Joint Semi-Annual Interagency Coordination Report by the

Office of the Attorney General

and the

Texas Health and Human Services Commission

First and Second Quarters
Fiscal Year 2000
September 1, 1999 - February 29, 2000

Joint Semi-Annual
Interagency Coordination Report

by the

Medicaid Fraud Control Unit
and
Elder Law and Public Health
Office of the Attorney General

and the

Office of Investigations and Enforcement
Texas Health and Human Services Commission

Pursuant to
Texas Government Code §531.103

First and Second Quarters of Fiscal Year 2000
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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 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 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 at Chapter 36 of the Human Resources Code.

Beginning with Fiscal Year 2000, the agreement between HHSC and ELD will be merged into the MOU between HHSC and MFCU. Thus, there will be one agreement, covering numerous matters, between HHSC and OAG.

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 MFCU formally began in May 1998. The communication that these meetings established helped to identify new trends in fraud, increased accountability, and generally improved 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 Elder Law and Public Health Division (ELD) as well as staff from OIE's utilization review program.

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

Medicaid Fraud and Abuse Referrals Statistics

HHSC's MEDICAID FRAUD, ABUSE, AND WASTE REFERRAL STATISTICS

The Health and Human Services Commission's Office of Investigations and Enforcement statistics for the first and second quarters of Fiscal Year 2000 are as follows.

Action	1st Quarter	2nd Quarter	Total
Cases Opened	544	143	687
Cases Closed	382	877	1259
Providers Excluded	0	0	0

HHSC's MEDICAID FRAUD, ABUSE, AND WASTE RECOUPMENTS

The Health and Human Services Commission's Office of Investigations and Enforcement recoupments for the first and second quarters of Fiscal Year 2000 are as follows.

Office of Investigations and Enforcement Departments	1st Quarter	2nd Quarter	TOTAL
Medicaid Program Integrity	$896,072	$4,928,772	$5,824,844
Utilization Review (DRG-hospitals)	$6,892,000	$6,263,086	$13,155,086
Case Mix Review (nursing homes)	$744,038	$1,838,412	$2,582,450
TEFRA Claims	$41,245	$105,888	$147,133
Compliance Monitoring & Referral	$3,541,561	$2,596,336	$6,137,897
Surveillance and Utilization Review Subsystems (SURS)	$433,437	$309,395	$742,832
Medicaid Fraud and Abuse Detection System (MFADS)	$2,964,623*	$562,379*	$3,527,002
TOTAL	**$15,512,976**	**$16,604,268**	**$32,117,244**

** 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

The Medicaid Program Integrity Department (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 Commission's liaison with the following state and federal agencies:

- Office of the Attorney General's (OAG) Medicaid Fraud Control Unit;
- OAG Elder Law and Public Health Division;
- OAG Consumer Protection Division;
- U.S. Department of Health and Human Services (HHS);
- U.S. Health Care Financing Administration (HCFA);
- Federal Bureau of Investigation (FBI);
- Drug Enforcement Agency (DEA);
- Texas Department of Public Safety (DPS);
- Medicare Fiscal Intermediaries: Blue Cross of Texas, Palmetto;
- Medicaid Insuring Agent: National Heritage Insurance Company (NHIC);
- Texas Department of Health (TDH);
- Texas Department of Human Services (TDHS); and
- Texas Department of Mental Health and Mental Retardation (MHMR);

MEDICAID PROGRAM INTEGRITY REFERRAL SOURCES

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

- OAG Medicaid Fraud Control Unit;
- OAG Elder Law and Public Health Division;
- Health Facility Compliance;
- Texas Department of Health and 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, MPI, OIE;
- Explanation of Benefits (EOB);
- State Dental Director;
- Utilization Review Division, OIE;
- Vaccine for Children, TDH;
- State Board of Dental Examiners;
- Legislative inquiries;
- National Heritage Insurance Company;
- Medicaid Fraud and Abuse Detection System (MFADS); and
- Other Medicaid operating agencies (i.e. individual program areas, audit, cost report area, regional workers, utilization reviews).

MEDICAID PROGRAM INTEGRITY COMPLAINTS AND REFERRALS CASE DEVELOPMENT

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 the Medicaid Fraud Control Unit of the Office of the Attorney General.

MEDICAID PROVIDER SANCTIONS/ADMINISTRATIVE PENALTIES

HHSC's Medicaid Program Integrity (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.

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

- Referral to peer review outside the Commission;
- 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. Department of Health and Human Services, 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'S MEDICAID FRAUD CONTROL UNIT

The Medicaid Fraud Control Unit (MFCU) of the Office of the Attorney General of Texas (OAG) 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 unit conducts criminal investigations into allegations of fraud, physical abuse, and criminal neglect by Medicaid providers--for example, 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 unit 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. The unit does not have prosecutorial authority. The unit's 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.

MFCU'S REFERRAL SOURCES

The Medicaid Fraud Control Unit receives referrals from a wide range of sources--concerned citizens, Medicaid recipients, current and former provider employees, other state agencies, and federal agencies. Although unit 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 unit strives for a blend of simple and complex cases, and big and small cases representative of Medicaid provider types.

MFCU's MEDICAID FRAUD AND ABUSE REFERRAL STATISTICS

The Medicaid Fraud Control Unit statistics for the first and second quarters of Fiscal Year 2000 are as follows.

Action	1st and 2nd Quarters FY2000
Cases Opened	92
Cases Closed	77
Cases Presented	34
Criminal Charges Obtained	23
Convictions	17
Overpayments and Misappropriations Identified	$5,426,982.44
Cases Pending	326

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 OAG's Elder Law and Public Health Division (ELD). Prior to that time, although 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), OAG had relatively few investigations – and no lawsuits – regarding *civil* Medicaid fraud.

With the creation of the Civil Medicaid Fraud Section, OAG has dedicated the resources and efforts of the Elder Law and Public Health Division 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. 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, OAG is responsible for determining whether or not to prosecute the action on behalf of the State. If OAG does not intervene, the lawsuit is dismissed. On the other hand, if 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 HHSC, and has also received a handful of "qui tam" lawsuits. 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.