



ATTORNEY GENERAL OF TEXAS
GREG ABBOTT

**Office of the Attorney General
and
Texas Health and Human
Services Commission**

**Joint Semi-Annual Interagency
Coordination Report**

September 1, 2010 through February 28, 2011



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:

- HHSC OIG staff have trained MFCU users on their new Insurance Fraud Manager computer application.
- 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 efficiencies in Medicaid policy that allow for exploitation and abuse of the Medicaid program.
- OIG and MFCU have continued to work collaboratively with Medi-Medi to provide feedback to the Centers for Medicare and Medicaid Services (CMS) on the One Program Integrity database project. CMS is the federal agency that administers Medicare, Medicaid, and the Children's Health Insurance Program.
- OIG and MFCU have continued to attend quarterly meetings with the Medi-Medi contractor, law enforcement, and other stakeholders to discuss investigation leads and share case information.
- 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 aid 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.
- In locations throughout the state where OIG does not office field investigators, MFCU investigators have assisted in conducting on-site provider verifications for provider types that have shown a higher propensity towards potential fraud.

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. 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. MFCU and OIG are in current collaboration to update the existing MOU.

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**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.

Medicaid Fraud and Abuse Referral Statistics

HHSC-OIG Waste, Abuse & Fraud Referrals FY2011 (1st & 2nd Quarters) Received From:

| Referral Source | Received |
|---|----------|
| Anonymous | 64 |
| Attorney | 1 |
| HHSC-Medicaid/CHIP Division | 3 |
| HHSC – OIG Audit Division | 1 |
| HHSC – OIG Medicaid Provider Integrity (MPI) Self-Initiated | 9 |
| HHSC – OIG Utilization Review Division (UR) | 5 |
| HHSC-OIG General Investigations Division (GI) | 1 |
| HHSC-Research Analysis and Detection (TADS) | 1 |
| Law Enforcement Agency | 1 |
| Managed Care Organization (MCO/SIU) | 45 |
| Parent/Guardian | 73 |
| Provider | 20 |

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>.

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HHSC-OIG Waste, Abuse & Fraud Referrals FY2011 (1st & 2nd Quarters) Received From:

| Referral Source | Received |
|--|------------|
| Provider Self-Reported | 12 |
| Public | 101 |
| Recipient | 36 |
| Texas Attorney General Medicaid Fraud Control Unit (MFCU) | 20 |
| Texas Department of Aging & Disability Services (DADS) | 17 |
| Texas Department of Assistive & Rehabilitative Services (DARS) | 1 |
| Texas Department of State Health Services (DSHS) | 4 |
| Texas Medicaid Healthcare Partnership (TMHP) | 2 |
| Vendor Drug Program | 1 |
| Total Cases Received: | 418 |

HHSC-OIG Waste, Abuse & Fraud Referrals FY2011 (1st & 2nd Quarters) Referred To:

| Referral Source | Referred |
|---|------------|
| Claims Administrator – Educational Contact | 7 |
| HHSC-Health Plan Operations (Managed Care) | 1 |
| HHSC – OIG General Investigations Division (GI) | 1 |
| Managed Care Organization/Special Investigation Unit | 23 |
| Medical Transportation Program | 3 |
| Texas Attorney General Medicaid Fraud Control Unit (MFCU) | 105 |
| Texas Board of Dental Examiners | 5 |
| Texas Board of Medical Examiners | 11 |
| Texas Board of Pharmacy | 1 |
| Texas Board of Psychologists | 1 |
| Texas Department of Aging & Disability Services (DADS) | 22 |
| Texas Department of Family and Protective Services (DFPS) | 2 |
| Texas Department of State Health Services (DSHS) | 3 |
| United States Department of Health and Human Services OIG (HHS-OIG) | 22 |
| Total: | 207 |

Medicaid Fraud, Abuse & Waste Workload Statistics and Recoupments – FY 2011

| Action | 1 st Quarter FY2011 | 2 nd Quarter FY2011 | Total FY2011 |
|---------------------------------|-----------------------------------|-----------------------------------|-----------------|
| Cases Opened | 248 170 418 | | |
| Cases Closed | 161 108 269 | | |
| Referrals to MFCU | 50 | 55 | 105 |
| Referrals to Other Entities | 54 | 48 | 102 |
| MPI Cases Referred to Sanctions | 3 6 9 | | |
| On-site Provider | -- -- -- | | |

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| | | | |
|--|------------------------|------------------------|------------------------|
| Verifications | | | |
| Medicaid Fraud & Abuse Detection System² | | | |
| Cases Opened | 975 | 327 | 1302 |
| Cases Closed | 353 | 1183 | 1536 |
| Sanctions Recoupments³ | \$12,397,867.33 | \$34,419,503.30 | \$46,817,370.63 |
| Providers Excluded | 292 178 470 | | |

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

For over 30 years, the Texas Medicaid Fraud Control Unit (MFCU) has been conducting criminal investigations into allegations of fraud, physical abuse, and criminal neglect by health care providers in the Medicaid program. MFCUs are operating in 49 states and Washington, D.C., all with similar goals.

The staff increase mandated by the 78th Texas Legislature in House Bill 2292 brought Texas in line with other states with similar numbers of Medicaid recipients and Medicaid spending. The legislature appropriated funding that, when combined with federal grant funds, authorized expansion of the unit from 36 staff to 208. Currently, 54 investigators are commissioned peace officers. Field offices are open in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio, and Tyler. Two teams are located in the Dallas office and three teams are located in the Houston office. Both formal and informal task forces have been formed with the unit's federal and state investigative partners in conducting its criminal investigations. Cross-designated Special Assistant U.S. Attorneys work within each of the four federal judicial districts. Assistant Attorneys General also work Medicaid fraud and abuse cases within the state criminal justice system, either as assistant prosecuting attorneys for a county or as district attorneys pro tem.

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 | 58 |
| Health & Human Services Commission - Office of Inspector General | 109 |
| Law Enforcement | 10 |
| Medicaid Fraud Control Unit Self-Initiated | 38 |
| Other State Agencies | 9 |
| Providers | 10 |
| Public | 113 |
| U.S. Department of Health and Human Services, Office of Inspector General | 27 |
| Other | 27 |
| TOTAL | 401 |

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, physical therapists, licensed professional counselors, ambulance companies, case management centers, laboratories, podiatrists, nursing home administrators and staff, and medical equipment companies. Common investigations include assaults and criminal neglect of patients in Medicaid facilities, fraudulent billings by Medicaid providers, misappropriation of patient trust funds, drug diversions, and filing of false information by Medicaid providers. Unit 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, and exclusion from the Medicaid program. The provider is also subject to disciplinary action by his or her professional licensing board.

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During this reporting period, MFCU state 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 in prosecuting MFCU cases, 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 now used 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.

Medicaid Fraud and Abuse Referral Statistics

MFCU statistics for the first and second quarters of fiscal year 2011 are as follows.

| Action | 1st & 2nd Quarters FY2011 |
|-----------------------------------|--|
| Cases Opened | 297 |
| Cases Closed | 277 |
| Cases Presented | 162 |
| Criminal Charges Obtained | 87 |
| Convictions | 50 |
| Potential Overpayments Identified | 53,680.2 43.55 |
| Misappropriations Identified | 102,658.17 |
| Cases Pending | 1,452 |

The 1,452 current cases are split between provider fraud cases and physical and financial abuse cases: 88% are fraud cases and 12% are abuse cases. Cases on practitioners represent 33% of the fraud cases, and 56% are on medical support providers and 11% are on facilities and others.

OFFICE OF THE ATTORNEY GENERAL CIVIL MEDICAID FRAUD DIVISION

The Civil Medicaid Fraud Division (CMF) investigates and prosecutes civil Medicaid fraud cases under Chapter 36 of the Texas Human Resources Code (the Texas Medicaid Fraud Prevention Act).

Under the Texas Medicaid Fraud Prevention Act (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 OAG, 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 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.

The 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* 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.

Civil Medicaid Fraud Statistics

| CMF Docket | 1 st & 2 nd Quarters FY2011 |
|------------------------------|---|
| Pending Cases/Investigations | 329 ⁴ |
| Cases Closed | 35 |
| Cases Opened | 53 |

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

1. State of Texas v. Ortho/J&J (Topamax). Total recovery including state, federal, and relator’s portions was \$3,135,164.49.
2. State of Texas v. KOS. Total recovery including state, federal, and relator’s portions was \$506,507.00.
3. State of Texas v. Forrest. Total recovery including state and federal portions was \$7,676,167.92.
4. State of Texas v. Glaxo. Total recovery including state and federal portions was \$18,798,686.09.
5. State of Texas v. Allergan. Total recovery including state, federal, and relator’s portions was \$3,453,057.64.
6. State of Texas v. Novartis (McKee). Total recovery including state, federal, and relator’s portions was \$16,370,726.56.
7. State of Texas ex rel Ven-A-Care v. Mylan. Total recovery including state, federal, and relator’s portions was \$65,000,000.00.

⁴ Of this total, 323 matters concern Medicaid fraud cases and investigations, and 6 matters relate to other issues handled by CMF attorneys.

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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. Janssen Pharmaceuticals and its parent company, Johnson & Johnson, regarding the marketing of the drug Risperdal.
3. Sandoz, Inc. Pharmaceuticals for pricing fraud.
4. Schein, Watson, and Par pharmaceutical companies, and their subsidiaries for pricing fraud.
5. Caremark for falsely rejecting reimbursement requests from Texas Medicaid.

CMF obtained a judgment of approximately \$180 million against Alpharma USPD now known as Actavis MidAtlantic LLC, and Purepac Pharmaceutical now known as Actavis Elizabeth LLC. after a jury trial in Travis County. This judgment represents the first jury trial under Texas' Medicaid Fraud Prevention Act. Texas expects the defendant to appeal.

CMF continues its heavy involvement in multi-state cases or investigations against Medicaid providers which are under seal and cannot be revealed at this time publicly.