



JOINT ANNUAL INTERAGENCY COORDINATION REPORT

Fiscal Year 2025

INTRODUCTION

Pursuant to Texas Government Code, Section 544.0051(f), the Joint Interagency Coordination Report summarizes the collective efforts of the Texas Health and Human Services Office of Inspector General and the Texas Office of Attorney General to detect and prevent fraud, waste and abuse in the Texas Medicaid program for fiscal year (FY) 2025. Contributing to the report are:

- **Texas Health and Human Services Office of Inspector General (OIG)**
The Office of Inspector General prevents, detects, audits, inspects, reviews and investigates fraud, waste and abuse in the provision and delivery of all Texas health and human services and enforces state law related to the provision of those services.
- **Texas Office of Attorney General, Medicaid Fraud Control Unit (MFCU)**
The Texas Medicaid Fraud Control Unit investigates allegations of criminal fraud by Medicaid providers and abuse and neglect of Medicaid beneficiaries in a variety of settings, including health care facilities funded by the Medicaid program. Upon request by local and federal authorities, MFCU provides prosecution assistance.
- **Texas Office of Attorney General, Healthcare Program Enforcement Division (HPED)**
The Healthcare Program Enforcement Division investigates allegations of unlawful acts against the Medicaid, CHIP and Healthy Texas Women programs to prosecute meritorious civil claims and recover taxpayer dollars.

OIG, MFCU and HPED worked closely to strengthen collaborative efforts and information sharing in FY 2025 by:

- Conducting meetings between the MFCU Director, the Inspector General and key staff from both agencies.
- Engaging in regular meetings between MFCU, the OIG Investigations and Utilization Reviews Division, and the OIG Chief Counsel Division to focus resources and efforts on:
 - Maximizing recoveries while minimizing provider abrasion and duplicative efforts for specific cases under investigation.
 - Identifying unusual provider billing trends and other concerning provider activities.
- Dedicating OIG legal, analytic and investigative resources to support and coordinate MFCU and HPED efforts involving violations of the Texas Health Care Program Fraud Prevention Act and the Federal False Claims Act, and to participate in multistate investigations and settlement negotiations.

HIGHLIGHTS OF COORDINATION ACTIVITIES

The OIG and OAG are committed to collaboration and coordination in their efforts to identify and deter fraud, waste and abuse in the Medicaid program. These efforts range from the alignment of cross-agency processes to opportunities for management and staff at the OIG, MFCU and HPED to participate in joint training.

In FY 2025 the offices:

- Continued cross-agency processes to recoup provider overpayments when no criminal charges are filed and to deconflict overlapping administrative, civil and criminal investigations.
- Continued the scheduling of informal telephone and virtual conferences between OIG Investigations and Utilization Reviews Division supervisors and MFCU Field Office supervisors to discuss the advantages or disadvantages of parallel investigations when subject matter overlapped.
- Continued working collaboratively under the current Memorandum of Understanding (MOU) between OIG, MFCU and HPED. The MOU is updated every five years as a federal requirement for MFCUs and Medicaid single state agencies; it governs interagency cooperation and exchanges of information.
- Worked with one another to support criminal prosecutions, to include MFCU criminal investigators and prosecutors working with the OIG to secure access to and review of documentary evidence in possession of the OIG.
- Continued sharing of the MFCU closed case report with the OIG to assist in identification of the correct provider when restitution checks are received from court agencies that reference only a single defendant name.
- Supported each other's investigations, including the OIG providing advanced data analytics that assisted several OAG investigations.
- Coordinated with and made use of assistance from the OIG when requested data responses from managed care organizations (MCOs) were not received within the agreed time frame.
- Continued participation in the Texas Fraud Prevention Partnership (TFPP) group and individual meetings which are a collaboration between the OIG, MFCU and Texas Medicaid managed care organizations and dental maintenance organizations. These meetings promote collaboration in the prevention of fraud, waste and abuse, taking place three times a year.
- Coordinated and collaborated on multistate civil matters, which included attorneys and auditors serving on national investigation and settlement teams.
- Engaged in deconfliction communications.
- Made referrals to other units as appropriate.

KEY METRICS

The activities in the latest annual reporting period reflect progress and success in identifying and deterring fraud, waste and abuse in the Medicaid program.

HHS OFFICE OF INSPECTOR GENERAL

Action	FY 2025
Provider Enrollment Applications Processed	32,011
Individual Screenings Processed	91,991
Medicaid Investigation Cases Opened	1,737
Medicaid Investigation Cases Completed	1,884
Referrals to MFCU	270
Referrals to Other Entities	772
Hospital Claim Reviews Completed	15,674
Nursing Facility Reviews Completed	305
Settlement Agreements Executed	99
Credible Allegation of Fraud (CAF) Payment Holds Imposed	1
MFCU Directed Payment Holds Imposed	1
Medicaid Providers Excluded	364
Audits Completed*	34
Total Amount Recovered*	\$465,691,516

*Figures and audits include Medicaid and non-Medicaid totals.

OAG MEDICAID FRAUD CONTROL UNIT

Action	FY 2025
Referrals Received	2,201
Cases Pending	669
Cases Opened	245
Charges Obtained	185
Medicaid Overpayments Identified	\$27,771,861
Convictions	78
Fines and Restitution*	\$153,842,637

*Medicaid = \$15,678,444; non-Medicaid = \$138,164,193

OAG HEALTHCARE PROGRAM ENFORCEMENT DIVISION

Action	FY 2025
Cases Opened	83
Cases Closed	86
Cases Pending	355
Total Amount Recovered	\$71,605,100

SIGNIFICANT CASES

OIG MEDICAID PROGRAM INTEGRITY CASES

In FY 2025, the OIG settled several matters with significant recoveries, including:

- A \$17 million settlement with a pediatric hospital group, which self-disclosed that it was paid for more observation services than allowed by Medicaid.
- More than \$11.2 million in settlements from an initiative examining separate claims for injections and infusions already included in the emergency department evaluation and management rate.
- The recovery of \$1.2 million after an audit found that a provider billed Medicaid for unallowable facility fees during teleservices appointments.
- A \$1 million settlement with two Texas pharmacies that improperly billed Medicaid for COVID-19 test kits and automatic refills for test kits in violation of Medicaid policy.

OAG MEDICAID FRAUD CONTROL UNIT CASES

In FY 2025, MFCU concluded several cases with significant court-ordered Medicaid restitution. These include:

- The conviction of a physician with ordered Medicaid restitution of more than \$6.4 million and 120 months of prison time.
- The conviction of a marketer with ordered Medicaid restitution of more than \$4.9 million and 72 months of prison time.
- A plea with a durable medical equipment company with ordered Medicaid restitution of more than \$1.7 million and 60 months of prison time.

OAG HEALTHCARE PROGRAM ENFORCEMENT DIVISION CASES

In FY 2025, HPED settled several matters with significant recoveries. These include:

- A state civil action against Molina Healthcare, Inc. yielding a total Texas recovery of \$40 million including state, federal and relator portions.
- A state civil investigation against BioReference Laboratories, Inc., yielding a total Texas recovery of \$4.2 million including state and federal portions.

ONGOING OAG HEALTHCARE PROGRAM ENFORCEMENT DIVISION CASES

HPED continues to pursue significant cases against the following defendants:

- Drug manufacturer Tris Pharma, Inc. and Tris CEO Ketan Mehta for unlawfully promoting an ADHD drug through misleading claims about the drug's efficacy, causing the drug to be misbranded under federal and state law.
- Two adolescent medicine providers for the unlawful provision of cross-sex hormones and other drugs to transition minors' biological sex in violation of Texas Health and Safety Code § 161.702, Texas Occupations Code § 164.052(a)(24) and Texas Business and Commerce Code § 17.46(a), (b)(24).
- Drug manufacturers Bristol-Myers Squibb Company and Sanofi-Aventis U.S. LLC for promoting Plavix when they knew the drug had no therapeutic benefit on large groups of patients, thereafter causing the submission of claims paid by Texas Medicaid.

- Drug manufacturer Regeneron Pharmaceuticals, Inc. for inflating the average sales price (ASP) for the clinician-administered drug Eylea in its reports to CMS by failing to report credit card subsidies as price concessions. Texas Medicaid relies on drug manufacturers' ASP reporting to determine the Medicaid reimbursement methodology. Therefore, Texas Medicaid's payments for Eylea were also inflated.
- Lab testing company Medical Diagnostic Laboratories, LLC for misrepresentations to Texas Medicaid related to Texas Medicaid best price rules.
- Drug manufacturer Gilead Sciences, Inc. for misrepresentations to Texas Medicaid concerning the defendant engaging in unlawful marketing schemes involving numerous drugs to incentivize medical providers to prescribe its drug over other drugs on the market.
- Lab testing company Laboratory Corporation of America for misrepresentations to Texas Medicaid related to kickbacks and Texas Medicaid best price rules. The parties are engaging in briefing on the merits in the Texas Supreme Court.
- Drug manufacturer AstraZeneca for providing illegal kickbacks to physicians in the form of reimbursement support services and nurse educator services in connection with the prescription of certain drugs.
- Drug manufacturer Eli Lilly for providing illegal kickbacks to physicians in the form of reimbursement support services and nurse educator services in connection with the prescription of certain drugs.
- Pediatric dentists and dental marketing companies for engaging in illegal kickback schemes. The dental practices paid the dental marketing companies unlawful fees to steer patients to the dental practices and provided illegal remuneration to Medicaid beneficiaries.
- Planned Parenthood for failing to repay Medicaid millions of dollars for claims submitted after Planned Parenthood was disqualified and terminated from the Medicaid program.
- HPED also continues to investigate other matters that are under seal and cannot be described in detail at this time.

