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 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 provided by 12 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.

In addition, HB 2292 appropriated funding to expand the MFCU to up to 236 staff. The United States Department of Health and Human Services, Office of Inspector General, approved a staged expansion and matching federal grant funds to increase the unit to 208 by the end of fiscal year 2005. The grant application submitted for FY 2006 requested staffing for 215 positions strategically located around the state. The MFCU is currently staffed with 170 employees, including more than 40 commissioned peace officers. Field offices are open in Dallas, Houston, Lubbock, Tyler, El Paso, McAllen, San Antonio, and Corpus Christi.

MEMORANDUM OF UNDERSTANDING

The MOU between the MFCU and the HHSC-OIG was updated and expanded in November 2003, in accordance with HB 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 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 continued progress and success in this area, thanks to a renewed cooperative spirit and the efforts of both agencies. For example, the following has occurred in the last six months:

- Both agencies continue to uphold their commitment to promptly send and/or act upon referrals. The resultant working relationship between the two agencies is recognized by other states as highly effective.
- Monthly meetings continue between HHSC-OIG and MFCU staff to discuss referrals of cases and to conduct joint investigations.
- Communication on cases is consistent and ongoing throughout all staff levels, ensuring all case resources and knowledge are shared and efforts are not duplicated.
- Joint training across the two agencies continues. This reporting period included MFCU staff attendance at the Second Annual OIG Summit held in August 2005. HHSC-OIG Medicaid Provider Integrity investigators attended the National Association of Medicaid Fraud Control Unit's (NAMFCU) Introduction to Medicaid Fraud training in Dallas in April 2005.
- An agreement was signed allowing MFCU staff to use the HHSC-OIG mobile dental unit to conduct clinical examinations during the course of their criminal investigations of Medicaid dental providers.
- When appropriate, the same professional consultants are used to assist with strengthening and testifying in cases that require specific expertise.

THE HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

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). 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 provides 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 Inspectors General 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; and coordinating enforcement functions with other health and human services agencies, the OAG and the 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 MFCU; provides investigative support and technical assistance to other OIG divisions and some outside agencies; and 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; and 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, and 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, or workers compensation insurance; 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 FY2005 (3rd & 4th Quarters)

Referral Source	Received
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	27
Governor's Office	1
State Legislator	5
Center for Medicare Service (CMS)	1
Citizens Commission on Human Rights	1
Dallas District Attorney's Office	1
Health and Human Services – Office of Inspector General (HHS-OIG)	4
Texas Department of Aging & Disability Services (DADS)	33
Texas Health Steps	3
Texas Department of State Health Services (DSHS)	13
Texas Medicaid Healthcare Partnership (TMHP)	3
Texas Department of Mental Health and Mental Retardation (MHMR)	1
Law Enforcement Agency	1
Managed Care Organizations /SIU's	12
2003 PAM II Study (Comptroller's Office)	18
Parent/Guardian	6
Provider	24
Public	38
Recipient	96
Anonymous	31
Board of Dental Examiners	2
Board of Medical Examiners	28
Board of Nurse Examiners	129
Board of Pharmacy	3
HHSC – Audit Division	1
HHSC – Compliance	1
HHSC – General Investigations	3
HHSC – Internal Affairs	7
HHSC – Sanctions	2
HHSC – Medicaid/Chip Division	1
HHSC – MPI-OIG Self-initiated (MPI)	10
HHSC – Utilization Review	10
Surveillance, Utilization, Review System (SURS)	2
Vendor Drug	1
Total Cases Received:	**523**

WASTE, ABUSE, AND FRAUD REFERRALS SENT FY2005 (3rd & 4th Quarters)

Referral Source	Referred
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	64
Medicare Part A& B	4
Palmetto GBA	2
Health and Human Services – Office of Inspector General	2
Department of Family and Protective Services (DPRS)	1
Out of State	1
Texas Department of State Health Services	2
Texas Worker Compensation Commission	1
Board of Chiropractic Examiners	1
Board of Dental Examiners	13
Board of Medical Examiners	6
Board of Nurse Examiners	1
Board of Pharmacy	2
Board of Psychologists	1
Board of Social Worker Examiners	1
Claims Administrator – Educational Contract	41
HHSC – General Investigation	1
HHSC – Internal Affairs	1
HHSC – TPR	2
Vendor Drug	3
TOTAL:	**150**

Medicaid Fraud, Abuse, and Waste Workload Statistics and Recoupments

OIG workload statistics and recoupments for the third and fourth quarters of fiscal year 2005 are as follows.

Action	3rd Quarter FY2005	4th Quarter FY2005	Total FY2005
Medicaid Provider Integrity			
• Cases Opened	267	256	**736**
• Cases Closed	150	230	**549**
• Providers Excluded	53	102	**412**
Medicaid Fraud & Abuse Detection System [1]			
• Cases Opened	724	675	**1982**
• Cases Closed	354	780	**1825**
Office of Inspector General Recoupments	**3rd Quarter FY2005**	**4th Quarter FY2005**	**Total FY2005**
Sanctions [2]	$7,525,152	$768,198	**$46,828,148**

[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

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. The unit has grown to 170 employees during this reporting period. Of this number, over 40 are commissioned peace officers. Field offices are in operation in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio and Tyler. Cross-designated Special Assistant U.S. Attorneys (SAUSAs) have been hired to work 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 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. 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. The SAUSAs hired by the MFCU are gaining in experience in the federal system and in prosecuting white collar crime cases. 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 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
Administrators	2
Department of Aging and Disability Services	219
Federal Bureau of Investigation	14
Health and Human Services Commission	62
Law Enforcement	4
Medicaid Fraud Control Unit Self-Initiated	37
National Association of Medicaid Fraud Control Units	4
Public	92
U.S. Department of Health and Human Services, Office of Inspector General	6
Other State Agencies	5
Other	24
TOTAL	**469**

Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the third and fourth quarters of fiscal year 2005 are as follows.

Action	3rd & 4th Quarters FY2005
Cases Opened	465
Cases Closed	259
Cases Presented	65
Criminal Charges Obtained	52
Convictions	30
Potential Overpayments and Misappropriations Identified	$12,407,846.81
Settlements	$11,070,083
Cases Pending	803

OFFICE OF THE ATTORNEY GENERAL
ANTITRUST & CIVIL MEDICAID FRAUD DIVISION

Background and History

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 and 4th Quarters FY2005
Pending Cases/Investigations	128
Cases Closed	6
Cases Opened	27

Although there are now over 128 total cases/investigations listed on the docket, as a practical matter that number is significantly greater because, in more than one case or investigation, there are multiple potential defendants that most likely will each be separately civilly prosecuted.

One case was settled during this time period. In *United States of America and State of Texas, ex rel. Jennifer Hudnall v. ResCare, Inc.* et al., CV1154-H, U.S. Dist., Northern Dist. of Tex., Dallas Division, a settlement was reached with the defendants for a payment of $2,150,000. The case involved allegations of over-billing or false billing for mental health services.

CMF is continuing to litigate claims 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 May 2006. In addition, CMF has continued to pursue a case against Abbott Laboratories, Baxter, and B. Braun for false price reporting. This case will be set for trial no earlier than May 2006. Since the inception of CMF, a majority of its resources have been consumed by prosecution of pharmaceutical manufacturers for false price reporting, and this trend will continue for the foreseeable future. CMF continues its heavy involvement in multi-state cases or investigations against Medicaid providers.