THE ATTORNEY GENERAL OF TEXAS

KEN PAXTON

OFFICE OF THE ATTORNEY GENERAL

AND

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

OFFICE OF INSPECTOR GENERAL

JOINT ANNUAL INTERAGENCY COORDINATION REPORT

SEPTEMBER 1, 2013, THROUGH AUGUST 31, 2014

TEXAS Health and Human Services Commission

JOINT ANNUAL INTERAGENCY COORDINATION REPORT

INTRODUCTION

This joint 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 §531.103 of the Texas Government Code, as amended by Senate Bill 59, 83rd Legislature, 2013. The report summarizes statistical data and other information relating to the joint efforts of HHSC OIG and OAG to uncover fraud, waste, and abuse in the state Medicaid program for the period of September 1, 2013, through August 31, 2014.

RECENT DEVELOPMENTS

OIG and 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.

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. The activities in the latest annual reporting period continue to reflect progress and success in uncovering fraud, waste, and abuse. The following actions have occurred in the last 12 months.

- Effective communication with managed care organizations (MCOs) have improved reporting procedures with the expansion of managed care in fiscal year 2014. OIG and MFCU have participated in quarterly meetings with the MCO Special Investigative Units to share information, best practices, and exchange information on cases of mutual interest.
- OIG and MFCU have worked jointly to improve communication, to share resources and information about providers under investigation, and to ensure parallel criminal and administrative actions result in the most successful case dispositions.
- OIG has a full-time Chief Dental Officer and Dental Hygienist who maintain mobile dental equipment, enabling real time examination of patients in various settings as part of dental investigations. The examinations are performed to confirm whether services billed to the Medicaid program were actually rendered and to obtain additional evidence to support allegations of professional misconduct related to Medicaid dental services. OIG worked in conjunction with MFCU on two criminal investigations in FY 2014 utilizing OIG's mobile dental equipment and the expertise of the OIG Chief Dental Officer and Dental Hygienist to work in collaboration with MFCU dental consultants in conducting the patient examinations.
- OIG and MFCU have shared information developed through claims analysis, investigative findings, and prosecution analysis to address 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 each other information about referrals and to act on them. 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 organizations. Regular ongoing communication on cases at all staff levels has helped to ensure that OIG and MFCU share case resources and knowledge and avoid duplication of effort. Other states recognize the ensuing working relationship between the two agencies as highly effective.
- MFCU is participating in Department of Justice Health Care Fraud Strike Forces in Houston and Dallas. The strike force in Dallas consists of investigators from United States Department of Health and Human Services OIG, Federal Bureau of Investigation, and MFCU. This strike force recently indicted a doctor for providing false certifications of medical necessity to home health agencies and durable medical equipment companies that resulted in $25 million in losses to Medicaid and $350 million to Medicare.
- OIG, in conjunction with the CMS Medicaid Integrity Group (MIG) auditors, facilitated various audits. These audits involved reviewing documentation to support claims paid for pharmacy and medical services. Nine final reports were issued in fiscal year 2014 with total questioned costs of $6,027,136.00.
- During the 2012-14 fiscal years, OIG Compliance Division audited 34 Women's Health Program providers in the areas of operations, medical records, finances, and Titles V, X, XIX and XX. The provider audits included centers for disease detection, laboratories, community oriented care centers, family planning facilities, and county hospital districts.
- During fiscal year 2014, the OIG Compliance Division completed 509 nursing facility reviews, comprising 46 percent of the total participating nursing facilities.
- The Utilization Review Department within the Compliance Division completed 630 hospital reviews during fiscal year 2014.
- The Lock-In Program holds routine monthly meetings with MCOs, and is receiving a record number of referrals from MCOs. For the year ending August 31, 2014, the Lock-in Program received an average of 52 referrals per month and a total of 618 referrals for the entire year. As of August 31, 2014, the Lock-In Program had 698 people "locked" into a single pharmacy or primary care physician.

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. The MOU ensures the cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases and has proven beneficial to both agencies.

In addition, pursuant to the requirements of Senate Bill 8 of the 83rd Legislature (regular session), OIG entered into MOUs with both DPS and OAG for the coordination and support of law enforcement officers dedicated to Medicaid provider integrity.

HHSC OIG and the Office of the Attorney General Civil Medicaid Fraud Division (OAG CMF) have entered into a MOU to coordinate work on overpayment cases. HHSC OIG and OAG CMF have also entered into a MOU to use HHSC OIG positions to work in conjunction with CMF. The MOU specifies that three OIG positions will be hired as attorneys and the attorneys will be housed at CMF and work as Special Assistant Attorneys General. All three positions are filled.

THE HEALTH AND HUMAN SERVICES COMMISSION OFFICE OF INSPECTOR GENERAL

The 78th Texas Legislature created OIG to strengthen HHSC's authority to combat fraud, waste, and abuse in health and human services programs. OIG provides program oversight of HHS activities, providers, and recipients through its Compliance, Chief Counsel, Operations, and Enforcement divisions, which identify and reduce fraud, waste, and abuse, and improve HHS system efficiency and effectiveness.

The Compliance Division performs audits, reviews, and non-audit procedures of providers who contract with HHSC to administer programs. The division also includes a Managed Care Audit Unit in response to the implementation of statewide managed care.

The Chief Counsel and Enforcement divisions play an intricate role in coordinating with OAG as it relates to provider investigations and sanction actions.

The Operations division consists of Research, Analysis and Detection (RAD) which helps OIG address quality-of-care issues, identifies and initiates recovery of inappropriate Medicaid payments. The RAD unit within OIG also oversees the Surveillance and Utilization Review Subsystems (SURS), a federally required fraud detection tool, as well as overseeing the Medicaid Fraud and Detection System, a computer system that detects, identifies, and analyzes provider billing patterns.

OIG Operations also houses the Managed Care Unit, which works closely with managed care Special Investigative Units, and the Provider Integrity Research and Review unit, which performs background checks on providers enrolling and re-enrolling in the Medicaid program.

Within the Enforcement Division, the Medicaid Provider Integrity (MPI) section performs the following duties:

- Investigates allegations of fraud, waste, and abuse involving Medicaid providers and other HHS programs.
- Refers cases to Sanctions, refers cases and investigative leads to law enforcement agencies, licensure boards, and regulatory agencies, and refers complaints to MFCU.
- 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 adverse actions on providers of various state health care programs found to have committed Medicaid fraud, waste, and 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 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 OAG.

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

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

MEDICAID FRAUD AND ABUSE REFERRAL STATISTICS

HHSC OIG Fraud, Waste & Abuse Referrals Received FY 2014

Referral Source	Received
Anonymous	298
Attorney	1
Centers for Medicare and Medicaid Services (CMS)	34
HHSC Medicaid/CHIP	3
HHSC – OIG Medicaid Provider Integrity (MPI) Self-Initiated	149
HHSC – OIG Compliance Division	11
HHSC - OIG Internal Affairs Division	1
HHSC – OIG Operations	17
HHSC – OIG Sanctions Division	1
HHSC – OIG Technology Analysis, Development and Support (TADS)	1
HHSC – OIG Utilization Review Division (UR)	2
HHSC - Ombudsman	1
Law Enforcement Agency	2
Data analytics	109
Managed Care Organization/Special Investigative Unit	147
Maximus – Enrollment Broker	1
Parent - Guardian	130
Provider	76
Provider Self-Reported	33
Public	132
Recipient	158
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	24
Texas Board of Dental Examiners	2
Texas Board of Medical Examiners	1
Texas Department of Aging and Disability Services (DADS)	25
Texas Department of Family and Protective Services (DFPS)	2
Texas Department of State Health Services (DSHS)	14
Texas Medicaid Healthcare Partnership (TMHP)	28
Texas State Legislator	1
United States Department of Health and Human Services OIG (U.S. HHS OIG)	1
Total Received	**1,405**

HHSC OIG Fraud, Waste & Abuse Referrals Made FY 2014

Referral Source	Referred
Claims Administrator – Claims/Record Review	4
Claims Administrator – Educational Contact	148
HHSC – OIG General Investigations Division (GI)	1
HHSC – OIG Third Party Liability Division (TPL)	1
HHSC – Ombudsman	5
Managed Care Organization/Special Investigative Unit	68
Medical Transportation Program	4
Out-of-State	1
Palmetto Government Benefits Administrators (GBA)	11
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	144
Texas State Board of Dental Examiners	29
Texas Board of Licensed Professional Counselors	3
Texas Medical Board	24
Texas State Board of Pharmacy	2
Texas Board of Nursing	3
Texas Board of Optometry	2
Texas Board of Orthotics and Prosthetics	3
Texas Board of Physical Therapy Examiners	2
Texas Department of Aging and Disability Services (DADS)	460
Texas Department of Assistive and Rehabilitative Services (DARS)	1
Texas Department of Family and Protective Services (DFPS)	2
Texas Department of State Health Services (DSHS)	19
United States Department of Health and Human Services OIG (U.S. HHS OIG)	24
Vendor Drug Program	13
Total Referred	**974**

Medicaid Fraud, Waste & Abuse Workload Statistics and Recoupments – FY 2014

Action	1st & 2nd Quarters FY 2014	3rd & 4th Quarters FY 2014	Total FY 2014
Cases Opened	613	792	1,405
Cases Closed	408	913	1,321
Referrals to MFCU	12	132	144
Referrals to Other Entities	204	626	830
MPI Cases Completed & Transferred to Sanctions	2	21	23
MPI CAF Holds Referred to Sanctions	0	39	39
On-site DME Provider Verifications	303	234	537
Sanctions Recoupments	$9,007,977.84	$6,996,834.51	$16,004,812.35
Providers Excluded	169	216	385

Medicaid Fraud & Abuse Detection System[1]

Action	1st & 2nd Quarters FY 2014	3rd & 4th Quarters FY 2014	Total FY 2014
Cases Opened	945	1,505	2,450
Cases Closed	744	1,596	2,340

[1] Medicaid Fraud & Abuse Detection System (MFADS) is a detection source and as such the numbers are duplicated within sections that work or take action on MFADS generated cases.

OFFICE OF THE ATTORNEY GENERAL MEDICAID FRAUD CONTROL UNIT

The Office of the Attorney General Medicaid Fraud Control Unit (MFCU) is mandated by the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG) to investigate fraud by Medicaid providers and physical and financial abuse of patients in Medicaid-funded nursing facilities, primarily nursing homes. The unit receives 75 percent of its funding through a grant from HHS-OIG and 25 percent from general revenue.

The Medicaid Fraud Control Unit has 196 commissioned and non-commissioned investigators, forensic accountants, prosecutors and support staff dedicated to pursuing Medicaid provider fraud and physical and financial abuse. With field offices in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen San Antonio and Tyler, MFCU maintains a presence across the state. MFCU prosecutors are not authorized by state law to independently prosecute Medicaid fraud, but are available upon request to assist district attorneys and the U.S. Attorney Offices with prosecution. MFCU prosecutors have been cross-designated as Special Assistant United States Attorneys in all four U.S. Attorney's districts and local district attorneys deputize them as needed on a case-by-case basis.

REFERRAL SOURCES

MFCU receives referrals from a wide range of sources including HHSC-OIG, concerned citizens, Medicaid recipients, current and former provider employees, state and federal agencies, and law enforcement. Referrals that have a substantial potential for criminal prosecution are investigated. The following chart provides a breakdown of referral sources for fiscal year 2014.

Referral Source	FY 2014
Federal Agencies and Entities	100
HHSC OIG	260
HHSC – Other than OIG	165
Hot Line / Ombudsman	4
Local Law Enforcement	30
Other	37
Provider Related	118
Public	146
Self-Initiated	37
State Boards and Agencies	34
Total Received	**931**

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 fraud by Medicaid providers, such as billing for services or products not provided, billing for services by unqualified staff, billing for services or drugs not medically necessary, billing for unnecessary medical transportation, padding cost reports, paying kickbacks and trafficking in stolen Medicaid recipient numbers. In addition, we investigate physical abuse of patients in Medicaid funded facilities and the theft of patient's funds and medications by facility staff.

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 (CMFD), MFCU is not authorized to pursue civil collection of fraudulent overpayments that are uncovered during an investigation. Such collection efforts are made by the CMFD or HHSC-OIG using their administrative authority to recover overpayment.

During this reporting period, various district attorneys deputized MFCU prosecutors to pursue 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 been especially helpful to prosecution in increasing the number of Medicaid fraud cases through the federal system. Under this arrangement, MFCU Assistant Attorneys General have been cross-designated as SAUSAs. They reside primarily in the federal district offices. As SAUSAs, they have U.S. Attorney's Office authority to prosecute Medicaid fraud cases in federal court. The unit also has one Assistant Attorney General who works in the Harris County District Attorney's Office in Houston.

MEDICAID FRAUD AND ABUSE REFERRAL STATISTICS

Action	FY 2014
Cases Opened	584
Cases Closed	533
Cases Presented	313
Criminal Charges Obtained	114
Convictions	97
Potential Overpayments Identified	$48,508,731.20
Misappropriations Identified	$323,708.50
Cases Pending	1,319

OFFICE OF THE ATTORNEY GENERAL CIVIL MEDICAID FRAUD DIVISION

Under Chapter 36 of the Texas Human Resources Code, the Texas Medicaid Fraud Prevention Act (TMFPA), 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 $500 million for the state treasury. With an FY 2014 budget of $4.8 million, CMF's recovery of $38 million for the state[2] treasury in fiscal year 2014 was more than seven 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 treble damages plus interest, the imposition of civil penalties per violation, the recovery of costs and attorneys' fees, as well as the automatic suspension or revocation of the Medicaid provider agreement and/or license of certain providers.

Like that of the MFCU, the CMF caseload is largely attributable to third-party referrals. The TMFPA permits private parties, sometimes called "whistleblowers," to file lawsuits alleging TMFPA violations on behalf of themselves and of the State of Texas. This authority is similar to that given to private parties under the federal False Claims Act. These cases are filed under seal and are commonly referred to as *qui tam* actions. Once filed, the OAG is responsible for determining whether or not to intervene as a party and prosecute the action on behalf of the state. When this authority was added to the TMFPA in 1997, the statute required dismissal of a case if the State did not intervene. In May 2007, the Act was amended to permit the private party, 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 relator is entitled to a share of the recovery, but the recovery cap is less when the State intervenes. The 2007 amendments brought the TMFPA into conformity with federal law to permit Texas to retain an additional 10 percentage points of Medicaid recoveries that are shared with the federal government. After amendments to the TMFPA in 2013 that addressed changes in federal law, the TMFPA was re-certified as qualifying for the additional 10 percentage points

CIVIL MEDICAID FRAUD STATISTICS

CMF Docket	FY 2014
Pending CMF Cases/Investigations[3]	409
Cases Closed	116
Cases Opened	111

During this reporting period, CMF settled and recovered funds in 12 matters with recoveries of $1 million or higher:

1. *State of Texas ex rel Gonzalez v. Mego* -- On the eve of trial, Defendants agreed to settle allegations of false and fraudulent billing for medical services requiring a state license that were in fact

[2] This is the amount that went to Texas taxpayers only, and does not include amounts sent to the federal government, relators, and the attorney fees of the Office of the Attorney General.

[3] There are an additional 16 cases that relate to non-Medicaid matters handled by CMF.

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. Total recovery including state, federal, and relator's portions will be $5,500,000 after all payments are made.

2. *State of Texas ex rel Ven-a-Care v. Major Pharmaceuticals*-- Total recovery including state, federal, and relator's portions will be $5,000,000 after all payments are made.
3. *State of Texas v. Nyco/Fougera*—Total recovery Total recovery including state and federal portions was $22,750,000.
4. *United States and Texas ex rel Reynolds v. Planned Parenthood*-- Total recovery including state, federal, and relator's portions was $1,410,792.
5. *State of Texas v. HiTech* -- Total recovery including state and federal portions was $25,000,000.
6. *United States and Texas ex rel Barry v. Ortho (Johnson & Johnson)* -- Total recovery including state, federal, and relator's portions was $1,287,781.
7. *United States and Texas ex rel Kirk v. Carefusion*--- Total recovery including state, federal, and relator's portions was $1,439,843.
8. *State of Texas v. Cypress* -- Total recovery including state and federal portions was $2,000,000.
9. *State of Texas ex rel Schutte v. HEB*—Total recovery including state, federal, and relator's portions was $12,000,000.

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. Multiple administrative matters being prosecuted jointly with HHSC's Office of Inspector General against the following dental and orthodontia providers: M&M Orthodontics, National Orthodontix, Westmoreland Dental, Harlingen Family Dental, and Antoine Dental.
3. AstraZeneca for unlawful marketing of the atypical antipsychotic Seroquel.

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