Activities of the Health and Human Services Commission and the Office of the Attorney General in Detecting and Preventing Fraud, Waste, and Abuse in the State Medicaid Program

MEMORANDUM OF UNDERSTANDING

Pursuant to the requirements of Senate Bill 30 of the 75th Legislature, a memorandum of understanding (MOU), initially executed in April 1998, between the Office of Investigations and Enforcement (OIE) of the Texas Health and Human Services Commission (HHSC) and the Office of the Attorney General (OAG), was updated in October 2001 as it proved to be beneficial to both agencies. The updated MOU, initially limited to the HHSC's Medicaid Program Integrity Department (MPI) and the Medicaid Fraud Control Unit (MFCU) of the OAG, has now been expanded to include the Elder Law and Public Health Division (ELD) of the OAG. This change was necessary in that the OAG has designated ELD to investigate and prosecute civil Medicaid fraud and *qui tam* actions relating to Title XIX of the Social Security Act. The MOU facilitates the development and implementation of joint written procedures for processing cases of suspected fraud, abuse, or waste under the state Medicaid program. The MOU also insures cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases arising in the state.

INTERAGENCY COORDINATION EFFORT

HHSC and the OAG recognize the importance of regular communication and coordination in the fight against fraud and abuse in the Medicaid program. Monthly meetings between staff of the MPI and the MFCU formally began in May 1998. In the spring of 1999, the meetings were extended to twice a month and expanded to include the OAG's ELD as well as staff from the HHSC OIE Utilization Review Department (UR). Beginning in the fall of 2002, both agencies agreed to hold these meetings on a quarterly basis while continuing daily informal communication and referrals. The quarterly meetings focus on major initiatives to identify new trends in fraud, increase accountability, and further improve the working relationship between the two agencies.

In August 2002, the MFCU and MPI formulated a joint investigation strategy to combat fraud in the Medicaid case management program. A number of investigations are currently in progress by both agencies. Meetings are held on a routine basis to share information about the project.

THE HEALTH AND HUMAN SERVICES COMMISSION, OFFICE OF INVESTIGATIONS AND ENFORCEMENT

Senate Bill 30, enacted by the 75th Legislature, directed the Texas Health and Human Services Commission (HHSC) to create the Office of Investigations and Enforcement (OIE). Established to investigate fraud and abuse in the provision of health and human services and enforce state law relating to the provision of those services, the OIE 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.

Medicaid Program Integrity (MPI) is responsible for investigating allegations or complaints of Medicaid fraud, abuse, or misuse. This department investigates allegations, imposes sanctions, processes provider exclusions, and coordinates provider education. The MPI has primary responsibility for activities relating to investigation and administrative sanction of Medicaid provider fraud, abuse, and waste across all Texas state agency lines, regardless of where the provider contract is administered. MPI refers cases involving fraud or abuse of a criminal nature to the MFCU.

Utilization Review (UR) is responsible for monitoring utilization review activities in Medicaid contract hospitals. UR is also responsible for developing and implementing a statewide effective and efficient nursing home case mix assessment review program.

Systems Resources (SR) provides systems analysis support to OIE and its operating functions. SR serves as OIE's liaison with all health and human services agencies as it relates to the development, implementation, and operation of automated systems that support health and human services programs. SR manages the contract for the Medicaid Fraud and Abuse Detection System (MFADS).

Medicaid Fraud and Abuse Referrals Statistics

Medicaid Fraud, Abuse, and Waste Recoupments

Recoupments and dollars identified for recovery for the first and second quarters of fiscal year 2003 are as follows.

RECOUPMENTS BY OIE FOR FISCAL YEAR 2003 (1st and 2nd Quarters)

Office of Investigations and Enforcement Divisions	1st Quarter FY2003	2nd Quarter FY2003	TOTAL FY2003
Medicaid Program Integrity	$419,103	$1,320,284	**$3,353,883**
Civil Monetary Penalties	$26,038	$587,279	**$1,208,313**
Utilization Review (DRG-hospitals)	$6,067,632	$8,986,214	**$15,053,846**
TEFRA Claims – Children's Summary	$0	$21,555	**$21,555**
TEFRA Claims – Psychiatric Summary	$28,030	$4,440	**$32,470**
Case Mix Review (Nursing Homes)	$3,539,599	$3,178,648	**$6,718,247**
Surveillance and Utilization Review Subsystems (SURS)*	$51,778	*	**$51,778**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$447,936	$455,593	**$903,529**
TOTAL	**$10,580,116**	**$14,554,013**	**$25,134,129**

Note: Total recoupment dollars reflect all active cases within OIE.

*SURS—Dollars identified for recovery are shown in the chart on page 5. Actual recoupments will be reported in the quarter in which they are collected. SURS cases that are referred to Medicaid Program Integrity for full investigation are reflected in the MPI and civil monetary penalties recoupments.

RECOUPMENTS BY OIE FOR FISCAL YEAR 2003 (1st and 2nd Quarters)

Office of Investigations and Enforcement Divisions	1st Quarter FY2003	2nd Quarter FY2003	TOTAL FY2003
Third Party Liability and Recovery:			
Recoveries (Provider):			
• Other Insurance Credits*	$60,025,842	$65,545,232	**$125,571,074**
• Provider Refunds	$1,251,604	$1,921,755	**$3,173,359**
• Texas Automated Recovery System (TARS)	$3,307,079	$2,088,998	**$5,396,077**
• Recipient Refunds	$18	$0	**$18**
• Pharmacy	$2,921,510	$1,470,938	**$4,392,448**
Recoveries (Recipient):			
• Credit Balance Audit	$1,179,258	$4,963,814	**$6,143,072**
• Amnesty Letter	$0	$0	**$0**
• Tort	$5,805,534	$3,579,988	**$9,385,522**
TOTAL	**$74,490,845**	**$79,570,725**	**$154,061,570**

* Other insurance credits are estimated pending the completion of a data repair project.

RECOUPMENTS BY OIE FOR FISCAL YEAR 2003 (1st and 2nd Quarters)

Health and Human Services Divisions	1st Quarter FY2003	2nd Quarter FY2003	TOTAL FY2003
Medicaid Audits (cost settlement based on cost reimbursement methodology)*	$11,065,393*	$7,848,895*	**$18,914,288***
Vendor Drug:			
• Recoveries	$1,715,116	$2,462,445	**$4,177,561**
• Manufacturer Rebates	$83,964,138	$97,301,835	**$181,265,973**
Customer Services/Provider Resolutions	$26,868	$3,053	**$29,921**
TOTAL	**$96,771,515**	**$107,616,228**	**$204,387,743**

* Overpayments for Medicaid Audits are reported as net based on Cost Settlements. Managed care payment settlements are excluded from the calculation. Overpayments are calculated based on the difference in total interim payments and cost, less any previous settlements completed during the period.

DOLLARS IDENTIFIED FOR RECOVERY BY OIE FOR FISCAL YEAR 2003 (1st and 2nd Quarters)

Office of Investigations and Enforcement Divisions	1st Quarter FY2003	2nd Quarter FY2003	TOTAL FY2003
Medicaid Program Integrity - *dollars identified*	$2,033,599	$1,764,178	**$3,797,777**
Civil Monetary Penalties - *dollars identified*	$621,034	$568,352	**$1,189,386**
Surveillance and Utilization Review Subsystems (SURS) - *dollars identified*	NA	$86,055	**$86,055**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars identified*	$182,635	$108,287	**$290,922**
TOTAL	**$2,837,268**	**$2,526,872**	**$5,364,140**

NOTE: These amounts represent claims inappropriately paid based on policy and/or investigations. It does not represent the actual dollars that may be recoverable.

Medicaid Fraud, Abuse, and Waste Workload Statistics

OIE Workload statistics for the first and second quarters of fiscal year 2003 are as follows.

Action	1st Quarter FY2003	2nd Quarter FY2003	Total FY2003
Medicaid Program Integrity:			
• Cases Opened	193	336	**529**
• Cases Closed	92	221	**313**
• Providers Excluded	7	140	**147**
Utilization Review:			
• Case Mix (Nursing Homes) - Cases Closed	389	325	**714**
• Case Mix (Nursing Homes) - # of Reviews	8,008	6,540	**14,548**
• Hospitals - Cases Closed	342	345	**687**
• Hospitals - # of Reviews	8,736	12,013	**20,749**
Medicaid Fraud & Abuse Detection System:			
• # of Cases Identified	415	97	**512**

Action	1st Quarter FY2003			2nd Quarter FY2003		
LOCK-IN*:	Sept 02	Oct 02	Nov 02	Dec 02	Jan 03	Feb 03
• Fee-for-Service (FFS)	567	532	518	535	519	520
• STAR	313	302	316	312	290	310
• STAR+PLUS	74	72	74	75	77	75
TOTAL	**954**	**906**	**908**	**922**	**886**	**905**

***LOCK-IN:** CFR, Title 43, Volume 3, Section 431.54 (e) requires "Lock-in of recipients who over-utilize Medicaid services. If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only." The Texas Administrative Code, Title 45, Part I, Chapter 43 outlines the Texas Utilization Control Methods. Fee-for-Service clients can be limited to a doctor and/or pharmacy. Managed Care Organization members can be limited to a pharmacy. STAR+PLUS members were added to the Lock-in process on September 1, 2001.*

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 also 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)]

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. 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 does not conduct civil investigations, impose provider sanctions, or take administrative action against Medicaid providers. Its investigations are criminal; the penalties assessed against providers can include imprisonment, fines, and exclusion from the Medicaid program. The MFCU presents its cases to state and federal authorities for criminal prosecution.

Referral Sources

The MFCU receives referrals from a wide range of sources including concerned citizens, Medicaid recipients, current and former provider employees, other state agencies, and federal agencies. Although MFCU staff review every referral received, they cannot investigate each one. There are neither the human nor monetary resources to do so. Therefore, cases are prioritized. The MFCU strives for a blend of cases that are representative of Medicaid provider types.

Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the first and second quarters of fiscal year 2003 are as follows.

Action	1st and 2nd Quarters FY2003
Cases Opened	65
Cases Closed	66
Cases Presented	23
Criminal Charges Obtained	16
Convictions	19
Overpayments and Misappropriations Identified	$5,938,458.45
Cases Pending	329

OFFICE OF THE ATTORNEY GENERAL, ELDER LAW AND PUBLIC HEALTH DIVISION

In August of 1999, the Civil Medicaid Fraud Section within the OAG's ELD was created to investigate and prosecute civil Medicaid fraud cases under Chapter 36 of the Texas Human Resources Code (the Medicaid Fraud Prevention Act). Under the 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 ELD, 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 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" lawsuits, 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.

To date, the ELD has settled actions against three defendants in qui tam cases for $5,275,919 in damages and $2,075,000 in attorney's fees for a total of $7,350,919.

The section continues to aggressively prosecute a civil action against Warrick Pharmaceuticals, Dey, Inc. and Roxane Pharmaceuticals. The trial is set for August 2003. Investigations of other pharmaceutical companies for similar behavior continue.

Civil Medicaid Fraud Statistics

The ELD statistics for the first and second quarters of fiscal year 2003 are as follows.

Action	1st and 2nd Quarters FY2003
Total Cases on Docket	16
Cases Opened	3
Cases Closed	0
Total Investigations on Docket	13
Investigations Opened	2
Investigations Closed	0