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 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 delineates both agencies' roles in handling civil fraud claims under the Medicaid Fraud Prevention Act, found in Chapter 36 of the Human Resources Code. These two separate documents were incorporated into one MOU, which was executed in October 2001. This document clarifies and reaffirms the roles of the agencies.

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 2002 are as follows.

RECOUPMENTS BY OIE FOR FISCAL YEAR 2002 (1st and 2nd Quarters)

Office of Investigations and Enforcement Departments	1st Quarter FY2002	2nd Quarter FY2002	Total
Medicaid Program Integrity	$5,124,723	$257,906	**$5,382,629**
Civil Monetary Penalties	$944,801	$72,968	**$1,017,769**
Utilization Review-DRG (hospitals)	$5,059,154	$2,205,042	**$7,264,196**
Utilization Review- Tax Equity & Fiscal Responsibility Act (TEFRA) – Children's Summary	$2,985	$20,869	**$23,854**
Utilization Review- Tax Equity & Fiscal Responsibility Act (TEFRA) – Psychiatric Summary	$0	$2,834	**$2,834**
Nursing Home Reviews	$2,454,842	$1,919,770	**$4,374,612**
Surveillance and Utilization Review Subsystems (SURS)	$464,089	$223,012	**$687,101**
Compliance Monitoring and Referral	$2,216,641 (CARTS only)	$224,782 (CARTS only)	**$2,441,423**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$578,426	$430,053	**$1,008,479**
TOTAL	**$16,845,661**	**$5,357,236**	**$22,202,897**

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

RECOUPMENTS BY OIE FOR FISCAL YEAR 2002 (1st and 2nd Quarters)

Office of Investigations and Enforcement Departments	1st Quarter FY2002	2nd Quarter FY2002	Total
Third Party Liability and Recovery:			
Recoveries (Provider):			
• Provider Refunds	$951,031	$1,493,318	**$2,444,349**
• Texas Automated Recovery System (TARS)	$2,646,468	$1,749,698	**$4,396,166**
• Recipient Refunds	$0	$765	**$765**
• Pharmacy	$452,183	$2,518,203	**$2,970,386**
Recoveries (Recipient):			
• Credit Balance Audit	$895,316	$6,749,504	**$7,644,820**
• Amnesty Letter	$45	$363	**$408**
• Tort	$5,158,216	$4,386,234	**$9,544,450**
TOTAL	**$10,103,259**	**$16,898,085**	**$27,001,344**

RECOUPMENTS BY OIE FOR FISCAL YEAR 2002 (1st and 2nd Quarters)

Office of Investigations and Enforcement Departments	1st Quarter FY2002	2nd Quarter FY2002	Total
Medicaid Audits (cost settlement based on cost reimbursement methodology)*	$41,704,036	$3,343,601	**$45,047,637**
Vendor Drug:			
• Recoveries	$1,617,619	$1,898,758	**$3,516,377**
• Manufacturer Rebates	$79,937,663	$71,912,282	**$151,849,945**
Customer Services/Provider Resolutions	$25,881	$43,625	**$69,506**
TOTAL	**$123,285,199**	**$77,198,266**	**$200,483,465**

* 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 Referral Statistics

Statistics for the first and second quarters of fiscal year 2002 are as follows.

Action	1st Quarter FY2002	2nd Quarter FY2002	Total
Medicaid Program Integrity			
• Cases Opened	157	151	**308**
• Cases Closed	134	138	**272**
• Providers Excluded	81	19	**100**
Utilization Review			
• Nursing Homes – Cases Closed	317	403	**720**
• Nursing Homes – Number of Reviews	5,781	7,635	**13,416**
• Hospitals – Cases Closed	363	139*	**502**
• Hospitals - Number of Reviews	5,083	2,693*	**7,776**
Medicaid Fraud & Abuse Detection System			
• Number of Cases Identified	108	853	**961**
• 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.	$32,187**	$1,487,689**	**$1,519,876****

* 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	1st Quarter FY2002	2nd Quarter FY2002	Total
Customer Services/Provider Resolutions			
• Cases closed (appeal/complaint cases)	2,563	1,628	**4,191**
• # of Administrative/Agency Hearings (oral appeals-offered instead of informal hearing for HHSC UR cases only)	14	8	**22**

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. 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 2002 are as follows.

Action	1st and 2nd Quarters FY2002
Cases Opened	72
Cases Closed	75
Cases Presented	31
Criminal Charges Obtained	19
Convictions	17
Overpayments and Misappropriations Identified	$13,289,695.46
Cases Pending	300

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 second quarter of fiscal year 2002, the OAG settled a qui tam case filed against TAP Pharmaceuticals for the payment of $3,466,356,01. After payment of the federal share and the realtor's share, Texas recovered $1,347,867.91. In addition, the OAG settled a qui tam case filed against Bayer, Inc. for the payment of $783,684.00. After payment of the federal share and relator's share, Texas recovered $666,029.40.

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 continues.

Civil Medicaid Fraud Statistics

The ELD statistics for the first and second quarters of fiscal year 2002 are as follows.

Actions	1st and 2nd Quarters FY2002
Total Matters	19
Total Cases on Docket	12
Cases Opened	3
Cases Closed	1
Total Investigations on Docket	7
Investigations Opened	4
Investigations Closed	0