



OFFICE OF THE ATTORNEY GENERAL
AND
TEXAS HEALTH AND HUMAN
SERVICES COMMISSION

JOINT SEMI-ANNUAL INTERAGENCY
COORDINATION REPORT

SEPTEMBER 1, 2012 THROUGH FEBRUARY 28, 2013



JOINT SEMI-ANNUAL INTERAGENCY COORDINATION REPORT

INTRODUCTION

This joint report between Health and Human Services Commission (HHSC), Office of the Inspector General (OIG) and the Office of the Attorney General (OAG) is pursuant to §531.103 of the Texas Government Code, as adopted by Senate Bill 30, 75th Legislature, 1997. 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, 2012, through February 28, 2013.

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 biannual reporting period continue to reflect progress and success in uncovering fraud, waste, and abuse. The following actions have occurred in the last six months.

- OIG and MFCU have increased communication with managed care organizations (MCOs) and have improved reporting procedures with the expansion of managed care in FY 2012. OIG and MFCU have participated in quarterly meetings with the 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 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.
- OIG continues to investigate allegations related to fraud, waste, and abuse by Texas Medicaid dentists on billing related to orthodontic services. OIG has completed a significant number of investigations and others are still in process. For those cases with completed investigations, OIG is aggressively pursuing administrative enforcement to recover overpayments. OIG has also increased and expanded

its investigative activities on dentists who bill other dental procedures beyond orthodontia. There has been a significant increase in complaints related to over-utilization of services, medically unnecessary services, solicitation, and improper inducements to Medicaid recipients by dentists in the large metropolitan areas of the state. Many dental providers have been placed on payment holds based on credible allegations of fraud. Such fraud consists of falsification of prior authorization documentation, solicitation, improper inducements, medically unnecessary services, and billing for services not rendered. The payment holds are an important protection against future federal and state payments based on false claims. OIG and MFCU are presently sharing evidence and exchanging information to ensure both administrative and criminal investigations have successful conclusions.

- OIG has completed investigations of multiple hearing aid providers. OIG started this initiative in calendar year 2011 based on identified and systemic fraud, waste, and abuse by this type of provider. As with the dental providers, OIG has placed numerous hearing aid providers on payment hold to prevent future state and federal payments to unscrupulous providers. These cases remain open in OIG with the Sanctions unit to continue the administrative enforcement process of recovering inappropriate overpayments, imposing civil monetary penalties, and possible exclusion. OIG is also working collaboratively with MFCU to share evidence and information to ensure successful outcomes in these investigations. These investigations have prompted a thorough review of Medicaid policy for hearing aid providers to help reduce future fraud, waste, and abuse. Additionally, HHSC is reviewing the Medicaid rates paid to hearing aid providers to ensure reimbursements do not create excessive or unanticipated costs to the Medicaid program.
- OIG is currently working on an investigative initiative that focuses on providers enrolled as Comprehensive Outpatient Rehabilitation Facilities (CORF) and Outpatient Rehabilitation Facilities (ORF). OIG targets these investigations to evaluate the high volumes of therapy provided to Medicaid children as well as allegations of improper solicitation and inducements.
- 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 is actively analyzing and preparing for investigative initiatives into other historical abuses by provider types where Medicaid dollars are at risk.
- OIG executed a contract with 21st Century Technologies (21CT) to implement a comprehensive solution to identify suspected fraud, waste, and abuse through graph pattern analysis logic using 21CT's technology, called LYNXeon. OIG and 21CT tested the LYNXeon by analyzing a subset of Medicaid data for a specific time period. With the initial analysis of this limited subset of data (estimated to be approximately 11 percent of the total Medicaid data available), 21CT was able to identify suspicious payments, many of which had an extremely high probability of being fraud related. OIG staff will continue to work with the vendor on the implementation of the next phase of the project, which includes expanding the data sets feeding into LYNXeon, development and implementation of a new investigative case management system and implementation of a data management solution.
- In FY 2012, OIG determined that it needed to shift more resources to the Medicaid Provider Integrity (MPI) Section to focus on fraud, waste, and abuse investigations of Medicaid providers. This action 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 consultants to perform medical

records reviews that are an essential part of provider investigations. OIG has decreased the processing time it takes to complete cases from approximately four years to approximately twelve weeks, becoming more active and aggressive with investigations. When OIG identifies provider fraud, waste, and abuse schemes as systemic or endemic to a certain provider type, OIG now takes its own initiative in cases by investigating and determining the extent of the program non-compliance or fraud. MPI has aggressively used new federal legislation in investigations to place payment holds on providers when investigators can verify a credible allegation of fraud. As a result, the number of providers on payment hold has increased significantly in FY 2012 and FY 2013 compared to previous fiscal years.

- OIG Compliance Division is in the process of auditing 34 Women's Health Program providers in the areas of operations, medical records, finances, and Title V, X, XIX and XX. The types of providers the Compliance Division has identified for audit are centers for disease detection, laboratories, community oriented care centers, family planning facilities, and county hospital districts. The Compliance Division is auditing facility operations and finances. After an initial audit of 30 facilities, OIG has identified approximately \$1.8 million for potential recovery.
- The OIG Compliance Division has completed 110 nursing facility reviews, comprising 10 percent of the total participating nursing facilities, from September 1, 2012, through February 28, 2013. Since September 1, 2012 (initiation of FY 2013 retrospective reviews), \$8,457,701.41 in overpayments have been identified via extrapolation and approximately \$2,439,013 in actual dollars in error have been identified in these reviews. The identified amounts are subject to "reconsideration and appeal" by each nursing facility.
- The Quality Review Department within the Compliance Division has completed 347 hospital reviews from September 1, 2012, through February 28, 2013. They have identified \$15,028,489 in net overpayments for recovery.
- The Limited Program or Lock-in Program (LP) works by limiting certain recipients to a single primary care provider, a single pharmacy, or both. Abuse can occur if a recipient engages in "doctor shopping" or "pharmacy shopping," or otherwise misusing benefits. Currently, LP has 314 people locked into a single pharmacy or primary physician. The LP held a workshop in June 2012 to hear concerns from MCOs about potential abuse of prescription medications or service providers, and holds routine monthly meetings with the MCOs. The MCOs have received education from the LP on how to identify high-risk candidates, and have started making referrals to the LP.
- On August 10, 2012, the Compliance Division issued a report to a contractor that identified \$112,647 in questioned costs, representing approximately 38 percent of the total contract. The report also identified that not only had the provider been reimbursed for a fire loss by the program, but had also received an insurance reimbursement. The case has been referred to the Travis County District Attorney's office.
- During the first six months of FY 2013, a WIC auditor in the WIC Vendor Monitoring Unit assisted the USDA in gathering evidence against a participating vendor. The vendor was approximately \$108,000 deficient in vendor invoices for items sold in the WIC program. A large amount of the missing invoices was for milk allegedly sold by the vendor. The WIC auditor asked the vendor's milk supplier to meet her at the bank where USDA investigators met the milk supplier instead. The milk supplier informed USDA investigators that the owner of the participating vendor had requested receipts for the total missing amount. The owner was convicted and sentenced in federal court for conspiring to commit WIC 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. 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.

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, and Enforcement Divisions,¹ 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.

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. 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 the following:

- 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.
- 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 Fraud, Waste & Abuse Referrals Received FY 2013 (1st & 2nd Quarters)

Referral Source	Received
Anonymous	36
Attorney	2
HHSC Medicaid/CHIP	2
HHSC – OIG Medicaid Provider Integrity (MPI) Self-Initiated	42
HHSC – OIG Utilization Review Division (UR)	1
HHSC – TAD	1
Managed Care Organization/Special Investigation Unit	37
Parent/Guardian	9
Provider	8
Provider Self-Reported	4
Public	36
Recipient	5
Texas Board of Dental Examiners	2
Texas Department of Aging & Disability Services (DADS)	8
Texas Department of Family and Protective Services (DFPS)	1
Texas Department of State Health Services (DSHS)	1
Texas Medicaid Healthcare Partnership (TMHP)	2
Texas State Legislator	1
United States Department of Health and Human Services OIG (U.S. HHS OIG)	2
Total Received	200

HHSC OIG Fraud, Waste & Abuse Referrals Referred FY 2013 (1st & 2nd Quarters)

Referral Source	Referred
Claims Administrator – Educational Contact	6
Managed Care Organization/Special Investigation Unit	39
Texas Attorney General Medicaid Fraud Control Unit (MFCU)	39
Texas Board of Dental Examiners	2
Texas Board of Nursing	1
Texas Board of Orthotics and Prosthesis	1
Texas Department of Aging & Disability Services (DADS)	6
United States Department of Health and Human Services OIG (U.S. HHS OIG)	3
United States Department of Labor	1
Total Referred	98

Medicaid Fraud, Waste & Abuse Workload Statistics and Recoupments – FY 2013

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Action	1st Quarter FY 2013	2nd Quarter FY 2013	Total FY 2013
Cases Opened	75	125	200
Cases Closed	73	81	154
Referrals to MFCU	24	15	39
Referrals to Other Entities	26	33	59
MPI Cases Completed & Transferred to Sanctions	3	14	17
MPI CAF Holds Referred to Sanctions	0	11	11
On-site DME Provider Verifications	31	20	51
Sanctions Recoupments ²	\$8,355,942.06	\$14,605,842.77	\$22,961,784.83
Providers Excluded	37	31	68

Medicaid Fraud & Abuse Detection System³

Action	1st Quarter FY 2013	2nd Quarter FY 2013	Total FY 2013
Cases Opened	1,901	574	2,475
Cases Closed	839	1,017	1,856

² 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.

³ 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 Medicaid Fraud Control Unit (MFCU) is charged with investigating fraud, waste, and abuse in the Medicaid program. In order to fulfill its mission, MFCU relies on referrals from OIG, state nursing home regulators, and local law enforcement agencies. MFCU conducts referral-based investigations, in part, because the federal grant that funds 75 percent of its operations specifies that OIG will conduct data mining of Medicaid claims providers submit, 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 \$835 million in suspected Medicaid overpayments and has obtained more than 920 criminal convictions. The unit has a staff of 196 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 OAG to independently prosecute Medicaid fraud, MFCU’s prosecutors must be cross-designated as Special Assistant U.S. Attorneys (SAUSAs) allowing OAG prosecutors to prosecute Medicaid fraud in federal court under the supervision of the U.S. Attorneys offices or as special assistant district attorneys. MFCU prosecutors have received cross-designation in all four U.S. Attorneys’ 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 concerned citizens, Medicaid recipients, current and former provider employees, HHSC OIG, other state agencies, and federal agencies. MFCU staff review every referral the unit receives, including 7,846 complaints and intake reports received from the DADS Client Assessment, Review and Evaluation System this reporting period. Referrals that have a substantial potential for criminal prosecution are investigated. 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
Federal Agencies and Entities	27
HHSC OIG	29
HHSC – Other than OIG	97
Hot Line / Ombudsman	0
Local Law Enforcement	5
Other	11
Provider Related	73
Pubic	151
Self-Initiated	12
State Boards and Agencies	9
Total Received	414

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 its investigations. Instead, HHSC OIG generally recovers fraudulent overpayments that MFCU investigators identify.

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's authority to prosecute Medicaid fraud cases in federal court. 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 2013 are as follows.

Action	1st & 2nd Quarters FY 2013
Cases Opened	250
Cases Closed	262
Cases Presented	140
Criminal Charges Obtained	73
Convictions	56
Potential Overpayments Identified	\$32,552,869.95
Misappropriations Identified	\$16,695.42
Cases Pending	1,208

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 \$400 million for the state treasury. With an annual budget of just \$6.2 million, CMF's recovery of \$130 million for the state treasury in FY 2012 was more than twenty 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. 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 reviewing potential additional amendments in order to continue to be eligible for the additional 10 percentage points of Medicaid recoveries.

CIVIL MEDICAID FRAUD STATISTICS

CMF Docket	1st & 2nd Quarters FY 2013
Pending CMF Cases/Investigations	452
Cases Closed	59
Cases Opened	68

During this reporting period, CMF settled and recovered funds in 15 matters, 8 of which were payments or recoveries over \$1 million:

1. *United States and Texas ex rel McCoyd et al v. Abbott (Depakote)* -- Total recovery including state, federal, and relator's portions was \$28,638,754.89.
2. *State of Texas v. All Smiles* -- Total recovery including state, federal, and relator's portions was \$1,200,000.00.
3. *State of Texas ex rel Galmines v. Novartis (Elidel)* -- Total recovery including state, federal, and relator's portions was \$19,900,000.00.

4. *State of Texas ex rel Ven-A-Care v. Endo* -- Total recovery including state, federal, and relator's portions was \$25,000,000.00.
5. *State of Texas ex rel Ven-A-Care v. Pharmacia/Upjohn/Lederle* -- Total recovery including state, federal, and relator's portions was \$25,000,000.00.
6. *State of Texas ex rel Ven-A-Care v. Actavis (installment payment on \$84 million settlement)* -- Total payment including state, federal, and relator's portions was \$19,000,000.00.
7. *State of Texas v. Inwood* – This settlement represents a total recovery of \$3,000,000.00 for the state and federal portions.
8. *State of Texas v. Upsher*– This settlement represents a total recovery of \$7,900,000.00 for the state and federal portions.

In addition, CMF concluded a settlement with Caremark resolving several pending lawsuits in April 2013 that will be detailed in the next report.

CMF continues to pursue significant cases against the following defendants:

1. 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.
2. Richard Malouf, D.D.S., All Smiles Dental Center, Inc., et al for misrepresentations in the provision of dental/orthodontic services.
3. Ranbaxy, an India-based generic drug manufacturer, for falsely reporting prices to Texas Medicaid used to calculate reimbursement to pharmacies.

Finally, the Dental Fraud Task Force headed by the Deputy Attorney General for Civil Litigation is comprised of senior officials from CMF, MFCU, HHSC, and OIG. The task force continues its investigation and review of fraudulent billing by orthodontic and dental providers is ongoing. Further details about the investigation cannot be included in this public report at this time.