Clete Buckaloo, Director of Law Enforcement
Office of the Attorney General

Senate Health and Human Services Committee
March 20, 2012

MEDICAID FRAUD CONTROL UNIT OVERVIEW:

- The Medicaid Fraud Control Unit (MFCU) has the responsibility for the investigation of criminal fraud by Medicaid providers. The mission of the MFCU is, through aggressive criminal investigation and prosecution, to create an industry deterrent so that Medicaid recipients can receive medical care in an environment as free as possible from fraud, physical abuse, and criminal neglect.

- In 2003, the Legislature expanded the MFCU by 200 FTEs and created eight field offices throughout the state. The expansion has paid off; restitution amounts have increased from $7.1 million in FY 2003 to more than $125 million in FY 2011. In addition, convictions have increased from 39 convictions in 2003 to 122 convictions in 2011. Restitution dollars obtained by MFCU go back to HHSC and the state Medicaid program.

- The primary source of the MFCU cases is from referrals from agencies under the supervision of HHSC and state, local and federal law enforcement agencies such as the HHSC-OIG, the FBI, and DEA. Cases also come from private citizens, Medicaid recipients, and Medicaid providers who have observed fraud or abuse, as well as from competitors, disenchanted former employees and ex-spouses and girlfriends. The Unit also generates approximately 13% of the cases from its independent effort. Many of these cases are spin-offs from referrals or from other cases because the original referral only identified a small portion of the fraudulent activity or individuals involved.

- After an investigation has been opened, it is MFCU's responsibility to collect evidence to support a criminal prosecution. In addition, MFCU has the responsibility to document any overpayment to support court ordered restitution at sentencing and to support administrative collection by HHSC, if appropriate.

- The MFCU is in constant communication with HHSC regarding Medicaid fraud. Both conduct formal and informal meetings on a regular basis. HB 2292 requires that the MFCU Director and the HHSC Inspector General meet on a quarterly basis. In addition to these formal meetings, the director of the Medicaid Fraud Control Unit communicates with the Inspector General on a weekly basis via telephone and e-mail. The MFCU Intake Section Chief has formal meetings monthly with the HHSC-OIG Director of Medicaid Provider Integrity and his staff and the Director of Sanctions. MFCU investigators and auditors coordinate joint investigations with HHSC investigators on a regular basis. HHSC provides

the MFCU with referrals and MFCU confirms the receipt of the referrals in writing. MFCU advises HHSC as to the status of referrals on a weekly basis. They provide HHSC with a pending case list on a monthly basis and provide HHSC with copies of all indictments. At the conclusion of an investigation, MFCU provides HHSC with a Closing Memo, court documentation, and a copy of the Investigative Report.

DENTAL/ORTHODONTIC FRAUD:

The MFCU is responsible for the investigation of criminal fraud by Medicaid providers. This includes fraudulent billing for orthodontic services.

We currently have 119 dentists under investigation. Thirty-one of the cases involve allegations of fraud in the billing of orthodontic services. Seven of the pending cases, representing approximately $3 million in alleged fraud, have been completed and presented to prosecutors. Two subjects involved in an alleged $808,000 fraud have been indicted and are awaiting trial.

In the past two years, we have presented 38 cases for prosecution, have had 15 subjects indicted, and obtained 7 convictions. All the defendants have been adjudicated, four received pre-trial diversions, one received probation or deferred adjudication and two received jail time. The two were sentenced to a total of 83 months and ordered to pay $1.8 million in restitution.

MEDICAID FUNDED LONG-TERM CARE FACILITIES:

While 90% of our cases involve fraud, 10% involve the other kinds of criminal activity. This other activity includes theft of medications, and physical and/or financial abuse. In the fraud area, we deal with billing for specific services that were not rendered and we deal with billing for substandard care. We work cases involving facility staff stealing medications that were prescribed for residents. We work cases where facility staff steal money from resident's trust funds and we work cases where facility staff physically abuse residents. The physical abuse ranges from simple assault to injuries caused by negligent acts, such as scalding residents, dropping residents, failing to prevent or treat bed sores, and failing to prevent residents from wandering away from a facility and being injured or killed.

MEDICAL TRANSPORTATION:

The Medical Transportation program includes ambulance companies and other providers of transportation for Medicaid recipients. Our cases typically relate to ambulance companies that transport patients who are ambulatory or wheelchair bound and do not qualify for ambulance transportation. If an ambulance company can get one dialysis

patient as a client, it has the opportunity to bill up to $100,000 a year. This scheme can include doctors who falsely certify patients for ambulance transportation.

We currently have 69 transportation cases open. This includes cases on 25 defendants who have been indicted and are awaiting trial. These cases represent $4.9 million in losses to Medicaid and Medicare. We also have one defendant convicted and awaiting sentencing.

In the past two years, we have presented 32 cases to prosecutors, had 26 subjects indicted, and obtained 31 convictions. Of the 31 convictions, 16 of the defendants have been adjudicated. Three received pre-trial diversions, 5 received deferred adjunction or probation and 8 received jail time. The 8 were sentenced to a total of 48 years and ordered to pay $8.5 million in restitution.

MFCU ACCOMPLISHMENTS

December 2002 through January 2012

Medicaid Overpayments Identified *	$603.9 million
MFCU Convictions (Fraud and Abuse combined)	786
Court-ordered Restitution (Fraud and Abuse combined)	$531.6 million

***** *OAG identifies Medicaid overpayments, and the OIG (HHSC) determines whether the case is further investigated and if there are additional overpayments to the provider that should be recovered.*