ATTORNEY GENERAL OF TEXAS
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Office of the Attorney General and Texas Health and Human Services Commission

Joint Semi-Annual Interagency Coordination Report

September 1, 2011 through February 29, 2012

TEXAS
Health and Human Services Commission

Activities of the Health and Human Services Commission, Office of the Inspector General and the Office of the Attorney General in Detecting and Preventing Fraud, Waste, and Abuse in the State Medicaid Program

RECENT DEVELOPMENTS

The Health and Human Services Commission (HHSC) and the Office of the Attorney General (OAG) continue to build upon the success of their efforts in detecting and preventing fraud, waste, and abuse in the Medicaid program. Reinforced by legislative action, the two agencies are making timely and relevant referrals to each other, and cooperative efforts have resulted in a number of successful investigations of fraudulent providers.

The HHSC Office of Inspector General (OIG) and the OAG Medicaid Fraud Control Unit (MFCU) recognize the importance of partnership and regular communication in the coordinated effort to fight fraud and abuse in the Medicaid program. Activities in the latest biannual reporting period continue to reflect progress and success in this area. For example, the following has occurred in the last six months:

- OIG and MFCU staff have worked proactively to increase communication with managed care organizations and improve reporting procedures in advance of the expansion of managed care in FY2012.
- OIG and MFCU staff have worked jointly to improve communication, to share resources and information regarding providers under investigation, and to ensure parallel criminal and administrative actions result in the most successful case dispositions.
- OIG and MFCU have shared information developed through claims analysis, investigative findings, and prosecution analysis to improve deficiencies in Medicaid policy that allow for exploitation and abuse of the Medicaid program.
- OIG and MFCU have continued to attend quarterly meetings with the Centers for Medicare and Medicaid Services (CMS) Medi-Medi contractor, law enforcement, and other stakeholders to discuss investigation leads and share case information. CMS is the federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program.
- Both agencies have continued to uphold their commitment to promptly send and/or act upon referrals. The ensuing working relationship between the two agencies is recognized by other states as highly effective.
- Monthly meetings have continued between OIG and MFCU staff to discuss referrals of cases and other mutually beneficial projects that aide investigative activities by both entities.
- Communications on cases have remained consistent and ongoing throughout all staff levels, ensuring all case resources and knowledge are shared and efforts are not duplicated.
- OIG continues to investigate allegations related to fraud, waste, and abuse by Texas Medicaid dentists of billing related to orthodontic services. A significant number of investigations have been completed and others are still in process. Many dental providers have been placed on payment holds based on credible allegations of fraud attributable to falsification of prior authorization documentation submitted to the State for these services. The payment holds are an important protection against future federal and state dollars being paid based on false claims. OIG and MFCU are presently sharing evidence and exchanging information to ensure both the administrative and criminal investigation have successful conclusions. OIG is also working toward finalizing its investigations on multiple hearing aid providers. This was an initiative started by OIG in calendar year 2011 based on identified and systemic fraud, waste, and abuse by this provider type. As with the dental providers, OIG has placed numerous hearing aid providers on payment hold to protect against future state and federal dollars being paid to unscrupulous providers. OIG is also working collaboratively with MFCU to share evidence and information to ensure successful outcomes in these investigations.
- In FY 2012, the Office of Inspector General (OIG) determined that more resources needed to be shifted to the Medicaid Provider Integrity Section (MPI) to focus on fraud, waste, and abuse investigations of Medicaid providers. This resulted in a transfer of 52 full time employees from the General Investigations section of OIG to MPI. MPI increased the number of field investigators in the

Dallas, San Antonio, Houston, and Pharr regional offices. MPI added additional full time nurses and contracted with consultants to perform medical records reviews which are an essential part of provider investigations. OIG has decreased the processing time it takes to complete cases from from approximately four years to approximatley eight weeks, becoming more active and aggressive with investigations. When OIG identifes provider fraud, waste, and abuse schemes as systemic or endemic to a certain provider type, OIG now self-initiates cases to investigate and determine the extent of the program non-compliance and/or fraud. MPI has agressively used new federal legislation in investigation to place payment holds on providers when investigators can verify a credible allegation of fraud. Accordingly, the number of providers on payment holds has increased significantly in FY 2012 compared to previous fiscal years.

MEMORANDUM OF UNDERSTANDING (MOU)

As required by HB 2292 of the 78th Texas Legislature, the MOU between MFCU and HHSC-OIG was updated and expanded in November 2003. After extensive collaboration, the MOU was again updated in May 2012. It continues to ensure the cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases and has proven beneficial to both agencies.

THE HEALTH AND HUMAN SERVICES COMMISSION OFFICE OF INSPECTOR GENERAL

The 78th Texas Legislature created OIG to strengthen HHSC's authority to combat waste, abuse, and fraud in health and human services programs. OIG provides program oversight of health and human service (HHS) activities, providers, and recipients through its Compliance, Chief Counsel, and Enforcement Divisions,[1] which are designed to identify and reduce waste, abuse, or fraud, and improve HHS system efficiency and effectiveness. Specifically, the Chief Counsel and Enforcement Divisions play an intricate role in coordinating with the OAG as it relates to provider investigations and sanction actions.

Within the Enforcement Division, the Medicaid Provider Integrity (MPI) section investigates allegations of waste, fraud, and abuse involving Medicaid providers and other health and human services programs; refers cases to Sanctions; refers cases and investigative leads to law enforcement agencies, licensure boards, and regulatory agencies; refers complaints to MFCU; and provides investigative support and technical assistance to other OIG divisions and outside agencies. Under the Chief Counsel, the Sanctions section imposes administrative enforcement intervention and/or adverse actions on providers of various state health care programs found to have committed Medicaid fraud, waste, or abuse by violating state and federal statutes, regulations, rules or directives, and investigative findings. Sanctions monitors the recoupment of Medicaid overpayments, damages, and penalties, and may negotiate settlements and/or conduct informal reviews, as well as prepare agency cases and provide expert testimony and support at administrative hearings and other legal proceedings against Medicaid providers, when applicable. Sanctions works directly with MFCU in excluding convicted providers from the Medicaid program, collecting restitution in criminal cases, and imposing payment holds at the request of the OAG. Sanctions also ensures proper accounting, reporting, and disbursement of funds awarded in litigation by the Civil Medicaid Fraud Division.

OIG has clear objectives, priorities, and performance standards that emphasize:

- Coordinating investigative efforts to aggressively recover Medicaid overpayments;
- Allocating resources to cases that have the strongest supporting evidence and the greatest potential for monetary recovery; and
- Maximizing the opportunities for case referrals to MFCU.

[1] Information on specific organizational units within these Divisions may be found in OIG's Annual Report at https://oig.hhsc.state.tx.us/Reports/reports.aspx.

Medicaid Fraud and Abuse Referral Statistics

HHSC-OIG Waste, Abuse & Fraud Referrals FY2012 (1st & 2nd Quarters) Received From:

Referral Source	Received
Anonymous	68
Attorney	1
US HHS OIG	1
HHSC-Medicaid/CHIP Division	1
HHSC – OIG Limited Program	1
HHSC – OIG Medicaid Provider Integrity (MPI) Self-Initiated	16
HHSC – OIG Utilization Review Division (UR)	1
HHSC-Research Analysis and Detection (TADS)	1
Managed Care Organization/Special Investigation Unit	47
Parent/Guardian	56
Law Enforcement	1
Provider	67
Provider Self-Reported	2
Public	69
Recipient	40
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	17
Texas Department of Aging & Disability Services (DADS)	15
Texas Department of Family and Protective Services (DFPS)	3
Texas Department of State Health Services (DSHS)	8
Texas Governor's Office	1
Texas State Board of Dental Examiners	1
US Senate	1
Total Cases Received:	**418**

HHSC-OIG Waste, Abuse & Fraud Referrals FY2012 (1st and 2nd Quarters) Referred To:

Referral Source	Referred
Claims Administrator – Educational Contact	9
Drug Enforcement Administration	1
HHSC- Ombudsman	1
Managed Care Organization/Special Investigation Unit	47
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	81
Texas Board of Dental Examiners	11
Texas Board of Medical Examiners	8
Texas Board of Nursing	1
Texas Board of Pharmacy	1
Texas Department of Aging & Disability Services (DADS)	15
Texas Department of Family and Protective Services (DFPS)	1
Texas Department of State Health Services (DSHS)	2
Texas State Board of Examiners of Professional Counselors	1
Third Party Resources	1

United States Department of Health and Human Services OIG (HHS-OIG)	7
Vendor Drug Program	1
Total:	**188**

Medicaid Fraud, Abuse & Waste Workload Statistics and Recoupments – FY 2012

Action	1st Quarter FY2012	2nd Quarter FY2012	Total FY2012
Cases Opened	217	201	418
Cases Closed	174	120	294
Referrals to MFCU	42	39	81
Referrals to Other Entities	62	45	107
MPI Cases Referred to Sanctions	1	11	12
On-site DME Provider Verifications	51	44	95
Medicaid Fraud & Abuse Detection System[2]			
Cases Opened	1,485	1,451	2,936
Cases Closed	985	943	1,928
Sanctions Recoupments[3]	$462,189	$21,031,006	$21,493,195
Providers Excluded	208	204	412

[2] MFADS is a detection source and as such the numbers are duplicated within sections that work or take action on MFADS generated cases.

[3] May include OAG identified amounts and Medicaid global settlements. Amounts listed in OAG's statistics may also include potential overpayments identified by OIG. The amount reported includes recoveries and civil monetary penalties.

OFFICE OF THE ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT

The Medicaid Fraud Control Unit (MFCU) is charged with investigating waste, fraud, and abuse in the Medicaid program. In order to fulfill its mission, MFCU relies on referrals from HHSC's Office of Inspector General (OIG), state nursing home regulators, and local law enforcement agencies. MFCU conducts referral-based investigations, in part, because the federal grant that funds 75% of its operations specifies that OIG will conduct data mining of Medicaid claims submitted by providers and refer potential fraud cases to MFCU for criminal investigation. In addition to OIG referrals, MFCU also investigates allegations of abuse and embezzlement at Medicaid-funded nursing homes from state agencies that oversee nursing homes and local law enforcement agencies that investigate patient abuse.

Since 2002, MFCU has identified more than $770 million in suspected Medicaid overpayments and has obtained more than 800 criminal convictions. The unit has a staff of 193 commissioned peace officers, forensic accountants, prosecutors and other officials dedicated to pursuing Medicaid fraud. With field offices in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio, and Tyler, MFCU maintains an on-site presence across the state. Because the legislature has not authorized the Office of the Attorney General to independently prosecute Medicaid fraud, MFCU's prosecutors must be cross-designated as Special Assistant United States Attorneys – which allows OAG prosecutors to prosecute Medicaid fraud in federal court under the supervision of the U.S. Attorneys' offices – or special assistant district attorneys. MFCU prosecutors have received cross-designation in all four U.S. Attorneys' districts and are deputized by local district attorneys on an as-needed case-by-case basis.

Referral Sources

MFCU receives referrals from a wide range of sources including concerned citizens, Medicaid recipients, current and former provider employees, HHSC-OIG, other state agencies, and federal agencies. MFCU staff review every referral received. MFCU then investigates referrals that have a substantial potential for criminal prosecution. The current addition of staff and field offices has enabled the unit to respond quickly and efficiently to the referrals investigated. The following chart provides a breakdown of referral sources for this reporting period.

Referral Source	Received
Department of Aging and Disability Services	71
Health & Human Services Commission - Office of Inspector General	90
Law Enforcement	17
Managed Care Organizations	31
Medicaid Fraud Control Unit Self-Initiated	24
Medicaid Providers	22
Medicare Contractors	12
National Association of Medicaid Fraud Control Units	3
Private Health Insurance Organizations	4
Public	113
State and Federal Agencies	10
U.S. Department of Health and Human Services, Office of Inspector General	7
Other	23
TOTAL	**427**

Criminal Investigations

MFCU conducts criminal investigations into allegations of fraud, physical abuse, and criminal neglect by Medicaid healthcare providers. The provider types cover a broad range of disciplines and include physicians, dentists, home health agencies, physical therapists, licensed professional counselors, ambulance companies, case management companies, laboratories, podiatrists, nursing home administrators and staff, and medical equipment companies. Common investigations include assaults and criminal neglect of patients in Medicaid-funded facilities, fraudulent overbilling for products and services that were not actually rendered, misappropriation of patients' trust funds by nursing home staff, theft of patients' prescription drugs by care givers, and filing of false information by Medicaid providers. MFCU investigators often work cases with other state and federal law enforcement agencies. Because MFCU's investigations are criminal, the penalties assessed against providers can include imprisonment, fines, court-ordered restitution and exclusion from the Medicaid program. The provider is also subject to disciplinary action by his or her professional licensing board. Unlike the Civil Medicaid Fraud Division, MFCU is not authorized to seek recovery of fraudulent overpayments that are uncovered during the Unit's investigations. Instead, fraudulent overpayments identified by MFCU investigators are generally recovered by HHSC-OIG.

During this reporting period, MFCU prosecutors have been deputized by various district attorneys to prosecute Medicaid fraud cases. As the unit continues to offer its expertise to assist local district attorneys with Medicaid fraud prosecutions, this trend is expected to continue. MFCU's partnership with the four federal judicial districts has proven to be especially beneficial in increasing the number of Medicaid fraud cases prosecuted through the federal system. Under this arrangement, MFCU Assistant Attorneys General have been cross-designated as Special Assistant U.S. Attorneys (SAUSAs). They are housed primarily in the federal district offices. As SAUSAs, they are authorized to prosecute Medicaid fraud cases in federal court through the authority of the U.S. Attorney's Office. The unit also has two Assistant Attorneys General who work in the Harris County District Attorney's Office in Houston.

Medicaid Fraud and Abuse Referral Statistics

MFCU statistics for the first and second quarters of fiscal year 2012 are as follows.

Action	1st & 2nd Quarters FY2012
Cases Opened	228
Cases Closed	276
Cases Presented	122
Criminal Charges Obtained	43
Convictions	59
Potential Overpayments Identified	$29,605,493.96
Misappropriations Identified	$17,110.50
Cases Pending	1254

OFFICE OF THE ATTORNEY GENERAL CIVIL MEDICAID FRAUD DIVISION

Under Chapter 36 of the Texas Human Resources Code (the Texas Medicaid Fraud Prevention Act), the Civil Medicaid Fraud Division (CMF) is charged with taking legal action to recover fraudulent overpayments to Medicaid providers. These often lengthy and complex cases require a substantial investment of time and resources but have yielded more than $370 million for the state treasury. With an annual budget of just $6.2 million, CMF's recovery of $68.4 million for the treasury in FY 2011 was more than ten times the cost of operating the division.

To fulfill its fraud prevention duties, CMF issues civil investigative demands, requires providers to answer sworn responses to written questions, and conducts sworn examinations under oath prior to litigation. 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.

Like the MFCU, CMF must rely upon referrals from third parties for its caseload. Whistleblower lawsuits have been the primary source of CMF's enforcement docket. In these cases, which are filed under seal and commonly referred to as *qui tam* actions, the OAG is responsible for determining whether or not to prosecute the action on behalf of the state. For most matters filed prior to May 2007, if the OAG does not intervene, the lawsuit is dismissed. However, 2007 amendments to the Act permit a citizen, known as the "relator," to continue to pursue the lawsuit even if the OAG does not intervene. In either circumstance, the Act provides that the Texas Medicaid Program recovers its damages and that the relator is entitled to a share of the recovery. The 2007 amendments duplicate portions of the federal False Claims Act and permit Texas to retain an additional 10% of Medicaid recoveries that are shared with the federal government. Texas received notice from the federal government in March 2011 that recent amendments to the Federal False Claims Act required amendments to the Act. Several of those changes to the Act were made in 2011 and the OAG is in the process of obtaining approval of those changes in order to continue to be eligible for the additional 10% of Medicaid recoveries.

Civil Medicaid Fraud Statistics

CMF Docket	1st & 2nd Quarters FY2012
Pending CMF Cases/Investigations	331
Cases Closed	52
Cases Opened	51

During this reporting period, CMF settled and recovered funds in 12 matters:

1. State of Texas ex rel Ven-A-Care v. Sandoz. Total recovery including state, federal, and relator's portions was $66,000,000.00.
2. State of Texas ex rel Ven-A-Care v. Watson. Total recovery including state, federal, and relator's portions was $29,500,998.93.
3. State of Texas v. UCB (Root). Total recovery including state, federal, and relator's portions was $1,295,903.30.
4. State of Texas v. Omni (Resnick). Total recovery including state, federal, and relator's portions was $1,300,727.73.
5. State of Texas v. Pfizer (Wethe). Total recovery including state, federal, and relator's portions was $429,190.12.
6. State of Texas v. Rowlett (Addison/Moore). Total recovery including state, federal, and relator's portions was $78,637.48.
7. State of Texas v. City of Hurst (Addison/Moore). Total recovery including state, federal, and relator's portions was $94,530.00.

8. State of Texas v. Southwest General (Addison/Moore). Total recovery including state, federal, and relator's portions was $58,750.00.
9. State of Texas v. Maxim (West). Total recovery including state, federal, and relator's portions was $8,564,817.00.
10. State of Texas v. UTSW (Gentillelo) Total recovery including state, federal, and relator's portions was $1,400,000.00.
11. State of Texas ex rel Ven-A-Care v. Actavis. Total recovery including state, federal, and relator's portions was $38,500,000.00.
12. State of Texas v. Hawthorn (Heiden). Total recovery including state, federal, and relator's portions was $1,845,416.78.

In addition, CMF went to trial in *State of Texas ex rel Jones v. Janssen* in Travis County District Court on January 9, 2012. After seven days of testimony in the plaintiff's case, Janssen agreed to settle with Texas for $158,000,000.00. The settlement was finalized and was scheduled to be paid in April 2012, and the funds will be recorded in the next semi-annual report.

CMF continues to pursue significant cases against the following defendants:

1. Caremark for failure to reimburse Medicaid for pharmacy benefits paid on behalf of dual eligible Medicaid recipients.
2. Carlos Mego M.D., Pedro Mego, M.D., Subbarao Yarra, M.D.,Yamil W. Aude, M.D. each individually and d/b/a/ Valley Heart Consultants, P.A., and Valley Heart Consultants, P.A for false and fraudulent billing for medical services requiring a state license that were in fact performed by unlicensed personnel, false and fraudulent billing for medical services that were "substantially inadequate" when compared to generally recognized medical standards, and conspiracy to defraud the Texas Medicaid program.
3. Caremark for falsely rejecting reimbursement requests from Texas Medicaid sent by Texas Medicaid in December 2006.

Finally, in response to reports of widespread waste, fraud, and abuse by orthodontic and dental Medicaid providers, the OAG and HHSC recently launched a targeted and coordinated response effort with the creation of a Joint Orthodontic and Dental Fraud Task Force. The Deputy Attorney General for Civil Litigation serves as chair of the task force, which is comprised of senior officials from CMF, MFCU, HHSC, and OIG. Because the task force's far-ranging investigation into fraudulent billing by orthodontic and dental providers is ongoing, further details about the investigation cannot be included in this public report at this time.