Pursuant to §531.103, Texas Government Code, as adopted by Senate Bill 30, 75th Legislature, 1997

# 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 under Senate Bill 30 of the 75th Legislature, a memorandum of understanding (MOU) executed in April 1998 between the Office of Investigations and Enforcement (OIE), Texas Health and Human Services Commission (HHSC), and the Office of the Attorney General (OAG), proves to be beneficial to both agencies. It assists in clarifying the roles and expectations between the HHSC's Medicaid Program Integrity Department (MPI) and the Medicaid Fraud Control Unit (MFCU) of the OAG in their collective mission to detect and prevent fraud, waste, and abuse in the Medicaid program.

The OAG's Elder Law and Public Health Division (ELD), which is responsible for investigating and prosecuting civil Medicaid fraud claims, entered into a separate MOU with the HHSC. This agreement, required by sections 531.103 and 531.104 of the Texas Government Code, delineates both agencies' roles in handling civil fraud claims under the Medicaid Fraud Prevention Act, found in Chapter 36 of the Human Resources Code.

## INTERAGENCY COORDINATION EFFORT

The two agencies recognize the importance of regular communication in presenting a united front in the fight against healthcare fraud and abuse in the Medicaid program. Monthly meetings between staff of the MPI and the MFCU formally began in May 1998. The communication that these meetings established helps to identify new trends in fraud, increases accountability, and generally improves the working relationship between the two agencies. In the spring of 1999, the meetings were increased to twice monthly and expanded to include the OAG's ELD as well as staff from the HHSC OIE Utilization Review Department (UR).

In addition to participating in the regular meetings between the MPI and the MFCU, the ELD has begun working closely with the staff of the MPI and the MFCU to develop procedures for referring potential civil Medicaid fraud matters to the ELD.

# Medicaid Fraud and Abuse Referrals Statistics

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

### Medicaid Fraud, Abuse, and Waste Referral Statistics

Statistics for the third and fourth quarters of Fiscal Year 2000 are as follows.

| Action | 3rd Quarter | 4th Quarter | Total |
|---|---|---|---|
| Cases Opened | 193 | 383 | 576 |
| Cases Closed | 329 | 276 | 605 |
| Providers Excluded | 89 | 209 | 298 |

### Medicaid Fraud, Abuse, and Waste Recoupments

Recoupments for the third and fourth quarters of Fiscal Year 2000 are as follows.

| Office of Investigations and Enforcement | 3rd Quarter | 4th Quarter | Total |
|---|---|---|---|
| Medicaid Program Integrity | $2,295,597 | $856,084 | $3,151,681 |
| Civil Monetary Penalties | $19,000 | $48,897 | $67,897 |
| Utilization Review (DRG-hospitals) | $10,890,436 | $7,463,139 | $18,353,575 |
| Case Mix Review (nursing homes) | $2,437,123 | $2,070,686 | $4,507,809 |
| Tax Equity & Fiscal Responsibility Act Claims | $199,836 | $15,372 | $215,208 |
| Compliance Monitoring & Referral | $4,089,404 | $2,319,174 | $6,408,578 |
| Surveillance and Utilization Review Subsystems | $310,225 | $373,802 | $684,027 |
| Medicaid Fraud and Abuse Detection System (MFADS) - *dollars identified for recovery* | $427,085* | $2,154,817* | $2,581,902* |
| MFADS - *dollars recovered* | $1,011,569 | $1,114,159 | $2,125,728 |
| **TOTAL** | **$21,680,275** | **$16,416,130** | **$38,096,405** |

** This amount represents claims inappropriately paid based on policy and/or investigations. It does not represent the actual dollars that may be recoverable.*

## Medicaid Program Integrity Department Responsibilities

The MPI has primary responsibility for activities relating to the detection, investigation, and sanction of Medicaid provider fraud, abuse, waste, and neglect across all Texas state agency lines, regardless of where the provider contract is administered. For purposes of Medicaid provider fraud, abuse, waste, and neglect, it acts as the HHSC's liaison with the following state and federal agencies:

- OAG/MFCU;
- OAG/ELD;
- OAG Consumer Protection Division;
- U.S. Department of Health and Human Services (HHS);
- U.S. Health Care Financing Administration;
- Federal Bureau of Investigation;
- Drug Enforcement Agency;
- Texas Department of Public Safety;
- Medicare Fiscal Intermediaries: Blue Cross of Texas, Palmetto;
- Medicaid Insuring Agent: National Heritage Insurance Company;
- Texas Department of Health (TDH);
- Texas Department of Human Services (TDHS); and
- Texas Department of Mental Health and Mental Retardation.

## 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).

## Medicaid Program Integrity Department Complaints and Referrals Case Development

The MPI conducts a preliminary investigation on all complaints and referrals alleging Medicaid provider fraud or abuse or historical non-compliance. If this preliminary investigation produces evidence of provider program abuse, the investigation continues. By federal law, 42CFR§455.15 and §455.21, all cases of suspected provider fraud are to be referred to MFCU.

## Medicaid Program Integrity Department Administrative Penalties

The HHSC's MPI has the authority to impose provider sanctions that could include:

- Exclusion from Medicare and Medicaid programs for a specified period of time;
- Suspension of payments;
- Recoupment of overpayments;
- Recoupment of projected overpayments (determined through a sampling process);
- Restricted reimbursement; and
- Civil monetary penalties.

The MPI also may take administrative actions against providers that could include:

- Referral to peer review outside the HHSC;
- Attendance at provider education sessions;
- Prior authorization of selected services;
- Review of all services before and/or after payment;
- Referral to appropriate licensing board;
- Referral to the U. S. HHS, including referrals for action under the Federal Civil Monetary Penalties Law;
- Posting of surety bonds;
- Attendance at provider corrective action meetings;
- Oral, written, or personal education contact; and
- Referral for recovery through judicial means.

## OFFICE OF THE ATTORNEY GENERAL, MEDICAID FRAUD CONTROL UNIT

The MFCU has been conducting 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, ambulance companies, laboratories, podiatrists, nursing home administrators and staff--in the Medicaid arena. Common investigations include assaults and criminal neglect of patients by Medicaid providers or occurring in a Medicaid facility, fraudulent billings by Medicaid providers, misappropriation of patient trust funds, drug diversion by Medicaid providers and/or their employees, 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 stakes for providers are imprisonment and fines. Because the MFCU does not have prosecutorial authority, its cases are presented to state and federal authorities for criminal prosecution. Once referred, these prosecutors determine whether a case will be accepted or declined for prosecution. And once a case is accepted, the prosecuting authority determines the course of the case.

## Referral Sources

The MFCU receives referrals from a wide range of sources--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 or monetary resources to do so. Therefore cases are prioritized. Even then, there may only be enough resources to look at a slice of the Medicaid provider's activity. The MFCU strives for a blend of simple and complex cases, and big and small cases representative of Medicaid provider types.

## Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the third and fourth quarters of Fiscal Year 2000 are as follows.

| Action | 3rd and 4th Quarters FY2000 |
|---|---|
| Cases Opened | 81 |
| Cases Closed | 95 |
| Cases Presented | 30 |
| Criminal Charges Obtained | 17 |
| Convictions | 15 |
| Overpayments and Misappropriations Identified | $2,848,291.05 |
| Cases Pending | 312 |

## 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 fighting 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 – the "relator" – is entitled to a percentage of the total recovery.

In its brief existence, the Civil Medicaid Fraud Section has already begun receiving referrals from the HHSC, and has also received a handful of "qui tam" lawsuits. The OAG intends to dedicate a significant level of resources towards these civil Medicaid fraud efforts, and will increase those resources as necessary to accomplish the purposes of the Medicaid Fraud Prevention Act.