INTRODUCTION

CREATION OF THE OFFICE OF INVESTIGATIONS AND ENFORCEMENT

Senate Bill 30, enacted by the 75th Legislature, directed the Texas Health and Human Services Commission (the Commission) to create the Office of Investigations and Enforcement (OIE). Established to investigate fraud and abuse in the provision of health and human services and enforce state law relating to the provision of those services, the OIE is required to set clear objectives, priorities, and performance standards for the office that emphasize:

- Coordinating investigative efforts to aggressively recover Medicaid overpayments;
- Allocating resources to cases that have the strongest supportive evidence and the greatest potential for recovery of money; and
- Maximizing the opportunities for referral of cases to the Office of the Attorney General.

MEDICAID FRAUD & ABUSE DETECTION SYSTEM - MFADS

Senate Bill 30 enacted, among other provisions, Texas Government Code, Section 531.106, which directs the Commission to use learning or neural network technology to identify and deter fraud and abuse in the Texas Medicaid program.

Medicaid Fraud and Abuse Detection System (MFADS) 3rd QUARTER FY2000

May 31, 2000 ended the 3rd quarter of the first option year of the MFADS contract. During this quarter two new targeted detection queries were deployed and client utilization reports were produced and delivered to the Texas Department of Human Services (TDHS). The contract amendment for the enhancements was signed with an effective date of May 1, 2000, with the work plan start date of May 15, 2000. The MFADS performance measures for the first quarter are detailed in the chart on page 3.

MFADS 4th QUARTER FY2000

August 31, 2000 ended the first option year of the MFADS contract. During this quarter one new targeted detection query and the enhanced model for 1999 were deployed. The MFADS performance measures for the second quarter are detailed in the chart on page 3.

MEDICAID FRAUD AND ABUSE DETECTION SYSTEM (MFADS)
PERFORMANCE MEASURES - FISCAL YEAR 2000

Performance Measures	FY98	FY99	FY00
# of Investigations Initiated Against Medicaid Providers	1,250	1,550	1,992
Phase 1	244		
Phase II	400		
Phase III	750		
Phase IV		24	
Phase V		192	
Phase VI		314	
Phase VII		1,037	
1st Quarter FY00			321
2nd Quarter FY00			1,022
3rd Quarter FY00			202
4th Quarter FY00			1,022
Total Number of Investigations Identified	1,394	1,567	2,567
% of FY Performance Measure Attained	112%	101%	129%
Total Dollars Identified for Recovery as a % of the MFADS Contract Cost	60% ($1,590,504)	100% ($3,176,646)	139% ($3,736,309)
Dollars Identified for Recovery			
Phase IV		$854,824	
Phase V		$180,025	
Phase VI		$2,021,483	
Phase VII		$166,369	
1st Quarter FY00			$2,964,623
2nd Quarter FY00			$561,614
3rd Quarter FY00			$427,085
4th Quarter FY00			$2,154,817
*Total Dollars Identified For Recovery		$3,222,701*	$6,108,139*
Total FY Contracted Cost	$2,650,840	$3,176,646	$2,687,992
% of FY 'Performance Measure Attained	138%	101%	163%
DOLLARS RECOVERED			
Phase III Recovery	$2,200,000	$89,112	
Phase IV Recovery		$60,791	
Phase V Recovery		$307,950	
Phase VI Recovery		$276,939	
Phase VII Recovery			
1st Quarter FY00			$414,051
2nd Quarter FY00			$878,785
3rd Quarter FY00			$1,011,569
4th Quarter FY00			$1,114,159
TOTAL RECOVERIES	$2,200,000	$734,792	$3,418,564

*This amount represents claims inappropriately paid based on policy and/or investigations. It does not represent the actual dollars that may be recoverable.

*This chart includes only activities by Systems Resources/MFADS staff that result in administrative recoupments as claims adjustments. Actions resulting from investigations referred by MFADS to MPI and the OAG are included in their reports.

Note: Total contracted cost for FY2000 has been increased from previous reports due to the contract amendment to provide additional services to support enhanced utilization review.

MFADS CONTRACTOR'S USE OF HUBS

According to the MFADS contract executed between the Commission and EDS, the primary contractor is required to submit a quarterly report on its efforts to utilize qualified Historically Underutilized Businesses (HUBs) vendors when purchasing goods and services necessary for the operation of MFADS. The contract dictates a commitment by EDS to attempt to reach a 5% level of HUB utilization. The percentage for the third quarter of fiscal year 2000 was .3%. The percentage for the fourth quarter of fiscal year 2000 was 4.8%. The project to date percentage was 2.6%.

MEDICAID FRAUD, WASTE & ABUSE STATISTICS

THE COMMISSION'S MEDICAID FRAUD, ABUSE, AND WASTE STATISTICS

For the third and fourth quarters of fiscal year 2000, the Medicaid Program Integrity division, Office of Investigations and Enforcement, achieved the following:

Action	3rd Quarter FY2000	4th Quarter FY2000	Total
Cases Opened	193	383	576
Cases Closed	329	276	605
Providers Excluded	89	209	298

FISCAL YEAR-2000 (3rd and 4th Quarters) RECOUPMENTS BY OIE

Office of Investigations and Enforcement Departments	3rd Quarter FY2000	4th Quarter FY2000	Total
Medicaid Program Integrity	$2,295,597	$856,084	$3,151,681
Civil Monetary Penalties	$19,000	$48,897	$67,897
Utilization Review-DRG (hospitals)	$10,890,436	$7,463,139	$18,353,575
Utilization Review- Tax Equity & Fiscal Responsibility Act (TEFRA)	$199,836	$15,372	$215,208
Case Mix Review (nursing homes)	$2,437,123	$2,070,686	$4,507,809
Compliance Monitoring and Referral	$4,089,404	$2,319,174	$6,408,578
Surveillance and Utilization Review Subsystems (SURS)	$310,225	$373,802	$684,027
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$1,011,569	$1,114,159	$2,125,728
TOTAL	**$21,253,190**	**$14,261,313**	**$35,514,503**

Cost Savings to the Texas Medicaid Program for Fiscal Year 2000[1]

Background

Effective September 1, 1997, the Commission formed the Office of Investigations and Enforcement (OIE). The OIE was established to investigate fraud and abuse in the provision of health and human services and enforce state law relating to the provision of those services.

In addition to its detection and investigative activities, the OIE has taken proactive measures to reduce errors in the billing, payment, and adjudication of claims for Medicaid services. Proactive measures taken by the Commission include fraud and abuse prevention training to Medicaid providers, including heath maintenance organizations, staff in the operating agencies, staff of the claims administrator, provider organizations, and provider staff. Other proactive measures undertaken by the Commission include workgroups with major provider associations, increased use of professional medical consultants, as well as a number of pilot projects designed to improve communication and education to providers.

Specific Achievements

In the long-term care program, the OIE staff has documented a consistent reduction in billing and assessment error rates. The average error rate for fiscal year 1999 was 14.63%, a reduction of 7.0% from fiscal year 1998. The average error rate for fiscal year 2000 was 12.4%, a reduction of 2.23% percent from fiscal year 1999 and 9.23% from fiscal year 1998. In fiscal year 2000, the OIE staff conducted 139 additional on-site reviews of nursing facilities, assessing a total of 25,973 records and clients, an increase of 1,693 assessments. In fiscal year 1999, the OIE staff made 3,617 assessment changes for 24,280 records. In fiscal year 2000, the changes were 3,238 for 25,973. The lower number of changes, even when based on additional records, reflects better assessment of client needs by the provider, which translates into better quality of care. Cost savings from Case Mix Review activities are estimated at slightly over $7 million for fiscal year 2000.

In fiscal year 1999, payments for long-term care services were slightly over $1.4 billion. In fiscal year 2000, payments for long-term care services were almost $1.5 billion. Based on these payments and the documented error rate, it is estimated that about $210 million were paid in error in fiscal year 1999 while $185.6 million were paid in error in fiscal year 2000, a reduction of $24.4 million.[2]

[1] Cost savings activities of OIE reported in April 2000 for the first six months of fiscal year 2000 were estimates based on prior performance and actual recoveries. Cost savings in this report are actual savings computed on 12 months of data.

[2] The error rate does not indicate fraud, abuse, or waste in the long-term care program. It does indicate erroneous assessments that may have resulted in higher, and in some cases lower, payments. The error rate is computed on a sample of records reviewed (approximately 26,000) during on-site visits (1,560) to long-term care facilities.

In the acute care program, the OIE has identified $72,131,445 in cost savings. Cost savings in the acute care program are defined as estimated savings to the state Medicaid program, which arise from administrative actions. In those situations where a sanction is taken against a provider, the savings also take into consideration the level of sanction. For example, if a provider is excluded from the Medicaid program, the cost savings are estimated based on the length of the exclusion. See the table on page 8.

For hospital inpatient services, the OIE identified a 2.6% reduction in error rate from 1998 to 1999, from 29.7% to 27.1%. At this time error rate was computed as the sum of the error rates for admission denials, DRG changes, and technical denials. Beginning with fiscal year 1999, error rate is computed as the average of the three error rates, rather than the sum, since these errors are not cumulative but independent.

In fiscal year 1999, the average error rate for the hospital program was 9%. In 1998, the average error rate was 9.9%, for a reduction of .9%. In fiscal year 2000, the average error rate for hospital reviews was 9.7%, an increase of .7%.

The error rate increase resulted from a decision by the OIE staff to focus the hospital utilization review sample on the more error-prone DRG's. This not only allowed increased recoveries, but it also highlighted the areas on which to focus provider education and outreach. During fiscal year 2000, Utilization Review staff recovered about $31.5 million dollars. Estimated payments to hospitals for inpatient care during fiscal year 2000 totaled $1,705,013,176 for a total of 2,405,230 services to Medicaid clients. Based on the level of payments, the OIE efforts result in approximately $31.5 million in cost savings for hospital inpatient services.[3]

Activities by the OIE during fiscal year 2000 have resulted in recoupments of $65,411,258 and cost savings of $72,131,445, for a total savings to the Texas Medicaid program of $137,542,703.[4]

[3] The error rate does not indicate fraud, abuse, or waste in hospital inpatient services. It does indicate erroneous assessments that may have resulted in higher, and in some cases lower, payments. The error rate is computed on a sample of records reviewed (approximately 36,000/year) during on-site visits and mail-in reviews (an average of 350 per fiscal year quarter).

[4] These figures do not include Third Party Recovery, Medical Appeals, and other program integrity activities performed by the Medicaid operating agencies. The tables on pages 23-24 provide a summary of program integrity activities by the Medicaid operating agencies and the Commission during the third and fourth quarters of FY2000.

COST AVOIDANCE/PROGRAM SAVINGS:

Medicaid Operating Agencies Cost Avoidance/Program Savings For Medicaid Fraud, Abuse, And Waste –FY2000

Office of Investigations and Enforcement Departments	TOTAL FY2000
Medicaid Program Integrity	$13,802,760 *based on total dollars identified *does not include civil monetary penalties
Utilization Review (DRG-hospitals)	$31,500,000
Case Mix Review (nursing homes)	$7,056,000
Surveillance and Utilization Review Subsystems (SURS)	$1,426,859
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$3,418,564
Compliance Monitoring & Referral	$12,546,475
Dental *Periodontal policy change *Actual $ paid to codes for March - August 1999	$2,380,787
TOTAL	**$72,131,445**

Texas Department of Mental Health and Mental Retardation	TOTAL FY2000
Medicaid Administration:	
• LON reviews for ICF-MR	$2,528,348
• LON reviews for HCS	$2,094,759
• IPC reviews	$825,284
TOTAL	**$5,448,391**

National Heritage Insurance Company	TOTAL FY2000
Medicaid Audits	$382,033,054
TOTAL	**$382,033,054**

Medicaid Operating Agencies Medicaid Fraud, Waste and Program Abuse Activities

The Medicaid Fraud, Waste and Program Abuse Task Force was formed in 1996 with the primary focus of exchanging information relevant to Medicaid fraud, waste or abuse activities of the health and human services operating agencies.

This task force meets quarterly to share information on fraud prevention activities.

Activities in the third and fourth quarters of fiscal year 2000 by the health and human services operating agencies have resulted in recoupments totaling $81,920,309 and civil monetary penalties, fines, or liquidated damages totaling $117,783,772. These totals include the Medicaid, Temporary Assistance for Needy Families (TANF), and Food Stamp programs.

The tables in Appendix A on pages 23-24 provide a detailed summary of program integrity activities by the health and human services operating agencies during the third and fourth quarters of fiscal year 2000.

Cost avoidance/program savings by the Medicaid operating agencies for fiscal year 2000 totals $459,612,890. See table on previous page (page 8)for details.

MEDICAID FRAUD DETECTION & ABUSE PREVENTION TRAINING PLAN

Under the provisions of Senate Bill 30, §531.105, the Commission is required to provide Medicaid fraud and abuse training to Medicaid contractors, providers and their employees and to state agencies associated with the Medicaid program.

Developed in cooperation with the Southwest Texas State University (SWT), the training component includes:

- An explanation of Medicaid fraud;
- Examples of fraud and/or abuse;
- The provider's responsibility for reporting fraud and/or abuse; and
- Information on the penalties for committing Medicaid fraud.

The training presentation also contains examples of actual schemes that have been used to defraud the Medicaid program. Participants are encouraged to ask questions and interact with the trainers. This informal and highly interactive presentation lasts approximately two hours; Continuing Education Credits (CEC) may be earned through SWT. For nursing facilities with Medicaid clients and home health agencies with Community Based Alternative (CBA) clients, the Fraud and Abuse training is offered in conjunction with the Texas Index of Level of Effort (TILE) training module. The module is available from SWT as a web based on-line course or as a correspondence course.

HMO FRAUD AND ABUSE COMPLIANCE PLANS

As mandated by SB 30, Health Maintenance Organizations (HMOs), who contract with the Texas Department of Health (TDH) under the State of Texas Access Reform (STAR) program, are required to develop fraud and abuse compliance plans for submission to TDH. These compliance plans are reviewed and approved by Commission staff. All HMOs have submitted compliance plans as required by their contracts and SB30.

TRAINING AND TECHNICAL ASSISTANCE TO HEALTH MAINTENANCE ORGANIZATIONS

To date, the OIE staff has delivered training on fraud detection, prevention, and reporting to all managed care organizations under contract with the Texas Medicaid program.

Development of a Fraud & Abuse Compliance Plan

Prompted by the wide variety in the fraud and abuse compliance plans received by the Commission from the HMOs who contract for Medicaid reimbursement for medical services provided, the Commission contracted with SWT to compile a uniform fraud and abuse compliance plan that can be utilized by all the HMOs.

In order to develop the compliance plan, SWT researched current practices of health care organizations nationwide and explored the most recent sources of information available. SWT solicited input from Managed Care Organizations (MCOs)/HMOs and the Medicaid operating agencies to compile a model plan that is basic, but effective. The model plan includes all the elements suggested by the Office of the Inspector General (OIG), U.S. Health and Human Services Commission and Senate Bill 30, 75th Legislature.

In addition, SWT assessed the training and technical assistance needs of the MCOs and presented a report to the OIE at the Commission. From this assessment, the OIE developed a training curriculum specific to managed care, which will be offered to MCOs, their officers, and staff by Commission staff.

OIE Fraud Training
March 1 - August 31, 2000

Audience	# OF SEMINARS	ATTENDANCE
State Agencies and Associations	5	62
Managed Care Organizations	1	40
TOTALS	**6**	**102**

Effective July 15, 2000, SWT began accepting requests for the Fraud and Abuse training/TILE correspondence course. As of August 31, 2000, 56 copies of the correspondence course have been mailed to students.

Medicaid Fraud & Abuse Detection and

Prevention Publicity Efforts

Section 531.108 (b)(1) requires the Commission to "aggressively publicize successful fraud prosecutions and fraud-prevention programs through all available means, including the use of statewide press releases issued in coordination with the Texas Department of Human Services."

Within the Commission lies the primary responsibility for activities relating to the detection, investigation, and sanction of Medicaid provider fraud, abuse, and waste across all state agency lines, regardless of where the provider contract is administered. The Commission refers all suspected criminal Medicaid fraud complaints to the Medicaid Fraud Control Unit (MFCU) and refers all suspected civil Medicaid fraud complaints to the Elder Law and Public Health Division (ELD) both of the Office of the Attorney General (OAG) for potential prosecution. Any publicity efforts on criminal or civil prosecution originate from the OAG.

Medicaid Fraud and Abuse Prevention Communications Plan

The Commission relies on its *Medicaid Fraud and Abuse Prevention Communications Plan* (the Communications Plan) when informing stakeholders of fraud prevention activities. These activities are carefully accomplished through a collaborative effort between the Commission and those agencies in partnership on a specific investigation.

When working on fraud and abuse investigations in conjunction with the federal government, the Commission sometimes faces federal confidentiality restrictions. These cases can sometimes be the ones with the greatest publicity value in terms of recovery amounts and settlement terms.

OTHER COMMUNICATION TOOLS

The Commission continues to use other communications tools to disseminate information on Medicaid fraud and abuse detection and prevention efforts. Some of these tools include:

- Texas Health and Human Services Commission Web Page (www.hhsc.state.tx.us);
- Texas Health and Human Services Commission Newsletter, *The Service Connection*;
- Texas Department of Human Services Press Clippings;
- Texas Department of Human Services News Releases;
- Texas Department on Aging Newsletter Clip, *Aging Texas*;
- Public Hearings; and
- Targeted Mailings.

THE SERVICE CONNECTION

Texas Health and Human Services Commission newsletter, July 2000

Medicaid fraud training to go on-line

Working in conjunction with the Quality Institute at Southwest Texas State University, the Texas Health and Human Services Commission's Office of Investigations and Enforcement is working on the development of distance learning training programs. These innovative programs will be made available to staff of the Long Term Care Facilities that participate in the Medicaid program and for home health agencies that participate in the Community Based Alternative program. In addition to the various seminars that are held at various sites statewide, training in Identifying and Preventing Fraud and Abuse in the Medicaid program and the Texas Index of Level of Effort (TILE) Assessment will be offered as correspondence courses and in computer-based, on-line formats.

Charged with the responsibility of delivering training designed to reduce Medicaid fraud and also support the training of the TILE Assessment for the staff of the Long Term Care Facilities and Community Based Alternative Care Facilities, the Commission has taken a focused look at the need to offer training opportunities through a wide array of approaches. Additionally, legislative mandates for fraud training along with the frequent turnover of staff members in long term care and home health agencies, place an increased dimension on the need for training.

The contract with SWT calls for the correspondence courses to be available as of July 1, 2000, and for the computer-based courses to be on line as of September 1, 2000. The Commission will provide the mailing address for the correspondence courses prior to the date of onset. Access to the computer-based courses will be via the Commission Web Page with a direct link to SWT.

Content of both distance-learning courses will be adapted from current Medicaid Fraud Prevention Training and T.I.L.E. training material. Updates will be made as necessary, based on policy changes and/or Legislative actions.

As in the seminar structured training, a test will accompany the T.I.L.E. training module and a score of at least 70% correct answers will be required to pass the test. The test will be recorded as Pass/Fail. The Commission will inform participants of pass/fail status within seven working days of course completion. A *Certification of Completion* of the training course will be issued by the Commission when all requirements are met. 2.0 hours of Continuing Education credits will continue to be available for $20 from SWT for the fraud prevention portion of the training.

The Commission will also continue to conduct training seminars on an as needed basis for those who do not have computer access, do not wish to use either the correspondence or computer method of delivery, or just prefer a group training format.

Campaign targets transportation scam

The scenario follows a typical pattern - someone offers something for nothing. In this case, the "something" is free transportation for children who receive medical services that are often not needed.

The purpose of this scam is to offer children and/or their parents transportation for medical services that are often unneeded or never provided. Sometimes, the offer includes financial incentives, like school supply vouchers, meals, or even money. Occasionally, the person offering the inducement pretends to be a Medicaid representative in an effort to dupe a parent into giving permission for their children to be transported to a Medicaid provider who may be unscrupulous or committing fraud against the Medicaid program. Some of these scam artists have even told parents their Medicaid eligibility will be terminated if they do not allow their children to be transported to a service provider.

The Office of Investigations and Enforcement (OIE) investigates these cases carefully. The Commission has reviewed reports of small children being transported long distances and kept away from their homes for 8-10 hours. In one unfortunate case, a small child was left unattended in a van overnight.

The Commission has started to alert parents and Medicaid recipients of these dangerous scams by including an informational insert in the June Medicaid card mailing. The insert warns Medicaid clients not to allow their children to travel with anyone who offers free transportation for Medicaid services and never to give permission for their child to travel with unknown persons.

The mail-out information also advises clients on how to obtain transportation for their children or themselves. A toll-free number, 1-877-633-8747 is included in the mail-out.

We seek your cooperation to stop these practices. If your clients need transportation, please direct them to the toll-free number in the mail-out. If you have knowledge of any such scheme, please contact the OIE at 1-888-752-4888 and leave a message.

OFFICE OF INVESTIGATIONS AND ENFORCEMENT

STAFF PRESENTATIONS ON SB 30 AND RELATED TOPICS

March 1, 2000 - August 31, 2000

Presentation Date	Presentation Audience	Presentation Subject	Presenter
03/06/00	TCADA (Houston office)	SB30: Fraud Prevention in Medicaid	Teresa Habel D'onn Ward
03/07/00	TCADA (Dallas office)	SB30: Fraud Prevention in Medicaid	Teresa Habel D'onn Ward
03/20/00	TCADA (Austin office)	SB30: Fraud Prevention in Medicaid	Teresa Habel D'onn Ward
03/20/00	General Investigating Committee	OIE Overview and MFADS Presentation	Aurora LeBrun
03/21/00	Parkland Community Health Plan (Dallas)	SB30: Fraud Prevention in Medicaid	Teresa Habel
05/24/00	Legislative Budget Board	MFADS Presentation	Brian J. Klozik
06/19/00	General Investigating Committee	OIE Overview and MFADS Presentation	Aurora LeBrun
06/20/00	HCFA National Technology Conference, Washington, DC	Electronic Fraud Detection Initiatives	Aurora LeBrun
07/14/00	Permian Basin Health Information Management Association (Midland)	SB30: Fraud Prevention in Medicaid	Teresa Habel
08/10/00	Texas Department of Health/Bureau of Managed Care: Quarterly Meeting of Managed Care CEOs & Medical Director	SB30: Fraud Prevention in Medicaid	Aurora LeBrun Teresa Habel
08/28/00	National Association of Surveillance Officers (NASO) National Conference, Jackson Hole, Wyoming	MFADS Presentation	Aurora LeBrun

FRAUD PREVENTION EFFORTS BY THE TEXAS DEPARTMENT OF HUMAN SERVICES

Under the provisions of Texas Government Code, Section 531.108, the Commission is required to compile and disseminate accurate information and statistics relating to fraud prevention, including specific requirements to:

- Develop a cost-effective method of identifying applicants for public assistance in certain areas who are receiving benefits in other states;
- Verify automobile information used as eligibility criteria;
- Establish a computerized matching system with the Texas Department of Criminal Justice (TDCJ) to prevent an incarcerated individual from illegally receiving benefits; and
- Submit a semiannual report to the Governor and the Legislative Budget Board on the results of the computerized matching with other states and TDCJ.

Since the TDHS is the agency that determines eligibility for public assistance, to comply with the provisions contained in Section 531.108, the agency has worked closely with the Commission.

State-to-State Matches

Section 531.108 requires matching with states neighboring Texas. During fiscal year 2000, as a result of information received from Louisiana, 193 cases were denied or had benefits reduced. The savings from these denials or reductions in benefits was $26,286. Also as a result of the Louisiana information, 62 cases, with a theft amount of $9,470, were referred for fraud investigation, and 48 cases, with an estimated combined overissuance of $8,060, were referred for benefit claims establishment.

The information generated by the computer match with New Mexico resulted in the denial or lowering of benefits in 159 cases, with a total of $27,380. An additional thirteen cases, with a total theft amount of $4,885, were referred for fraud investigation, and another twelve cases, with a combined overissuance of $1,434, were referred for claims establishment.

The computer match project with Oklahoma provided information that resulted in the denial or reduction in benefits for 304 cases, resulting in $38,904 in savings.

Twenty-five cases were referred for fraud investigation, with a theft amount of $13,154, and thirty cases, with a combined overissuance of $13,154, were referred for claims establishment.

The TDHS has worked to initiate a matching program with Arkansas, but has not yet been successful in negotiating an agreement with that state.

Taking into account modern migration patterns within the United States, the TDHS has worked to identify additional opportunities for matching programs with other states. The Office of Inspector General (OIG) has conducted a match with the states of Tennessee and Florida, resulting in 29 identifications of individuals who may be receiving benefits in more than one state. These potential matches are currently undergoing investigation. In addition, the TDHS is working with a consortium of 20 other states and the District of Columbia to conduct a match to identify individuals who are receiving benefits in any two of the participating jurisdictions.

Motor Vehicle Information

Section 531.108 requires the use of motor vehicle data for use in eligibility determination to ensure that correct information regarding client resources is available to Texas Works Advisors. The TDHS has included motor vehicle registration and value information in its Data Broker initiative, which allows Texas Works Advisors to obtain information regarding client vehicle and property ownership.

Criminal Justice Matches

For fiscal year 2000 YTD (through June), the computer match with the Texas Department of Criminal Justice resulted in the denial or reduction of benefits in 2,011 cases, with a total savings of $43,957. In 48 cases, referrals were made for fraud investigation, with a total theft amount of $18,256, and in another 154 cases, referrals were made for claims establishment, with a combined overissuance of $38,295.

Other Fraud Prevention Initiatives

The TDHS has developed a comprehensive and innovative approach to quality control that emphasizes pro-active measures to save tax dollars and ensure that Texans receive the amount of benefits to which they are entitled. Anti-fraud initiatives are critical to the success of that effort. The TDHS' approach includes initiatives both to prevent fraud, and to detect and deter it wherever it occurs.

These initiatives include the continuation of the agency's nationally-recognized program, which identifies, investigates and prosecutes trafficking in Electronic Benefits Transfer (EBT) benefits. During fiscal year 2000, OIG conducted 32 criminal investigations and 488 administrative investigations with a total established theft amount of $172,387. During the same time period, trafficking cases investigated by OIG resulted in 14

criminal convictions and 484 administrative dispositions, with an established theft amount of $247,422.

The United States House of Representatives' Budget Committee established a Task Force on Welfare. The Task Force held its first hearing on July 19 and recognized Texas' leadership in the detection and deterrence of electronic benefits trafficking by inviting OIG to testify during its hearing on the subject. Texas was the only state invited to testify.

In March, the General Accounting Office, an arm of the United States Congress, issued a report recognizing two states – Maryland and Texas -- as doing the most to detect and deter Food Stamp trafficking. The report examined trafficking investigation and prosecution programs in 22 states. Among those 22 states, Texas accounted for 43 percent of all disqualifications from the Food Stamp program for participation in benefit trafficking.

During fiscal year 2000, OIG has completed 8,009 investigations (both field and administrative), resulting in 2,610 court adjudications, with $15.9 million in recoveries of taxpayer funds.

Quality Control

As a result of the TDHS' quality control initiatives, Texas lowered the AFDC-TANF Payment Error Rate (PER) by more than 40 percent between Federal Fiscal Year 1994 (FFY 1994) and FFY 1999, saving millions of dollars in public funds. During the same time period, Texas lowered the Food Stamp PER by more than 63 percent. For FFY 1999, Texas once more achieved the lowest Food Stamp PER of the nation's eight largest-issuance states.

For the past two years, Texas's performance in payment accuracy has earned the state enhanced federal funding for excellence in quality control. The $27.9 million award by the United States Department of Agriculture (USDA) to Texas for FFY 1999 was the largest obtained by any state in the history of the program. Enhanced funding and progress in lowering the PER for both programs could not have been achieved without the substantial contribution made by the TDHS' innovative fraud prevention and detection programs, which are considered a model for the nation.

For FFY 2000, year-to-date (YTD), the TDHS' state findings show the Food Stamp PER to be 3.60 percent. This finding is subject to regression during re-review by the USDA. The TDHS is optimistic that Texas will again qualify for enhanced federal funding for FFY 2000 when the federal agency completes its review of the state findings. The state findings for FFY 2000 YTD in the TANF program are 2.72 percent. Since TANF is now a block grant program, the PER is no longer subject to federal re-review and does not earn enhanced funding. However, the TDHS continues to emphasize accuracy in the determination of benefits.

MAINTENANCE AND PROMOTION OF A TOLL- FREE HOTLINE

To meet the provisions of Texas Government Code, §531.108, the Commission developed an agreement with TDH to utilize its existing toll-free hotline and operators to ensure that a toll-free hotline for reporting Medicaid fraud and/or abuse is maintained and promoted.

SPECIALIZED MEDICAID FRAUD DETECTION TRAINING FOR TOLL-FREE HOTLINE OPERATORS

The Commission's Education and Staff Development Department conducted specialized Medicaid fraud detection training for the Medicaid hotline operators who receive calls with information on suspected Medicaid fraud and/or abuse refer the information to the Commission's Medicaid Program Integrity (MPI) Department.

In addition, MPI maintains a 24-hour fraud line at 1-888-752-4888.

AVAILABLE TOLL-FREE NUMBERS

Callers who wish to use a toll-free hotline may call the following numbers:

- To report Medicaid provider fraud and/or abuse – 1-888-752-4888;
- To report Medicaid client fraud and/or abuse -- 1-800-436-6184;
- For Medicaid client information – 1-800-252-8263;
- For Medicaid provider information – 1-800-873-6768; and
- To report Medicare fraud and/or abuse – 1-800-447-8477 (HHSTIPS).

Hotline numbers are publicized through stuffers in recipient and provider mail outs, posters in appropriate offices of the operating agencies, and publications of the operating agencies and the Commission.

In June 2000 a mail-out from the Commission was sent to all Medicaid recipients that contained a notice, in English and in Spanish. This notice cautioned parents of Medicaid recipients to not allow their child to go with any unauthorized person offering transportation to a doctor, dentist, or other health care provider for Medicaid medical or dental services or to accept money or gifts for Medicaid reimbursed health or dental services. The mail-out also informed parents if a child requires treatment or services of a medical or dental health care provider and they have no means of transportation, they can call a toll-free number for information about available transportation. An English and Spanish copy of the test of the mail-out is below.

IMPORTANT INFORMATION FOR PARENTS

We have been warned that there are people offering free transportation for children to receive medical and dental services. You may even be told that you will lose your Medicaid benefits if you refuse this transportation.

This is a dangerous scam.

DO NOT allow your child to go with anyone offering free transportation for Medicaid services.

You will not lose your or your child's Medicaid benefits if you refuse to allow your child to go.

Here are some guidelines for safe transport and treatment for your children:

If you need transportation for your child or yourself to obtain medical or dental services, call this toll-free number **1-877-633-8747.**

Do not sign a form or otherwise give permission to an unauthorized person for medical or dental services for your child.

Do not accept money or gifts in exchange for Medicaid information or transportation for medical services.

To be sure that someone is a Medicaid employee, you can request to see identification. Also, you may ask for the name, address, and telephone number of their immediate supervisor and office.

Don't be a victim of Medicaid Fraud.

INFORMACIÓN IMPORTANTE PARA LOS PADRES

Tenemos información que ciertas personas han estado ofreciendo transporte gratis para menores que van a recibir servicios médicos y dentales. Algunas de estas personas le han dicho a los padres que pueden perder los servicios de Medicaid, si se niegan a recibir transporte.

Esto es un negocio fraudulento y peligroso.

NO permita que su niño vaya con ninguna persona que ofrece servicios gratis de transporte para menores que reciben servicios de Medicaid.

Usted NO PERDERA sus beneficios de los servicios de Medicaid ni los de su niño, si no acepta el transporte.

Si Ud. necesita transporte para su niño o para Ud. para ir al doctor o al dentista, llame a este número telefónico **1-877-633-8747.**

No firme ningún formulario o documento; no permita que una persona desconocida le dé servicios médicos o dentales a su niño.

No acepte dinero o regalos a cambio de información de servicios de Medicaid transporte para servicios médicos.

Si alguien le dice que es un empleado de Medicaid, Ud. debe solicitar ver una identificación. Tabién puede preguntarle el nombre, dirección y número de teléfono de su supervisor inmediato y de la oficina.

No sea una víctima de fraude de Medicaid.

Texas Health and Human Services Agencies
FY00 (3rd and 4th Quarters) Medicaid Fraud, Waste and Program Abuse Activities

PROGRAM RECOVERIES:

Agency Name	Overpayments				Monetary Penalties, Fines, Liquidated Damages or Other			
	Provider/Contractor/ Vendor		Recipient/Client		Provider/Contractor/ Vendor		Recipient/Client	
	Total $	Medicaid $	Total $	Medicaid $	Total $	Medicaid $	Total $	Medicaid $
Health & Human Services Commission:								
• Medicaid Program Integrity	$3,151,681	$3,151,681	NA	NA	$67,897	$67,897	NA	NA
• Utilization Review: hospitals	$18,353,575	$18,353,575	NA	NA	NA	NA	NA	NA
- Case Mix (nursing homes)	$4,507,809	$4,507,809	NA	NA	NA	NA	NA	NA
• Compliance Monitoring & Referral	$6,408,578	$6,408,578	NA	NA	NA	NA	NA	NA
• Surveillance & Utilization Review Subs ystems	$684,027	$684,027	NA	NA	NA	NA	NA	NA
• Tax Equity & Fiscal Responsibility Act Claims -TEFRA	$215,208	$215,208	NA	NA	NA	NA	NA	NA
• Medicaid Fraud & Abuse Detection System -MFADS - dollars recovered	$2,125,728	$2,125,728	NA	NA	NA	NA	NA	NA
Texas Departm ent of Human Services:								
• Office of Inspector General	NA	NA	$6,114,668[1]	$491,787	NA	NA	NA	NA
• Office of Programs – Community Care	$4,336	$4,336	NA	NA	$478.00	$478.00	NA	NA
• Long Term Care Regulatory	NA	NA	NA	NA	$884,352	NA	NA	NA
Texas Interagency Co uncil on Early Childhood Intervention – Provider Funding	$337,223	$337,223	NA	NA	NA	NA	NA	NA
Texas Department of Health:								
• Medical Appeals & Provider Resolution	$192,554	$192,554	NA	NA	NA	NA	NA	NA
• Third Party Resources	$247,407	$247,407	NA	NA	NA	NA	NA	NA
• Vendor Drug	$2,052,024	$2,052,024	NA	NA	$116,831,045[2]	$116,831,045	NA	NA
• Bureau of Children's Health	NA	NA	NA	NA	NA	NA	NA	NA
National Heritage Insurance Company – Medicaid Audits	$37,371,134[3]	$37,371,134	NA	NA	NA	NA	NA	NA
Texas Department of M ental Health & Mental Retardation – Medicaid Administration	$154,357	$94,714[4]	NA	NA	NA	NA	NA	NA
Texas Department of Protective & Regulatory Services	NA	NA	NA	NA	NA	NA	NA	NA
Texas Juvenile Probation Commission	NA	NA	NA	NA	NA	NA	NA	NA
Texas Commission on Alcohol & Drug Abuse [5]	NA	NA	NA	NA	NA	NA	NA	NA
Texas Rehabilitation Commission [6]	NA	NA	NA	NA	NA	NA	NA	NA
Texas Department on Aging	NA	NA	NA	NA	NA	NA	NA	NA
Texas Commission for the Blind	NA	NA	NA	NA	NA	NA	NA	NA
TOTAL	**$75,805,641**	**$75,745,998**	**$6,114,668**	**$491,787**	**$117,783,772**	**$116,899,420**	**NA**	**NA**

[1] Includes the following programs: Food Stamp, Temporary Assistance for Needy Families, Medicaid.

[2] Amount recovered through Manufacturer Rebates.

[3] Includes cost settlement based on cost reimbursement methodology.

[4] Majority of Medicaid dollars recouped resulted from billing and payment reviews conducted for Case Management and Mental Health Rehabilitation. Only federal share of the rate is recouped. For ICF/MR and the waiver programs there is a 100% recoupment.

[5] During the third and fourth quarters of FY00, TCADA did not expend any Medicaid dollars in any of the areas above and no recoveries were made.

[6] TRCs only Medicaid funded program during FY99 was the Deaf -Blind Multiple Disability Medicaid Waiver Program. While this program utilized Medicaid funds for client services, the administrative costs for this program were paid from the General Fund. Effective 9/1/99, this program was transferred to TDHS.

Texas Health and Human Services Agencies
FY00 (3rd and 4th Quarters) Medicaid Fraud, Waste and Program Abuse Activities

OTHER STATISTICS:

Agency Name	# of Eliminations from Participation		# of Case Investigations Closed		# of Criminal Investigations	# of Civil Judgements	# of Administrative/ Agency Hearings	
	Provider/ Contractor/ Vendor	Recipient/ Client	Provider/ Contractor/ Vendor	Recipient/ Client	Recipient/ Client	Provider/ Contractor/ Vendor	Provider/ Contractor/ Vendor	Recipient/ Client
Health & Human Services Commission:								
• Medicaid Program Integrity	298	NA	605	NA	NA	NA	NA	NA
• Utilization Review: case mix (nursing homes)	NA	NA	844	13,826	NA	NA	NA	NA
• Utilization Review: hospitals	NA	NA	710	19,530	NA	NA	NA	NA
Texas Department of Human Services:								
• Office of Inspector General	NA	3,183[1]	NA	4,850[2]	2,381[3]	NA	NA	4,889[4]
• Office of Programs – Community Care	171	NA	NA	NA	NA	NA	NA	NA
• Long Term Care Regulatory	16	NA	NA	NA	NA	2	50	NA
Texas Interagency Council on Early Childhood Intervention – Provider Funding	NA	NA	NA	NA	NA	NA	NA	NA
Texas Department of Health:								
• Medical Appeals & Provider Resolution	NA	NA	3,717	NA	NA	NA	5	NA
• Third Party Resources	NA	NA	NA	NA	NA	NA	NA	NA
• Vendor Drug	NA	NA	NA	NA	NA	NA	NA	NA
• Bureau of Children's Health	NA	NA	NA	NA	NA	NA	NA	NA
Texas Department of Mental Health & Mental Retardation – Medicaid Administration	13	NA	NA	NA	NA	NA	NA	NA
Texas Department of Protective & Regulatory Services	NA	NA	NA	NA	NA	NA	NA	NA
Texas Juvenile Probation Commission	NA	NA	NA	NA	NA	NA	NA	NA
Texas Commission on Alcohol & Drug Abuse	NA	NA	NA	NA	NA	NA	NA	NA
Texas Rehabilitation Commission	NA	NA	NA	NA	NA	NA	NA	NA
Texas Department on Aging	NA	NA	NA	NA	NA	NA	NA	NA
Texas Commission for the Blind	NA	NA	NA	NA	NA	NA	NA	NA
TOTAL	**498**	**3,183**	**5,876**	**38,206**	**2,381**	**2**	**55**	**4,889**

[1] Includes the following programs: Food Stamp and Temporary Assistance for Needy Families
[2] Includes the following programs: Food Stamp, Temporary Assistance for Needy Families, Medicaid
[3] Includes the following programs: Food Stamp, Temporary Assistance for Needy Families, Medicaid
[4] Includes the following programs: Food Stamp and Temporary Assistance for Needy Families