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 regarding providers under indictment who remit overpayments or seek a release of payment holds.
- 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 staff attendance at the OIG Annual Summit.
- 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 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.
- 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 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.

MPI continues 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). Additionally, criminal background checks are performed for any person or business entity that meets the definition of "indirect ownership interest" as defined in 1 *Texas Administrative Code* §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 made available in the January/February 2006 *Texas Medicaid Bulletin*, No. 192, and the February 2006 *CSHCN Provider Bulletin*, No. 57.

In December 2006, MPI began conducting criminal history background checks on *ALL* Medicaid providers currently enrolled through TMHP, the state's claims administrator. During this reporting period, MPI has conducted 11,178 criminal history checks on Medicaid provider applicants, those under investigation, and current Medicaid providers.

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. For the third and fourth quarters of SFY 2007, OIG received 11 complaint referrals from MCOs based on their mandated Special Investigative Units (SIUs). All appropriate cases received from the SIUs were referred to the MFCU.

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 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 benefits of the MFCU's expansion are clear. The number of criminal cases opened has grown from 134 in the first half of FY 2004, the year the expansion began, to 387 this reporting period. The number of cases presented for prosecution increased from 57 to 244. Convictions increased from 12 to 66. The Medicaid Fraud Control Unit pending caseload jumped from 353 to 1296. It is expected that the pending case load will level out to an average of 1300 cases.

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 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 FY2007 (3rd & 4th Quarters) Received From:

Referral Source	Received
Anonymous	11
Attorney General's Medicaid Fraud Control Unit	4
Department of Aging & Disability Services (DADS)	35
Department of State Health Services (DSHS)	1
HHSC Ombudsman	3
Managed Care Organization/Special Investigative Unit (MCO/SIU)	11
OIG Research Analysis & Detection (TADS)	2
OIG MPI Self-initiated	31
OIG General Investigations	1
OIG Utilization Review Division	9
Parent/Guardian	31
Provider	17
Public	34
Recipient	47
Surveillance, Utilization, Review System (SURS)	2
U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG)	8
Total Cases Received:	**247**

HHSC-OIG Waste, Abuse & Fraud Referrals FY2007 (3rd & 4th Quarters) Referred To:

Referral Source	Referred
Attorney General's Medicaid Fraud Control Unit	165
Board of Dental Examiners	6
Board of Medical Examiners	5
Board of Nurse Examiners	4
Board of Optometry	1
Department of Aging & Disability (DADS)	10
Health and Human Services – OIG General Investigation Division (GI)	1
Department of State Health Services (DSHS)	5
HHSC - Vendor Drug Program	11
Palmetto GBA	7
Texas Department of Transportation (TX DOT)	2
Texas Medicaid & Healthcare Partnership (TMHP) - Educational Contact	43
U.S. Social Security Administration	1
U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG)	5
Total:	**266**

Medicaid Fraud, Abuse, and Waste Workload Statistics and Recoupments – FY 2007

Action	1st Quarter FY2007	2nd Quarter FY2007	3rd Quarter FY2007	4th Quarter FY2007	Total FY2007
Medicaid Provider Integrity					
• Cases Opened	166	182	129	117	594
• Cases Closed	62[1]	48	67	131	308
• Referrals to MFCU	58	44	77	88	267
• Referrals to Other Entities	57	109	40	61	267
• MPI Cases Referred to Sanctions	8	19	24	7	58
• On-site Provider Verifications	50	51	74	73	248
• Criminal History (CH) Checks Conducted	4,284	4,638	6,097	5,081	20,100
Medicaid Fraud & Abuse Detection System [2]					
• Cases Opened	328	973	177	490	1,968
• Cases Closed	766	595	152	557	2,070
Sanctions Recoupments [3]	$6,593,747	$1,463,849	$1,764,638	$2,792,050	$12,614,283
Providers Excluded	143	98	145	102	488

[1] Number originally documented for 1st Quarter of FY2007 was reported in error.
[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 28 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, 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, 52 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
Board of Nurse Examiners	4
Department of Aging and Disability Services	77
Federal Bureau of Investigation	13
Health & Human Services Commission - Office of Inspector General	120
Law Enforcement	5
Medicaid Fraud Control Unit Self-Initiated	84
National Association of Medicaid Fraud Control Units	4
Nursing Homes	6
Office of the Attorney General	10
Public	96
U.S. Department of Health and Human Services, Office of Inspector General	8
Other Agencies and Boards	7
Other	16
TOTAL	**450**

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 third and fourth quarters of fiscal year 2007 are as follows.

Action	3rd & 4th Quarters FY2007
Cases Opened	387
Cases Closed	330
Cases Presented	244
Criminal Charges Obtained	79
Convictions	66
Potential Overpayments Identified	28829
Misappropriations Identified	$190,663
Settlements	$35,398,575
Cases Pending	1296

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. 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	3rd & 4th Quarters FY2007
Pending Cases/Investigations	191
Cases Closed	8
Cases Opened	27

During this reporting period, CMF settled three cases:

1. State of Texas v. Harris County. Total recovery including both state and federal portions was $14,950,000.
2. State of Texas v. Emeritus. Total recovery was $1,857,612.91.
3. State of Texas v. Descant. Total recovery was $19,658.79.

CMF also opened a new case against Mylan Laboratories, Sandoz, Inc., and Teva Pharmaceuticals for pricing fraud. The allegations are that these defendants failed to provide correct drug pricing information to the Medicaid program, causing Medicaid to overpay for prescription drugs.

CMF continues to pursue significant cases against the following defendants:

1. Abbott Laboratories 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.

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.

Finally, the 2007 Texas Legislature approved a rider to expand CMF's budget to include an additional 41 staff members. The addition of these resources will greatly enhance CMF's ability to pursue Medicaid fraud litigation on behalf of the State of Texas.