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), 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), 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 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). The communication that these meetings established helps identify new trends in fraud, increases accountability, and improves the working relationship between the two agencies.

In 1999, Attorney General John Cornyn formed the Civil Medicaid Fraud and Collection Section. Until that time, the provisions of the Medicaid Fraud Prevention Act of 1995 had not been actively used. HHSC OIE has fully cooperated with the efforts of the new section.

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 first and second quarters of fiscal year 2001 are as follows.

RECOUPMENTS BY OIE FOR FISCAL YEAR 2001 (1st and 2nd Quarters)

Office of Investigations and Enforcement Departments	1st Quarter FY2001	2nd Quarter FY2001	Total
Medicaid Program Integrity	$816,507	$286,177	**$1,102,684**
Civil Monetary Penalties	$81,537	$0	**$81,537**
Utilization Review-DRG (hospitals)	$7,258,733	$6,413,153	**$13,671,886**
Utilization Review- Tax Equity & Fiscal Responsibility Act (TEFRA) – Children's Summary	$20,895	$7,534	**$28,429**
Utilization Review- Tax Equity & Fiscal Responsibility Act (TEFRA) – Psychiatric Summary	$23,058	$61,488	**$84,546**
Case Mix Review (nursing homes)	$2,245,274	$2,691,674	**$4,936,948**
Surveillance and Utilization Review Subsystems (SURS)	$151,956	$193,720	**$345,676**
Compliance Monitoring and Referral	$2,454,753	$2,596,567	**$5,051,320**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$630,052	$304,249	**$934,301**
TOTAL	**$13,054,388**	**$12,585,831**	**$25,640,219**

Note: Total recoupment dollars reflect all active cases within OIE. Investigations refer only to active, full, fraud and abuse investigations.

Medicaid Fraud, Abuse, and Waste Referral Statistics

Statistics for the first and second quarters of fiscal year 2001 are as follows.

Action	1st Quarter FY2001	2nd Quarter FY2001	Total
Medicaid Program Integrity			
• Cases Opened	103	241	**344**
• Cases Closed	97	135	**232**
• Providers Excluded	46	56	**102**
Utilization Review			
• Case Mix (nursing homes) – Cases Closed	362	355	**717**
• Case Mix (nursing homes) – Number of Reviews	6,244	5,916	**12,160**
• Hospitals – Cases Closed	349	345	**694**
• Hospitals - Number of Reviews	9,267	9,832	**19,099**
Medicaid Fraud & Abuse Detection System			
• Number of Cases Identified	4	626	**630**
• 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. NOTE: *Focus during 1st quarter FY01 was on finalizing and closing old cases.*	$675*	$335,518*	**$336,193***

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.

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. 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 such as 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 2001 are as follows.

Action	1st and 2nd Quarters FY2001
Cases Opened	74
Cases Closed	87
Cases Presented	44
Criminal Charges Obtained	20
Convictions	15
Overpayments and Misappropriations Identified	$9,408,040.80
Cases Pending	299

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, known as the "relator," is entitled to a percentage of the total recovery.

In the first two quarters of fiscal year 2001, the Civil Medicaid Fraud Section settled a lawsuit with Bayer Corporation, which will provide a recovery for the State of Texas of $783,564 in the next quarter of fiscal year 2001. In addition, suit was filed against Warrick Pharmaceuticals, Dey, Inc., and Roxanne Pharmaceuticals seeking approximately $79 million in damages and penalties. This section continues its investigation of pharmaceutical companies and drug manufacturers.

Civil Medicaid Fraud Statistics

The ELD statistics for the first and second quarters of fiscal year 2001 are as follows.

Case/Investigation Actions	1st and 2nd Quarters FY2001
Total Cases on Docket	9
Cases Opened	2
Cases Closed	0
Total Investigations on Docket	1
Investigations Opened	2
Investigations Closed	2