Joint Annual Interagency Coordination Report

Office of the Attorney General
Medicaid Fraud Control Unit
Civil Medicaid Fraud Division

Inspector General
Texas Health and Human Services

State Fiscal Year 2018

September 1, 2017 - August 31, 2018

OAG and OIG Joint Annual Interagency Coordination Report

State Fiscal Year 2018

Introduction

This joint interagency report between the Health and Human Services Commission (HHSC) Office of Inspector General (OIG) and the Office of the Attorney General (OAG) is pursuant to Texas Government Code §531.103(c). The report summarizes statistical data and other information involving the collective efforts of the OIG and OAG to identify and deter fraud, waste, and abuse in the state Medicaid program for the period of September 1, 2017, through August 31, 2018.

The OIG, the OAG Medicaid Fraud Control Unit (MFCU), and OAG Civil Medicaid Fraud Division (CMF) recognize the critical importance of collaboration and regular communication in the ongoing coordinated effort to identify and deter fraud, waste, and abuse in the Medicaid program. The OIG, MFCU, and CMF have worked closely to strengthen collaboration efforts and opportunities during the reporting period through:

- Meetings between the MFCU Director and the Inspector General and key OIG staff.
- Regular meetings involving MFCU and OIG investigation and litigation staff to focus resources and efforts on (a) specific cases under investigation to maximize recoveries and minimize provider abrasion and duplicative efforts, and (b) unusual provider billing trends and other concerning provider activity.
- Dedicated attorney and analyst resources to support and coordinate efforts of MFCU and CMF involving violations of both the state and federal false claims acts and multi-state settlement negotiations.

Highlights of Coordination Activities

The OIG and OAG are committed to collaboration and coordination in all aspects of the joint efforts to identify and deter fraud, waste, and abuse in the Medicaid Program. These efforts range from the alignment of cross-agency processes to opportunities for management and staff at OIG and MFCU to participate in joint training opportunities. A brief summary of the collaboration and coordination activities during the current report period include:

- Expanded cross-agency processes to recoup provider overpayments when no criminal charges are filed, and to de-conflict overlapping administrative and criminal investigations. Continued use of a “request & response” shared spreadsheet maintained by dedicated

personnel of OIG staff and MFCU to track evidence requests and process de-confliction requests.

- Quick response by OIG Medicaid Program Integrity supervisors and MFCU field office supervisors to schedule *ad hoc* telephone conferences to discuss pros and cons of parallel investigations when there is a subject matter overlap.
- Drafting and approval of a new memorandum of understanding (MOU) among HHSC-OIG, MFCU, and CMF. An updated MOU every five years is a federal requirement for MFCU's and Medicaid single-state agencies.
- Continuation of sharing MFCU closed case report with the OIG to assist identification of the correct provider name when restitution checks are received from court agencies that only reference a single defendant name.
- Submission of a recommendation to HHSC Long-term Care (formerly DADS) to review the HHSC-OIG as well as federal HHS-OIG exclusion list prior to issuing or renewing a nursing home administrator license.
- MFCU continues to coordinate and accept assistance from OIG when data requests from managed care organizations are not received within the agreed time frame.
- Participation of OIG personnel in a three day statewide MFCU healthcare fraud training conference held in San Marcos, TX.
- Joint participation with the managed care organization special investigative units (SIUs) and the Texas Fraud Prevention Partnership. The focus of these collaborative efforts is to coordinate among the OIG, MFCU, and the Medicaid health and dental managed care organizations in conducting fraud detection operations to deter fraud, waste, and abuse.
- Joint participation in quarterly managed care organization SIU meetings to share information, best practices, and exchange information on cases of mutual interest.

Key Metrics

The activities in the latest annual reporting period reflect progress and success in identifying and deterring fraud, waste, and abuse in the Medicaid program. The following activities reflect the efforts in fiscal year18.

HHSC Inspector General

Action	FY 2018
Provider Enrollment Screenings Completed	70,800
Investigation Cases Opened	2,391
Investigation Cases Closed	2,266

Referrals to MFCU	517
Referrals to Other Entities	1,183
Hospital Claim Reviews Completed	39,041
Nursing Facility Onsite Reviews	581
Settlement Agreements Executed	27
Credible Allegation of Fraud provider payment holds imposed	0
Medicaid Providers Excluded	257
Audits Completed	40
Total Amount Recovered	$115,468,712

OAG Medicaid Fraud Control Unit

Action	FY 2018
Referrals Received	1,584
Cases Pending	1,342
Cases Opened	528
Charges Obtained	82
Medicaid Overpayments Identified	$64,391,849.50
Convictions	69
Fines and Restitution	$139,385,275.11*

*Medicaid = $10,688,985.46; non-Medicaid = $128,696,289.65

OAG Civil Medicaid Fraud (CMF) Division

Action	Total FY 2018
Cases Opened	86
Cases Closed	102
Cases Pending	456
Total Amount Recovered	$185,688,277.89

During fiscal year 2018, CMF settled and recovered funds in 6 matters with recoveries of $2 million or higher. These include:

1. State of Texas ex rel Zayas v. Astrazeneca - Total recovery including state, federal, and relator portions was $90,000,000.

2. United States and Texas et al ex rel Sanofi v. Mylan - Total recovery including state, federal, and relator portions was $30,578,043.
3. State of Texas ex rel Foote v. Astrazeneca - Total recovery including state, federal, and relator portions was $20,000,000.
4. State of Texas ex rel Weathersby v. Endo - Total recovery including state, federal, and relator portions was $13,750,000.
5. United States and Texas ex rel. Rai v. Kool Smiles - Total recovery including state, federal, and relator portions was $12,090,830.
6. United States and Texas ex rel Anthony v. Health Services Management - Total recovery including state, federal, and relator portions was $2,615,000.

CMF continues to pursue significant cases against the following defendants:

1. Xerox Corporation and its subsidiaries for misrepresentations made to the Texas Medicaid program concerning the prior approval process for orthodontia while Xerox was the Claims Administrator for Texas Medicaid.
2. Several matters against multiple dental and orthodontia providers, including: M&M Orthodontics, National Orthodontix, Richard Herrscher, Harlingen Family Dental, RGV Smiles, Navarro Orthodontix, Richard Malouf, and Antoine Dental for misrepresentations to Texas Medicaid.
3. National pharmacy chain CVS for systematic false reporting to Texas Medicaid by CVS of "usual and customary" ("U&C") prices.
4. Pharmaceutical manufacturer Lupin for false reporting to Texas Medicaid about how much pharmacies paid to acquire the manufacturers' drugs.

CMF also continues to investigate multiple other matters that are under seal and cannot be described in detail at this time.