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 plan to combat fraud in the Medicaid case management program. Both agencies developed a joint investigation strategy and currently are in the early stages of the project. Meetings are held on a routine basis to share information about the project.

Medicaid Fraud and Abuse Referrals Statistics

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

Medicaid Fraud, Abuse, and Waste Recoupments

Recoupments for the third and fourth quarters of fiscal year 2002 are as follows.

RECOUPMENTS BY OIE FOR FISCAL YEAR 2002 (3rd and 4th Quarters)

Office of Investigations and Enforcement Divisions	3rd Quarter FY2002	4th Quarter FY2002	TOTAL FY2002
Medicaid Program Integrity	$165,879	$2,750,126	**$2,916,005**
Civil Monetary Penalties	$0	$1,005,072	**$1,005,072**
Utilization Review (DRG-hospitals)*	$3,952,528	$9,743,362	**$13,695,890**
TEFRA Claims – Children's Summary*	$0	$0	**$0**
TEFRA Claims – Psychiatric Summary*	$0	$0	**$0**
Case Mix Review (Nursing Homes)	$1,817,625	$1,566,031	**$3,383,656**
Surveillance and Utilization Review Subsystems (SURS)	$132,316	$182,689	**$315,005**
Compliance Monitoring and Referral (CMR)	$1,858,298	$26,763	**$1,885,061**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$537,578	$654,591	**$1,192,169**
TOTAL	**$8,464,224**	**$15,928,634**	**$24,392,858**

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

* Due to problems incurred during the Compass 21 conversion of the DHS Mainframe and UR hospital application, the quarter sample master lists and worksheets where not produced until February 2002. Therefore, the regional staff was unable to complete the number of hospital reviews, which are routinely processed during the second and third quarter months. In addition, weekly processing by the DHS-MIS mainframe has encountered several system errors. As a result, monthly reports and recoupment for DRG changes have not occurred since March 2002. Therefore, the monthly recoupment dollars for DRG is less than normal for this time period.

Third Party Liability (OIE) FOR FISCAL YEAR 2002 (3rd and 4th Quarters)

Office of Investigations and Enforcement Divisions	3rd Quarter FY2002	4th Quarter FY2002	TOTAL FY2002
Third Party Liability and Recovery:			
Recoveries (Provider):			
• Other Insurance Credits*	$17,550,000	$26,550,000	**$44,100,000**
• Provider Refunds	$1,528,345	$950,744	**$2,479,089**
• Texas Automated Recovery System (TARS)	$2,773,791	$2,124,410	**$4,898,201**
• Recipient Refunds	$0	$0	**$0**
• Pharmacy	$0	$3,399,925	**$3,399,925**
Recoveries (Recipient):			
• Credit Balance Audit	$1,499,663	$2,156,688	**$3,656,351**
• Amnesty Letter	$0	$0	**$0**
• Tort	$4,809,163	$5,216,023	**$10,025,186**
TOTAL	**$28,160,962**	**$40,397,790**	**$68,558,752**

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

OTHER HHSC RECOUPMENTS FOR FISCAL YEAR 2002 (3rd and 4th Quarters)

Health and Human Services Divisions	3rd Quarter FY2002	4th Quarter FY2002	TOTAL FY2002
Medicaid Audits (cost settlement based on cost reimbursement methodology)*	$6,577,209*	$3,691,960*	**$10,269,169***
Vendor Drug:			
• Recoveries	$1,630,075	$1,664,424	**$3,294,499**
• Manufacturer Rebates	$81,707,649	$84,472,982	**$166,180,631**
Customer Services/Provider Resolutions	$30,805	$15,183	**$45,988**
TOTAL	**$89,945,738**	**$89,844,549**	**$179,790,287**

* 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.

Medicaid Fraud, Abuse, and Waste Workload Statistics

OIE Workload statistics for the third and fourth quarters of fiscal year 2002 are as follows.

Action	3rd Quarter FY2002	4th Quarter FY2002	Total FY2002
Medicaid Program Integrity:			
• Cases Opened	243	235	**478**
• Cases Closed	162	399	**561**
• Providers Excluded	48	250	**298**
Utilization Review:			
• Case Mix (Nursing Homes) - Cases Closed	345	238	**583**
• Case Mix (Nursing Homes) - # of Reviews	6,664	4,553	**11,217**
• Hospitals - Cases Closed	335*	587*	**922***
• Hospitals - # of Reviews	6,861	11,548	**18,409**
Medicaid Fraud & Abuse Detection System:			
• # of Cases Identified	545	880	**1,425**
• Dollars Identified for Recovery **This amount represents claims inappropriately paid based on policy and/or investigations. It does not represent the actual dollars that may be recoverable.	**$190,090	**$1,380,366	****$1,570,456**

* Due to problems incurred during the Compass 21 conversion of the DHS Mainframe and UR hospital application, the quarter sample master lists and worksheets where not produced until February 2002. Therefore, the regional staff was unable to complete the number of hospital reviews, which are routinely processed during the second quarter months. In addition, the DHS Mainframe system was shut down on 10/31/01, and was not available for data entry until 01/18/02. Since that time the weekly processing has encountered several system errors, resulting in the monthly numbers for January and February to be less than normal.

Action	3rd Quarter FY2002	4th Quarter FY2002	Total FY2002
Customer Services/Provider Resolutions:			
• Cases Closed (appeal/complaint cases)	1,910	2,371	**4,281**
• # of Administrative/Agency Hearings (oral appeals-offered instead of informal hearing for HHSC UR cases only)	10	1	**11**

Other Statistics for Fiscal Year 2002:

Action	3rd Quarter FY2002			4th Quarter FY2002		
LOCK-IN*:	Mar 02	Apr 02	May 02	June 02	July 02	Aug 02
• Fee-for-Service (FFS)	530	567	551	552	538	556
• STAR	308	331	340	343	326	312
• STAR+PLUS	3	4	8	22	37	62
TOTAL	**841**	**902**	**899**	**917**	**901**	**930**

***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 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.*

Medicaid Program Integrity Department Responsibilities

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. Other divisions within OIE focus on detection and prevention of Medicaid provider fraud, abuse, and waste while insuring quality of care for Medicaid recipients in Texas.

Medicaid Program Integrity Department Referral Sources

The MPI receives complaints and referrals from a variety of sources and develops those complaints or referrals as appropriate. Examples of these sources include:

- OAG/MFCU;
- OAG/ELD;
- Health Facility Compliance;
- Texas Department of Human Services/Office of Inspector General;
- State Board of Licensed Vocational Nurse Examiners;
- State Board of Medical Examiners;
- State Board of Nurse Examiners;
- Texas Commission on Alcohol and Drug Abuse;
- Texas Pharmacy Board;
- State Board of Psychiatry;
- Long Term Care, TDHS;
- Medical Appeals, TDH;
- Managed Care, TDH;
- Providers or Provider's Employees;
- Public (i.e., recipients);
- Self Initiated, HHSC/MPI/OIE;
- Explanation of Benefits;
- State Dental Director;
- HHSC/OIE/UR;
- Vaccine for Children, TDH;
- State Board of Dental Examiners;
- Legislative Inquiries;
- National Heritage Insurance Company;
- MFADS; and
- Other Medicaid Operating Agencies (i.e., individual program areas, audit, cost report area, regional workers, utilization reviews).

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 may 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 third and fourth quarters of fiscal year 2002 are as follows.

Action	3rd and 4th Quarters FY2002
Cases Opened	100
Cases Closed	69
Cases Presented	35
Criminal Charges Obtained	23
Convictions	24
Overpayments and Misappropriations Identified	$7,193,469
Cases Pending	330

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

In August of 1999, Attorney General John Cornyn created the Civil Medicaid Fraud Section within the OAG's ELD. Prior to that time, although the ELD was responsible for investigating and prosecuting civil Medicaid fraud cases under Chapter 36 of the Texas Human Resources Code (the Medicaid Fraud Prevention Act), the OAG had relatively few investigations, and no lawsuits, regarding civil Medicaid fraud.

With the creation of the Civil Medicaid Fraud Section, the OAG has dedicated the resources and efforts of the ELD to fight fraud, waste, and abuse in the Medicaid system. 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 October 2003. Investigations of other pharmaceuticals for similar behavior continue.

Civil Medicaid Fraud Statistics

The ELD statistics for the third and fourth quarters of fiscal year 2002 are as follows.

Action	3rd and 4th Quarters FY2002
Total Cases on Docket	13
Cases Opened	4
Cases Closed	1
Total Investigations on Docket	11
Investigations Opened	8
Investigations Closed	1