



**Office of the Attorney General
and Texas Health and Human
Services Commission
Joint Semi-Annual Interagency
Coordination Report**

September 1, 2008 through February 28, 2009



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Pursuant to §531.103, Texas Government Code, as adopted by Senate Bill 30, 75th Legislature, 1997

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 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 disposition.
- OIG and MFCU are sharing 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.
- Quarterly meetings continued between OIG and MFCU executive management to ensure that collaboration is occurring at all levels of both organizations.
- OIG and MFCU continue 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 continue to attend quarterly meetings with the Medi-Medi contractor, law enforcement, and other stakeholders to discuss investigation leads and share case information.
- Both agencies 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 continued between OIG and MFCU staff to discuss referrals of cases and other mutually beneficial projects that aide investigative activities by both entities.
- Communication on cases remained consistent and ongoing throughout all staff levels, ensuring all case resources and knowledge were shared and efforts were not duplicated.
- In locations throughout the state where the OIG does not office field investigators, MFCU investigators assisted in conducting on-site provider verifications for provider types that have shown a higher propensity towards potential fraud.

OTHER DEVELOPMENTS

The 79th Texas Legislature approved an increase in staffing for HHSC-OIG for SFY 2008. Eleven new FTE's were allocated to the OIG's Medicaid Provider Integrity (MPI) section. The MPI staff is primarily devoted to investigating provider fraud, waste, and abuse in the Texas Medicaid Program. This staffing increase has allowed MPI to place additional investigators and nurse analysts in key areas of the state to more efficiently investigate issues related to Medicaid fraud, waste, and abuse. MPI has field staff located in Dallas, Houston, San Antonio, and Edinburg.

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The 78th Texas Legislature afforded the MFCU a unique opportunity for expansion. With agreement from the United States Department of Health and Human Services, Office of Inspector General, the unit has grown from 36 staff to nearly 200. Field offices are open in Corpus Christi, Dallas, El Paso, Houston, Lubbock, McAllen, San Antonio, and Tyler. Both formal and informal task forces have been formed with the unit's federal and state investigative partners in conducting its criminal investigations. The addition of staff from HHSC-OIG and MFCU located in several of the same key areas of the state has improved the ability of both to cooperatively investigate their cases and improved communication at the local level.

MEMORANDUM OF UNDERSTANDING

As required by HB 2292 of the 78th Texas Legislature, the MOU between the 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. The MFCU and the OIG are in current collaboration to update the existing MOU.

THE HEALTH AND HUMAN SERVICES COMMISSION OFFICE OF INSPECTOR GENERAL

The 78th Texas Legislature created the OIG to strengthen HHSC's authority to combat waste, abuse, and fraud in health and human services program. 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 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 the 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 in accordance with 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 the 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>.

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Medicaid Fraud and Abuse Referrals Statistics

HHSC-OIG Waste, Abuse & Fraud Referrals FY2009 (1st & 2nd Quarters) Received From:

Referral Source	Received
Anonymous	42
Attorney	3
Attorney General's Medicaid Fraud Control Unit	1
Department of Aging & Disability Services (DADS)	22
Managed Care Organization/Special Investigative Unit (MCO/SIU)	13
OIG Compliance	10
OIG MPI Self-initiated	13
OIG Utilization Review Division	8
OIG Audit	1
Parent/Guardian	40
Provider	16
Public	70
Recipient	54
Vendor Drug Program	1
Provider Self-Reported	5
Texas Department of Assistive and Rehabilitative Services (DARS)	2
Texas Department of Family and Protective Services (DFPS)	1
Texas Medicaid Healthcare Partnership (TMHP)	4
Total Cases Received:	306

HHSC-OIG Waste, Abuse & Fraud Referrals FY2009 (1st & 2nd Quarters) Referred To:

Referral Source	Referred
Attorney General's Medicaid Fraud Control Unit	74
Board of Dental Examiners	2
Board of Medical Examiners	2
Board of Nurse Examiners	1
Board of Orthotics and Prosthetics	1
Department of Aging & Disability (DADS)	3
Health and Human Services – OIG General Investigation Division (GI)	4
Health and Human Services – OIG Internal Affairs Division (IA)	2
Health and Human Services) – OIG Limited Program	1
Department of State Health Services (DSHS)	4
HHSC - Vendor Drug Program	1
HHSC – Long Term Care	2
Palmetto GBA	2
Texas Worker's Compensation Commission	1
Texas Medicaid & Healthcare Partnership (TMHP) - Educational Contact	9
U.S. Department of Health & Human Services, Office of Inspector General (HHS-OIG)	11
Out of State	1
Total:	121

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Medicaid Fraud, Abuse & Waste Workload Statistics and Recoupments – FY 2009

Action	1st Quarter FY2009	2nd Quarter FY2009	Total FY2009
Medicaid Provider Integrity			
• Cases Opened	178	128	306
• Cases Closed	153	95	248
• Referrals to MFCU	31	43	74
• Referrals to Other Entities	25	22	47
• MPI Cases Referred to Sanctions	3	4	7
• On-site Provider Verifications	90	65	155
Medicaid Fraud & Abuse Detection System²			
• Cases Opened	793	832	1,625
• Cases Closed	1,183	951	2,134
Sanctions Recoupments³	\$41,007,276	\$1,920,187	\$42,927,463
• Providers Excluded	118	238	356

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.

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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, 55 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. 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

The 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. Not all are investigated, however, because the statutory mandate restricts investigations to 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	176
Federal Bureau of Investigation	7
Health & Human Services Commission - Office of Inspector General	75
Law Enforcement	12
Medicaid Fraud Control Unit Self-Initiated	17
Medicare Contractors	3
National Association of Medicaid Fraud Control Units	5
Office of the Attorney General	7
Prosecutors	3
Providers	4
Public	66
U.S. Department of Health and Human Services, Office of Inspector General	6
Other Agencies and Boards	8
Other	16
TOTAL	405

Criminal Investigations

The MFCU conducts criminal investigations into allegations of fraud, physical abuse, and criminal neglect by Medicaid healthcare providers. The MFCU strives for a blend of cases representative of Medicaid provider types. 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

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Medicaid providers. Unit investigators often work cases with other state and federal law enforcement agencies. Because the 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.

Until the passage of House Bill 2292 in the 78th legislative session, the MFCU depended upon state and federal authorities for criminal prosecution of its cases. Now having concurrent jurisdiction with the consent of local prosecutors to prosecute certain state felony offenses, the unit can apply additional resources and assistance in the trial work. During this reporting period, MFCU state prosecutors have been deputized by various district attorneys to prosecute MFCU cases. As the unit continues to offer its expertise to assist local district attorneys in prosecuting MFCU cases, this trend is expected to continue. In addition, the Code of Criminal Procedure was amended to allow the OAG to institute asset forfeiture proceedings in cases that are filed by the OAG or requested by the OIG.

The MFCU's partnership with the four federal judicial districts has proven to be especially beneficial in increasing the number of MFCU cases prosecuted through the federal system. Under this arrangement, a cadre of MFCU Assistant Attorneys General has been cross-designated as Special Assistant U.S. Attorneys (SAUSA). They are housed primarily in the federal district offices. As SAUSAs, they are authorized to prosecute Medicaid healthcare cases in federal court through the authority of the U.S. Attorney's Office.

Medicaid Fraud and Abuse Referral Statistics

The MFCU statistics for the first and second quarters of fiscal year 2009 are as follows.

Action	1st & 2nd Quarters FY2009
Cases Opened	370
Cases Closed	289
Cases Presented	156
Criminal Charges Obtained	37
Convictions	45
Potential Overpayments Identified	\$19,350,306.80
Misappropriations Identified	\$72,479.02
Cases Pending	1423

OFFICE OF THE ATTORNEY GENERAL CIVIL MEDICAID FRAUD DIVISION

In early 2008, the Civil Medicaid Fraud Division (CMF) became a separate division within the OAG. Previously, CMF was a section within the Antitrust and Civil Medicaid Fraud Division from 2004-2008, and prior to that, CMF was part of the Elder Law and Public Health Division from 1999-2004. No matter where it has been located, the mission of the CMF has always been to investigate and prosecute 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, 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 Texas 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* 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 recent 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 FY2009
Pending Cases/Investigations	210 ⁴
Cases Closed	12
Cases Opened	34

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

1. State of Texas v. Abbott and Hospira (Ven-A-Care). Total recovery including state, federal, and relator's portions was \$28,000,000.
2. State of Texas v. Cephalon (Boise) Total recovery including state, federal, and relator's portions was \$10,761,177.92.

CMF settled four lawsuits against Eli Lilly regarding the drug Zyprexa for \$31,942,322.

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. Merck & Co. for misrepresentations to Texas Medicaid about the safety and efficacy of Vioxx.

⁴ Of this total, 204 matters concern Medicaid fraud cases and investigations, and 6 matters relate to other issues handled by CMF attorneys.

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3. Janssen Pharmaceuticals and its parent company, Johnson & Johnson, regarding the marketing of the drug Risperdal.
4. Mylan Laboratories, Sandoz, Inc., and Teva Pharmaceuticals for pricing fraud.
5. Schein, Watson, Alparma, Par, and Barr pharmaceutical companies, and their subsidiaries for pricing fraud.

In April 2009, CMF also filed suit a separate lawsuit against Caremark for falsely rejecting reimbursement requests from Texas Medicaid.

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.

In 2007, the Texas Legislature approved a rider to expand CMF's budget to include an additional 41 staff members. CMF is in the process of expanding its staff and currently employs 35 attorneys and 16 staff. CMF is utilizing this increased staff to review and make recommendations on pending, non-public Medicaid fraud matters, as well as to further its efforts in open litigation.