in their efforts to combat provider fraud and abuse.

During this reporting period OIG has met with Catapult Consultants, the Medicaid Integrity Program (MIP) contractor, to coordinate resources and discuss operational procedures for eight test audits/investigation that will be conducted during the course of 2007 and 2008. MPI investigators accompanied Catapult Consultants staff on the first test audit/investigation in November 2007. Work will continue with Catapult Consultant on communication protocols so investigations and audits of Medicaid providers are not duplicated.

The Deficit Reduction Act (DRA) of 2005 also created a major project designed to better coordinate Medicare and Medicaid program integrity. CMS, in partnership with the State of California, initiated a project, designed to share and analyze both Medicare and Medicaid data beginning in 2001. Now known as Medi-Medi, this work involves comparing data from both programs to reveal fraudulent patterns previously invisible to either program, independent of the other.

OIG has recently participated in on-going work group discussions with the CMS contractor, Optimal Solutions Group, Program Safeguard Contractors (PSC) and other state entities participating in this project to formulate a workload reporting measure to capture the results of cases identified through the Medi-Medi projects. OIG and MFCU staff continue to attend the quarterly Steering Committee meetings in Dallas to discuss cases and on-going developments related to the Medi-Medi project.

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 MFCU and the OIG will be working together in calendar year 2008 to update the existing MOU.

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 to Sanctions, 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. 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, provide expert testimony and support at administrative hearings and other legal proceedings against Medicaid providers, when applicable.

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 FY2008 (1st & 2nd Quarters) Received From:

Referral Source	Received
Anonymous	16
Attorney General's Medicaid Fraud Control Unit	3
Department of Aging & Disability Services (DADS)	41
Department of State Health Services (DSHS)	2
HHSC Ombudsman	0
Managed Care Organization/Special Investigative Unit (MCO/SIU)	15
OIG Research Analysis & Detection (TADS)	0
OIG MPI Self-initiated	11
OIG General Investigations	0
OIG Utilization Review Division	3
Parent/Guardian	37
Provider	13
Public	54
Recipient	45
HHSC – Medicaid/CHIP Division	2
Provider Self-Reported	2
Texas Board of Dental Examiners	1
Texas Department of Assistive and Rehabilitative Services (DARS)	1
Surveillance, Utilization, Review System (SURS)	2
U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG)	4
Total Cases Received:	**252**

HHSC-OIG Waste, Abuse & Fraud Referrals FY2008 (1st & 2nd Quarters) Referred To:

Referral Source	Referred
Attorney General's Medicaid Fraud Control Unit	91
Board of Dental Examiners	8
Board of Medical Examiners	7
Board of Nurse Examiners	1
Board of Optometry	1
Department of Aging & Disability (DADS)	9
Texas Board of Pharmacy	1
Health and Human Services – OIG General Investigation Division (GI)	3
Department of State Health Services (DSHS)	11
HHSC - Vendor Drug Program	5
Palmetto GBA	4
Texas Medicaid & Healthcare Partnership (TMHP) - Educational Contact	59
U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG)	12
Total:	**212**

Medicaid Fraud, Abuse & Waste Workload Statistics and Recoupments – FY 2008

Action	1st Quarter FY2008	2nd Quarter FY2008	Total FY2008
Medicaid Provider Integrity			
• Cases Opened	142	110	252
• Cases Closed	93	88	181
• Referrals to MFCU	24	67	91
• Referrals to Other Entities	96	25	121
• MPI Cases Referred to Sanctions	5	7	12
• On-site Provider Verifications	62	80	142
Medicaid Fraud & Abuse Detection System [1]			
• Cases Opened	573	812	1,385
• Cases Closed	451	324	775
Sanctions Recoupments [2]	590,063.00	6,147,179	6,737,242
Providers Excluded	101	222	323

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

[2] 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 nearly 30 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 49 states and Washington, DC, 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, 56 are commissioned peace officers. Field offices are open in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio and Tyler. Two teams are located in the Dallas office and three teams are located in the Houston office. Cross-designated Special Assistant U.S. Attorneys (SAUSAs) work within each of the four federal judicial districts.

Referral Sources

The MFCU receives referrals from a wide range of sources including concerned citizens, Medicaid recipients, current and former provider employees, 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 enabled the unit to respond quickly and efficiently to the referrals investigated. The following chart provides a breakdown of referral sources for this reporting period.

Referral Source	Received
Department of Aging and Disability Services	102
Federal Bureau of Investigation	6
Health & Human Services Commission - Office of Inspector General	142
Law Enforcement	9
Medicaid Fraud Control Unit Self-Initiated	33
Medicare Contractors	5
Office of the Attorney General	17
Providers	5
Public	66
U.S. Department of Health and Human Services, Office of Inspector General	10
Other Agencies and Boards	9
Other	18
TOTAL	**422**

Criminal Investigations

The MFCU conducts criminal investigations into allegations of fraud, physical abuse, and criminal neglect by Medicaid healthcare providers. The MFCU strives for a blend of cases that are representative of Medicaid provider types. The provider types 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.

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 unit 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 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.

The MFCU's partnership with the four federal judicial districts has proven to be especially beneficial in increasing the number of MFCU cases prosecuted through the federal system. Under this arrangement, a cadre of MFCU Assistant Attorneys General has been cross-designated as Special Assistant U.S. Attorneys (SAUSA). They are housed primarily in the federal district offices. As SAUSAs, they are authorized to prosecute Medicaid healthcare cases in federal court.

Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the first and second quarters of fiscal year 2008 are as follows.

Action	1st & 2nd Quarters FY2008
Cases Opened	289
Cases Closed	236
Cases Presented	179
Criminal Charges Obtained	65
Convictions	44
Potential Overpayments Identified	$19,617,259.02
Misappropriations Identified	$33,647.51
Settlements	$9,277,114.34
Cases Pending	1349

OFFICE OF THE ATTORNEY GENERAL
CIVIL MEDICAID FRAUD DIVISION

In early 2008, the Civil Medicaid Fraud Division (CMF) became a separate division within the OAG. Previously, CMF was a section within the Antitrust and Civil Medicaid Fraud Division from 2004-2008, and prior to that, CMF was part of the Elder Law and Public Health Division from 1999-2004. No matter where it has been located, the mission of the CMF has always been 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 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. For most matters filed prior to May 2007, if the OAG does not intervene, the lawsuit is dismissed. However, 2007 amendments to the Act permit a citizen, known as the "relator," to continue to pursue the lawsuit even if the OAG does not intervene. In either circumstance, the Act provides that the Texas Medicaid Program recovers its damages and that the relator is entitled to a share of the recovery. The recent amendments duplicate portions of the federal False Claims Act and permit Texas to retain an additional 10% of Medicaid recoveries that are shared with the federal government.

Statistics

CMF Docket	1st & 2nd Quarters FY2008
Pending Cases/Investigations	202[3]
Cases Closed	16
Cases Opened	26
Cases Reopened	1

During this reporting period, CMF settled and recovered funds in six matters:

1. State of Texas v. Medicis. Total recovery including state, federal, and relator's portions was $1,475,748.80.
2. State of Texas v. Merck/LaCorte. Total recovery including state, federal, and relator's portions was $14,234,670.00.
3. State of Texas v. Merck/Steinke. Total recovery including state, federal, and relator's portions was $24,216,141.00.
4. State of Texas v. Glaxo SmithKline. Total recovery including both state and federal portions was $1,369,477.00
5. State of Texas v. Purdue/Oxycontin. Total recovery including both state and federal portions was $3,661,209.64.

[3] Of this total, 196 matters concern Medicaid fraud cases and investigations, and 6 matters relate to other issues handled by CMF attorneys. CMF expects the number of Medicaid fraud cases to decrease as a result of its review and recommendation efforts.

6. State of Texas v. Marquez/Fulp. Total recovery including both state and federal portions was $3,128,466.00.

CMF continues to pursue significant cases against the following defendants:

1. Abbott Laboratories, its subsidiary Hospira, and B. Braun for pricing fraud.

2. Caremark for failure to reimburse Medicaid for pharmacy benefits paid on behalf of dual eligible Medicaid recipients

3. Merck & Co. for misrepresentations to Texas Medicaid about the safety and efficacy of Vioxx.

4. Janssen Pharmaceuticals and its parent company, Johnson & Johnson, regarding the marketing of the drug Risperdal.

5. Mylan Laboratories, Sandoz, Inc., and Teva Pharmaceuticals for pricing fraud.

CMF continues its heavy involvement in multi-state cases or investigations against Medicaid providers which are under seal and cannot be revealed at this time publicly.

In 2007, the Texas Legislature approved a rider to expand CMF's budget to include an additional 41 staff members. CMF is in the process of expanding its staff and currently employs 29 attorneys and 9 staff. CMF is utilizing this increased staff to review and make recommendations on pending, non-public Medicaid fraud matters, as well as to further its efforts in open litigation.