INTRODUCTION

BACKGROUND

The 75th Legislature in 1997 directed the Texas Health and Human Services Commission (HHSC) to create the Office of Investigations and Enforcement (OIE). The 78th Legislature created the new Office of Inspector General. The Office of Inspector General assumed all the duties of HHSC's Office of Investigation and Enforcement and also all fraud and abuse functions of other health and human services (HHS) agencies. It is responsible for investigation of fraud and abuse in health and human services programs. The Office of Inspector General will provide oversight of HHS activities, providers, and recipients through compliance and enforcement activities designed to identify and reduce waste, abuse, or fraud; and improve efficiency and effectiveness within the HHS system.

It was established to continue and expand the previous mission 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 OIG 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.

RECENT DEVELOPMENTS

The 78th Texas Legislature, Regular Session, 2003, enacted sweeping changes to the composition, structure, and delivery of health and human services in Texas. The 78th Legislature also strengthened Health and Human Services Commission's (HHSC) authority to combat fraud, abuse, or waste in health and human services programs. These mandates were enacted, for the most part, through House Bill 2292 but also through House Bill 1743. A major focus of House Bill 2292 is the consolidation and streamlining of services currently provided by twelve health and human services agencies into five agencies, under the direction of the HHSC. It also creates the Office of Inspector General within the HHSC, consolidating compliance and enforcement functions that were within the legacy agencies into the single office under the Executive Commissioner, HHSC.

Within the same legislation, the Office of the Attorney General (OAG) Medicaid Fraud Control Unit (MFCU) was appropriated funding. HHS OIG approved matched federal grant funds, which could expand the AG MFCU from its current level of 96 staff to up to 236 staff.

The MFCU has increased its staff by 55 and has opened field offices in Dallas, Houston, Lubbock, and Tyler.

The legislation contains provisions to improve the detection and prevention of fraud, waste and abuse by providers, recipients, contractors, and employees who participate in the delivery and receipt of health and human services programs, including the state Medicaid program. The HHSC and the OAG have established guidelines under which provider payment holds and exclusions from the Medicaid program are implemented. Timelines and minimum standards have been established for the HHSC Office of Inspector General for making referrals to the MFCU and vice versa. This will enhance the timely investigation of potentially fraudulent providers.

MEMORANDUM OF UNDERSTANDING

Pursuant to the requirements of Senate Bill 30 of the 75th Legislature, a memorandum of understanding (MOU) was executed in April 1998 between the HHSC's Medicaid Program Integrity Department (MPI) and the MFCU. The MOU was updated and expanded in November 2003 in accordance with House Bill 2292 which required HHSC and the OAG to enter into a new MOU no later than December 1, 2003. The revisions to delineate the roles and expectations of the respective agencies, which were required by HB 2292, were accomplished. The MOU facilitates the development and implementation of joint written procedures for processing cases of suspected fraud, abuse, and/or waste under the state Medicaid program. The MOU ensures cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases arising in the state and has proved to be beneficial to both agencies.

INTERAGENCY COORDINATION EFFORT

HHSC and the OAG recognize the importance of partnership and regular communication in the coordinated effort to fight fraud and abuse in the Medicaid program. This latest biannual reporting period has seen more progress and success in this area than in many prior periods, thanks to a renewed cooperative spirit and the efforts of both agencies. For example, the following has occurred in the last six months:

- An increased commitment by both agencies to promptly send and/or act upon referrals, accomplished by improving turnaround time in addressing recent referrals and systematically revisiting older referrals.

- Regular case presentation meetings initiated by HHSC OIG to introduce critical cases to MFCU staff in order to conduct joint investigations.

- Constant communication on cases throughout all staff levels, ensuring all case resources and knowledge is shared and efforts are not duplicated.

- Joint training across the two agencies - HHSC OIG staff attended MFCU training sessions in this reporting period and HHSC OIG management has planned two orientation sessions for MFCU staff during this upcoming reporting period.

Periodic planning sessions have occurred to coordinate case methodology guidelines that apply to all cases, regardless of type.

MFCU and MPI currently continue to move forward on a joint case management program project. Both agencies have selected cases to investigate, performed statistically valid random samples and have exchanged data with the Texas Department of Health to determine the Medicaid overpayments. One MFCU case management investigation is complete and will be presented for prosecution while several continue to be investigated. Meetings are held on an as-needed basis to share information and several joint investigation projects have been initiated.

MEDICAID ABUSE, WASTE & FRAUD STATISTICS

HHSC's MEDICAID ABUSE WASTE AND FRAUD STATISTICS

For the first and second quarters of fiscal year 2004, the Office of Inspector General achieved the following:

RECOUPMENTS BY OIG FOR FISCAL YEAR 2004 (1st and 2nd Quarters)

Office of Inspector General	1st Quarter FY2004	2nd Quarter FY2004	TOTAL FY2004
Medicaid Program Integrity	$2,699,051	$18,523,944	**$21,222,995**
Civil Monetary Penalties	$893,237	$13,071,164	**$13,964,401**
Utilization Review (DRG-hospitals)	$2,153,633	$4,821,062	**$6,974,695**
TEFRA Claims – Children's Summary[1]	0	0	**$0**
TEFRA Claims – Psychiatric Summary[2]	0	0	**$0**
Case Mix Review (Nursing Homes)	$3,222,915	$2,231,457	**$5,454,372**
Third Party Resources[3]	$78,531,621	$48,177,664	**$126,709,285**
Surveillance and Utilization Review Subsystems (SURS)	$388,419	$608,729	**$997,148**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$452,432	$373,502	**$825,934**
General Investigations	$4,622,061	$4,825,880	**$9,447,941**
WIC Investigation Recoveries	$1,534	$3,585	**$5,119**
Audits	$915,647	$10,669,119	**$11,584,766**
TOTAL	**$93,880,550**	**$103,306,106**	**$197,186,656**

[1]Children's TEFRA hospitals are sampled 2nd quarter only per fiscal year. The claims are distributed to staff for review during the 3rd quarter. Completion of reviews for the most recent sample are pending

[2]Free-standing Psychiatric TEFRA hospital reviews are of 21 year and under psychiatric inpatient stays, paid per diem. UR reviews substantiate that the patient required inpatient care in most cases. Very few claims are denied.

[3]Pharmacy Recoveries only reconciled through January 2004. Other Insurance Credits have been negatively impacted by CMS decision to limit what Texas can claim as an other insurance payment.

THIRD PARTY RECOVERIES FOR FISCAL YEAR 2004 (1st and 2nd Quarters)

Office of Inspector General	1st Quarter FY2004	2nd Quarter FY2004	TOTAL FY2004
Third Party Liability and Recovery:			
Recoveries (Provider)			
• Other Insurance Credits*	$58,271,124	*$33,312,499	**$91,583,623**
• Provider Refunds	$1,596,801	$1,308,830	**$2,905,631**
• Texas Automated Recovery System (TARS)	$5,752,045	$4,192,449	**$9,944,494**
• Recipient Refunds	0	0	**0**
• Pharmacy	$3,307,849	**$1,452,930	**$4,760,779**
Recoveries (Recipient)			
• Credit Balance Audit	$5,034,135	$2,086,340	**$7,120,475**
• Amnesty Letter	0	0	**0**
• Tort	$4,569,667	$5,824,616	**$10,394,283**
TOTAL	**$78,531,621**	**$48,177,664**	**$126,709,285**

* Pharmacy Recoveries only reconciled through January 2004.
**Other Insurance Credits have been negatively impacted by CMS decision to limit what Texas can claim as an other insurance payment.

MEDICAID FRAUD AND ABUSE DETECTION SYSTEM (MFADS) PERFORMANCE MEASURES

Performance Measures	FY03	FY04	FY05
Number of cases opened			
1st Qtr	415	451	
2nd Qtr	97	353	
3rd Qtr	532		
4th Qtr	593		
Total Cases Opened for the FY	**1,637**	**804**	
Potential Dollars identified for recovery	$182,635	$1,459,840[4]	
1st Qtr	$108,287	$1,308,507	
2nd Qtr	$446,050		
3rd Qtr	$2,189,638		
4th Qtr			
Total Potential dollars identified for recovery	**$2,926,610**	**$2,768,347**	
Actual Dollars Recovered:			
1st Qtr	$611,135	$452,432	
2nd Qtr	$455,593	$373,502	
3rd Qtr	$1,117,783		
4th Qtr	$288,801		
Total Recoveries	**$2,473,312**	**$825,934**	

[4] This includes the initial overpayment amount of $1,171,814.34 associated with the pharmacy audits – the overpayment amounts associated with this project were subsequently adjusted downward.

OIG WORKLOAD STATISTICS FOR THE FIRST AND SECOND QUARTERS OF FISCAL YEAR 2004:

Action	1st Quarter FY2004	2nd Quarter FY2004	Total FY2004
Medicaid Provider Integrity			
• Cases Opened	354	285	**639**
• Cases Closed	329	243	**572**
• Providers Excluded	240	124	**364**
Utilization Review			
• Case Mix (Nursing Homes) – Facilities Visited	336	298	**634**
• Case Mix (Nursing Homes) - Claims Reviewed	7,079	6,604	**13,683**
• Hospitals – Facilities Visited	116	189	**305**
• Hospitals - # of Claims Reviewed	5,072	5,860	**10,932**
Medicaid Fraud & Abuse Detection System			
• Cases Opened	451	353	**804**
• Cases Closed	559	415	**974**

OIG Cost Savings to the Texas Medicaid Program for Fiscal Year 2004

Background

In addition to its detection and investigative activities, the OIG has taken proactive measures to reduce errors in the billing, payment, and adjudication of claims for Medicaid services. Proactive measures taken by the HHSC include fraud and abuse prevention training to Medicaid providers, including health maintenance organizations, staff in the operating agencies, staff of the claims administrator, provider organizations, and provider staff. Other proactive measures undertaken by the HHSC 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. OIG staff actively participates in the design of medical and program policy with a focus to reduce erroneous payments while maintaining or improving quality of care to the Medicaid beneficiary. These proactive efforts have allowed OIG and the HHSC to increase cost avoidance activities, improve quality of care, and sustain improved relationships with the Medicaid providers.

COST AVOIDANCE/PROGRAM SAVINGS:

Medicaid Operating Agencies Cost Avoidance/Program Savings For Medicaid Fraud, Abuse, And Waste –FY2004

Office of Inspector General Departments	TOTAL FY2004
Medicaid Provider Integrity	$39,421,616[5]
Utilization Review (DRG-hospitals)	$6,974,695
Nursing Home Reviews	$5,454,372
Surveillance and Utilization Review Subsystems (SURS)	0
Medicaid Fraud and Abuse Detection System (MFADS)	$825,934
WIC Investigations	$898
TOTAL	**$52,677,515**

Office of Inspector General	TOTAL FY2004
Third Party Liability and Recovery:	
• Cost Avoidance	$215,195,471
TOTAL	**$215,195,471**

Office of Inspector General	TOTAL FY2004
Audits	$79,962,450
TOTAL	**$79,962,450**

[5] This figure represents Cost Savings in both the Medicaid Provider Integrity Departments as well as the Surveillance and Utilization Review Subsystems.

MEDICAID FRAUD DETECTION & ABUSE PREVENTION TRAINING PLAN

Under the provisions of the Texas Government Code, §531.105, HHSC 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. To conform to the mandate, HHSC offers this training through the education department of OIG and has developed, in cooperation with the Southwest Texas State University (SWT), a training program that is available as an on-line computer based course or as a correspondence course. Continuing Education Units (CEUs) are available through SWT for successful completion of this course.

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.

Training is also available in seminar format. The seminar presentation 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. Program content can be adapted to meet the needs of specific groups or organizations. This informal and highly interactive presentation lasts approximately two hours.

Distance Learning Program

The Distance Learning Program was developed as a collaborative effort between OIG and SWT. The goal of the program is to provide Medicaid fraud and abuse detection and prevention training to Medicaid contractors, providers, and their employees in the most efficient and economical method possible. The module is available from SWT as a web based on-line course or as a correspondence course. Go to one of the web site addresses listed in order to access information about either the correspondence or on-line course: http://www.hhsc.state.tx.us/. or http://www.ideal.swt.edu/extension/thhscgateway.html

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 fraud and abuse prevention training module is also available on-line as a separate tool.

TILE registrations for September 1, 2003-March 31, 2004 are as follows:

Type of Course	Total Enrolled
TILE Nursing Home Correspondence	243
TILE Nursing Home On-Line Computer Training	261
Community Base TILE Correspondence	202
Community Based TILE On-Line Computer Based Training	148
TOTAL	**854**

Minimum Data Systems (MDS) Workshops

In September 2001, HHSC contracted with the Texas Health Care Association/Education to conduct MDS training seminars/workshops. These workshops also include a fraud prevention component designed by HHSC-OIG. The Educational Institute on Aging and the Texas Healthcare Association conducted five (4) MDS workshops between September 2003 and February 2004, with a total audience of 206 participants representing 124 nursing facilities.

Expanded Fraud Prevention Training for Medicaid Providers

HHSC believes that provider education is an integral element of any fraud, abuse, and waste prevention plan. In December of 2001, representatives of HHSC met with the National Heritage Insurance Company (NHIC), contractor to providers of Medicaid services, to expand information presented in conjunction with the NHIC provider-training program "Success with Medicaid." This program's goal is to educate the providers on how to correctly submit Medicaid forms for reimbursement for services, prevent provider billing and coding errors, as well as to educate providers on their responsibilities to prevent fraud, abuse, and waste in the Medicaid program. A special fraud prevention curriculum was developed by HHSC for use in this training venue.

Staff Presentations on SB30 and Related Topics
September 1, 2003-February 29, 2004

Presentation Date	Presentation Audience	Presentation Subject	Presenter
Jan. 14, 2004	Community Health Choice	Fraud Training	Juanita Henry
Jan. 15, 2004	Ever Star+Plus	Fraud Training	Juanita Henry

MEDICAID FRAUD & ABUSE DETECTION AND PREVENTION PUBLICITY EFFORTS

Section 531.108 (b)(1) of the Government Code requires HHSC 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."

The primary responsibility for activities relating to the detection, investigation, and sanction of Medicaid provider fraud, abuse, and waste across all state agency lines, lies within HHSC, regardless of where the provider contract is administered. The HHSC refers suspected criminal Medicaid fraud complaints to the Medicaid Fraud Control Unit (MFCU) 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 HHSC 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 HHSC and those agencies in partnership on a specific investigation.

Other Communication Tools

The HHSC 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);
- Public Hearings;
- Targeted Mailings.

FRAUD PREVENTION EFFORTS BY THE OFFICE OF INSPECTOR GENERAL INVESTIGATIONS AND AUDIT

Pursuant to House Bill 2292, 78th Texas Legislature, Regular Session 2003, the Texas Department of Human Services, Office of Inspector General transferred into the newly formed Health and Human Services, Office of Inspector General to become the General Investigations Division. General Investigations is responsible for virtually all recipient fraud investigations including those involving Food Stamps (FS), Temporary Assistance for Needy Families (TANF), Medicaid, and the Children's Health Insurance Program (CHIP). Approximately 50% of the cost of the General Investigations Division is funded by Federal matching funds. The Office of Inspector General, General Investigations Division is also actively involved with Federal agencies in the investigation of terrorist organizations involved in funding operations through the Food Stamp program.

In the first two quarters of FY04, General Investigations established claims (completed cases) of potentially $13,357,975.19 for Food Stamp, TANF, and Medicaid. The Fiscal Division of the Department of Human Services is responsible for collection of claims established by General Investigations. In the first two quarters of FY04 DHS Fiscal collected $9,447,941 of the claims established by the General Investigations Division, for this and previous fiscal years. Claims established are the basis for all collections. Most claims established are eventually collected. There is a lag period between claims established and time of collection, due to the time necessary to pursue civil and criminal actions and the lag time in collecting the money through payment plans, recoupment, and federal income tax offset (garnishment of income tax returns for non-payment of claims).

In addition to recovery of funds, the General Investigations division realizes cost savings through the imposition of disqualification penalties in the FS and TANF programs. During the first two quarters of FY04, General Investigations imposed 3,316 disqualifications, for a cost savings of $1,389,338.04.

The General Investigation Division aggressively pursues overpayments that result from an intentional program violation, or fraud. Persons believed to have committed an intentional program violation are either referred for prosecution or referred for an administrative disqualification hearing (ADH), depending on the amount of the claim. To facilitate prosecution of flagrant violators the Office of Inspector General contracts with 143 Texas District Attorney's offices throughout the State.

The General Investigations Division is mandated by federal regulations to complete a minimum of 90% of Food Stamp cases within 180 days of the date that an overpayment is discovered. Pursuant to Senate Bill 30, 75th Texas Legislature, 1997, General Investigations has imposed upon itself a timeliness rating of 93% for completion of Food Stamp, TANF, and Medicaid cases. For the first two quarters of FY04, General Investigations has maintained a 94.1% timeliness completion rate of all cases received.

The General Investigations Division gives close consideration to assuring that all federal and state due process rights are accorded to persons investigated.

Summary Table of all General Investigation Activities

Description	1st Quarter FY2004	2nd Quarter FY 2004	TOTAL
Claims Established	$7,043,807	$6,314,168	$13,357,975
Collections*	$4,622,061	$4,825,879	$9,447,941
Disqualification Cost Savings**	$718,962	$670,376	$1,389,338
Referrals/Complaints Received	22,963	18,749	41,712
Cases Completed	23,752	23,598	47,350
% of Cases Completed w/in 180 Days	93.8%	94.5%	94.1%
Cases Referred for Prosecution	1,097	771	1,868
ADH Cases Completed	1,846	1,952	3,798
Cases Adjudicated	339	379	718
Civil Disqualifications	1,751	1,565	3,316
IEVS*** Matches Cleared	53,629	44,689	98,318
Other Data Matches Cleared	4,966	4,394	9,360

*Collection activity is the responsibility of TDHS Fiscal Division and is based on Claims Established by General Investigations.
**Disqualification cost savings is based on an average monthly savings per client of $82.78 for Food Stamps and $92.90 for TANF.
*** Income Eligibility and Verification System data source matches.

Food Stamp Program Investigations

Food Stamp investigations are mandated by 7 CFR 273.16(a)(1). Food stamp benefits are paid from Federal funds. Investigations into cases involving food stamps are separated into three types: Intentional Program Violations, Recipient Errors, and Agency Errors. Funds recovered for intentional program violations are distributed with 35% of the money recovered going to the State of Texas General Revenue Fund and the balance returned to the Federal Government. Funds recovered for recipient error cases are distributed with 20% going to the State of Texas General Revenue fund and the balance of the funds returned to the Federal Government. All funds for Agency Error cases are returned to the Federal Government.

The Office of Inspector General has been designated by the Office of the Governor and the Federal Food Nutrition Service as the State Law Enforcement Bureau (SLEB) for the purpose of acquiring Food Stamp Program Electronic Benefits for law enforcement and investigative purposes. Any law enforcement or investigative agency in need of benefits to conduct an investigation must acquire them from OIG. This SLEB designation has lead to General Investigations conducting post 9/11 food stamp trafficking investigations with several Federal Law Enforcement multi-Agency task forces investigating funding sources that sponsor terrorism. In addition, General Investigations routinely conducts investigations of retailers and clients involved in the trafficking of food stamp benefits. These investigations are often conducted jointly with United States Department of Agriculture (USDA) OIG.

Table for Food Stamp Fraud Investigations for first and second quarters of Fiscal Year 2004:

Description	1st Quarter FY2004	2nd Quarter FY 2004	TOTAL
Claims Established	$5,045,203	$4,624,005	**$9,669,208**
Collections	$3,661,507	$3,855,976	**$7,517,484**
Disqualification Cost Savings	$675,484	$612,406	**$1,287,891**
Cases Referred for Prosecution	590	392	**982**
ADH Cases Completed	1,534	1,613	**3,147**
Civil Disqualifications	1,381	1,223	**2,604**

Temporary Assistance for Needy Families (TANF) Program Investigations

TANF investigations are mandated by 45 CFR 235.10 and Texas Government Code sec. 531.114. Investigations into cases involving TANF are also separated into three types: Intentional Program Violations (IPV), Recipient Errors, and Agency Errors. When a TANF recipient is suspected of receiving more benefits than those for which they were eligible an investigation is conducted to determine why the overpayment occurred and the amount of the overpayment. For the first two quarters of FY04 General Investigations has established TANF claims totaling $2,426,075.35. Funds recovered from TANF investigations are returned to the TANF program.

For the first two quarters of FY04, General Investigations has disqualified 712 recipients from receiving TANF benefits, reflecting a cost savings of $101,446.80. A recipient is only disqualified from the program when there has been an affirmative finding that an IPV has occurred or when the recipient has signed a waiver of hearing and a voluntary disqualification agreement. Only persons who have committed an IPV are disqualified from receiving benefits, other household members remain eligible. The TANF disqualification

penalties were recently made more severe through an amendment to sec. 531.114 of the Texas Government Code as amended by sec. 2.26 of HB2292.

Table for TANF Fraud Investigations

Description	1st Quarter FY2004	2nd Quarter FY 2004	TOTAL
Claims Established	$1,246,046	$1,180,029	**$2,426,075**
Collections	$671,864	$665,436	**$1,337,300**
Disqualification Cost Savings	$43,477	$57,970	**$101,447**
Cases Referred for Prosecution	268	190	**458**
ADH Cases Completed	307	337	**644**
Civil Disqualifications	370	342	**712**

Medicaid Program Investigations:

Recipient Medicaid investigations are mandated by 42 CFR 455.15(b), Human Resource Code sec. 32.032 and Government Code sec. 531.102 as amended by HB2292 sec. 2.19 (f)(2)(B). When the eligibility of a Medicaid recipient is called into question, General Investigations conducts an investigation to determine whether the recipient is eligible for Medicaid benefits. Recipients that have fraudulently received more than $1,500 in Medicaid benefits are referred for prosecution, and a claim is established against recipients who have received Medicaid benefits for which they were not eligible. Funds recovered following Medicaid investigations are returned to the Medicaid program.

Table for Medicaid Fraud Investigations

Description	1st Quarter FY2004	2nd Quarter FY 2004	TOTAL
Claims Established	$752,558	$510,133	**$1,262,691**
Collections	$288,689	$304,467	**$593,156**
Disqualification Cost Savings	N/A	N/A	**N/A**
Cases Referred for Prosecution	239	189	**428**
ADH Cases Completed	5	2	**7**
Civil Disqualifications	N/A	N/A	**N/A**

Children's Health Insurance Program (CHIP) Investigations

CHIP investigations are new to OIG General Investigations and will be conducted pursuant to Health and Safety Code sec. 62.058 and HB2292 sec. 2.19 (a), which amends Government Code sec. 531.102. The General Investigations Division is currently

developing policies and procedures to implement CHIP investigations and recovery of misspent or fraudulently gained CHIP funds. The expected implementation date is projected at this time to be September 1, 2004.

Income and Eligibility Verification System (IEVS) Match Investigations

IEVS match investigations are mandated by 42 USC Sec. 1320b for the Food Stamp, Temporary Assistance for Needy Families (TANF), and Medicaid programs. A data match is conducted with outside entities such as the Texas Workforce Commission and the IRS. These matches determine whether there is a discrepancy between the eligibility information provided by a client and the eligibility information maintained by other entities. All IEVS matches must be cleared within 45 days of receipt. In the first two quarters of FY04 General Investigations has investigated 98,319 IEVS matches. IEVS matches provide the majority of the referrals that are successfully made into cases and eventually into collections.

IEVS Table

Description	1st Quarter FY2004	2nd Quarter FY 2004	TOTAL
IEVS Food Stamp Matches	33,016	34,555	67,571
IEVS TANF Matches	3,293	1,952	5,245
IEVS Medicaid Matches	17,320	8,182	25502
TOTAL	**53,629**	**44,689**	**98,318**

Other Match Investigations

Other match investigations are mandated by Human Resource Code sec. 22.027, Government Code sec. 531.0214 and 42 CFR 433. In addition to IEVS matches, the General Investigations Division investigates a series of matches with other entities. These include Interstate matches to identify recipients receiving benefits in bordering states, Texas Department of Criminal Justice and Federal Prisoner Verification System matches to identify prisoners receiving benefits, Social Security Administration and Bureau of Vital Statistics Deceased Individual matches to identify deceased persons receiving benefits, Nursing Home matches to identify nursing home patients receiving Food Stamp or TANF benefits, Workers Compensation matches, and Teacher's and Texas Employee's Retirement System matches. The latter two are conducted based on a recommendation by the State Auditor's Office

Other Matches Table

Description	1st Quarter FY2004	2nd Quarter FY 2004	TOTAL
Other Data Matches Cleared	4,966	4,394	9,360

Table of Audit Activities for the 1st and 2nd Quarter of Fiscal Year 2004

Office of Inspector General Audit Reviewed for HHS Agencies	Audits Reviewed	Audits Disallowed	Recovered
WIC Vendor Monitoring		$2,611	
WIC Fiscal Monitoring	12	$365	
Vendor Drug Audits	50		$274,165
Medicaid/Chip Audits[6]	NA	NA	NA
Single Audit	522	$5,613,462	
Department of Family and Protective Services (DFPS)	53	-$172,269	NA
Texas Commission on Alcohol and Drug Abuse (TCADA)*		$41,756	$130,676
Texas Department of Health Financial Compliance (TDH)*		$156,628	$110,142
Texas Department of Human Services (DHS)*	1500	$64,199,074	$10,000,000
Texas Mental Health and Mental Retardation (MHMR)*	383		$1,069,783
TOTALS	**2087**	**$70,013,896**	**$11,584,766**

[6] The Medicaid/CHIP Audit department is in the development stage. Data is not available at this time.

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is federally funded program. The WIC Program provides food instruments to over 846,000 participants in Texas for redemption at any of the 2500 WIC-authorized grocery stores located throughout the state. The WIC Vendor Monitoring Section is responsible for monitoring grocery stores to ensure compliance with the WIC Vendor Agreement, WIC policies, State Rule in 25 TAC, Chapter 31 and Federal Regulations located at 7 CFR Part 246. The WIC grant is funded on a federal fiscal year and part of the grant requirement is reporting on a federal fiscal year. Therefore, the monitoring efforts are recorded and reported accordingly. The monitors conduct unannounced overt and covert visits to the grocery stores as part of their monitoring efforts, conducting routine on-site monitoring visits as well as conducting compliance buys in which the monitor poses as a WIC participant and presents food instruments to the cashier to determine if the grocery store is in compliance. In the first six months of federal fiscal year 2004, the vendor monitors have achieved a reduction of WIC food costs in the amount of $872.95 due to monitoring disallowances. In federal fiscal year 2003, the vendor monitors achieved a reduction of WIC food costs in the amount of $1,737.52 due to monitoring disallowances.

Women, Infants and Children (WIC) Fiscal Monitoring

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) and CFR 246.19 requires the state agency to conduct monitor reviews of each local WIC agency at least once every two years. The review includes on-site reviews of 20% of the clinics at each local agency, a financial review and a food delivery review. A food delivery review consists of monitoring food instruments, equipment, breast pumps and infant formula. During the 2nd federal quarter of Fiscal year 2004 (January – March 2004) WIC, fiscal monitors conducted twelve reviews of local agencies and 19 clinics. The reviews resulted in a disallowance of $365.35.

Vendor Drug Audits

Authority: Title XIX of the Social Security Act under the Texas Medical Assistance Program administers the Vendor Drug Program. In addition to the Act the State must comply with 42 U.S.C.A §1396a (a) (37), and regulations, 42 CFR § 447.45

Compliance: Pharmacies that participate under this program must comply with State and Federal guidelines. The pharmacy agrees to the terms and conditions of the following:

- Health and Human Services Commission Provider Handbook
- Texas State Board of Pharmacy Rules and Regulations
- Texas Drug Code Index and Revisions

- Texas Administrative Code Title 1 Part 15 Chapter 354
- 42 CFR §431.107
- 42 CFR Part 455, Subpart B
- 42 CFR 7401
- 45 CFR part 76
- Title VI of the Civil Rights Act of 1964
- Section 504 of the Rehabilitation Act of 1973
- The Americans with Disabilities Act of 1990
- Equal Employment Opportunity
- Title XVIII (Medicare) or Title XIX (Medicaid) of the Social Security Act

Activities: The vendor drug audit department conducts audit of pharmacies to ensure compliance with state and federal guidelines and regulations. The objective of the audit is to express an opinion based on the results of the procedures we performed, to determine whether a pharmacy complied with the Texas Vendor Drug Program Contract requirements and whether the amounts submitted to HHSC for reimbursement were adequately supported. The audit includes but is not limited to, examination of pharmacy prescriptions, daily logs, and applicable accounting records for the audit period. The audits are conducted in accordance with Generally Accepted Government Auditing Standards.

Medicaid/Chip Audits
Authority: Title XIX (Medicaid) of the Social Security Act.

Activities: The OIG Audit department is in the development stage. The following includes the activities that will be assumed.

The OIG Audit department will develop a risk-based system for auditing HHS System contracts and grants. For conducting the risk assessment, information gathered from audit reports, information systems, contract monitoring, and other related activities will be reviewed and assessed. The risk assessment results will be used to plan on-site audits. These activities will include but not be limited to the following types of audits and/or reviews and other activities.

Contractor Compliance Audits
Compliance Audits Perform compliance audits of contractors to evaluate the extent to which contractors comply with federal, state, and agency requirements. Examine and evaluate the contractors' systems of internal controls designed to (1) ensure contract compliance and (2) to reduce the potential for fraud, abuse, and misuse of federal or state funds to an acceptable level.

Financial Audits Perform financial audits of agency contractors to provide reasonable assurance about whether financial information presented to agency complies with federal,

state, and agency requirements. Examine and evaluate contractors' systems of internal controls designed to (1) ensure compliance with laws and regulations and (2) reduce the potential for fraud, abuse, and misuse of state/federal funds to an acceptable level.

Cost Report Audits
Desk Review of Cost Reports Perform technical desk reviews of provider cost reports to ensure accuracy and integrity of statistical and financial information reported is in accordance with program rules and regulations. This audited statistical and financial information is utilized by HHS Rate Analysis to determine reimbursement rates for program services.

On-Site Cost Report Audits
Perform on-site audits of provider cost reports to ensure the accuracy and integrity of statistical and financial information reported and to ensure the data is in accordance with program rules and regulations. This audited statistical and financial information is utilized by HHS Rate Analysis to determine reimbursement rates for program services.

Forensic Audits
Proactive Forensic Audits perform financial and compliance audits of agency contractors by employing forensic audit methodologies to obtain a more detailed understanding of the contractor and its activities to detect potential fraud and abuse.

Reactive Forensic Audits Perform audits in coordination with investigative staff to prove or disprove suspicions of fraud and abuse, and if the suspicions are proven, identify the persons involved, support the findings by evidence, and present the evidence in an acceptable format in any subsequent disciplinary or criminal proceedings.

Nonaudit Services
Nonaudit services generally differ from audits in that auditors may (1) perform tasks requested by management that directly support the entity's operations, or (2) provide information or data to a requesting party without providing verification, analysis, or evaluation of the information or data, and therefore, the work does not usually provide a basis for conclusions, recommendations, or opinions on the information or data. These services may or may not result in the issuance of a report.

Contracts
HHSE agencies fund hundreds of contracts with Medicaid funds on a statewide basis. Currently, OIG Audit does not contract out for oversight audit activities; however, this may change as OIG considers the benefits of outsourcing audits with retaining fulltime state employees.

Single Audit Reviews

Authority: To comply with the Single Audit Act of 1984, the Single Audit Act Amendments of 1996, OMB Circular A-133 and the Texas State Single Audit Circular, the Audit department will complete desk reviews of all single audits submitted by Health and Human Services agencies identified as “coordinating” agencies providing funds to sub-recipients meeting the required spending levels under federal and state laws.

Single Audit activities were previously conducted at the HHS legacy agencies. During the past year, single audit activities have been consolidated within HHSC Office of Inspector General. After final implementation of HB 2292, the HHS agencies that will have sub-recipients subject to single audit requirements are:

Texas Health and Human Services Commission
Department of Aging and Disability Services
Department of State Health Services
Department of Family and Protective Services
Department of Assistive and Rehabilitative Services

Contracts: Literally hundreds of contracts between HHSE agencies and sub-recipients statewide are subject to Single Audit requirements. Single audit reviews are completed by OIG staff.

For the period 12/1/03 - 3/31/04:
255 reviews were completed, $2,806,731 Questioned Costs were reported (not "overpayments")

For the period 12/1/03 - Present
267 reviews were completed, $2,806,731 Questioned Costs were reported (not "overpayments")

Department of Family and Protective Services (DFPS)

The Cost Reporting Unit (CRU) conducts desk review audits to ensure that the financial and statistical information presented in the cost report conforms to all applicable requirements (reference TAC§700.1801(9)). The CRU also performs on-site audits to ensure the fiscal integrity of the 24-hour child-care services program (reference TAC§700.1801(11)). If the CRU finds information contained in the cost report to be unallowable or unsupported this information may be excluded or adjusted from the cost report (reference TAC§700.1802(f)). If the review determines that allowable costs have been excluded from the Cost Report, the Cost Reports are adjusted to include these allowable costs.

In fiscal year (FY) 2004, for the months of December through February, the CRU completed 20 desk review audits and 1 on-site audit. Thirteen facilities had net

adjustments for unallowable costs of -$203,132. Two facilities had no net change in their costs as submitted. Six facilities had net adjustments to include allowable costs, which increased their reported costs by a net value of $125,815. The net total costs excluded for all 21 cost reports were -$77,317.

Texas Commission on Alcohol and Drug Abuse (TCADA)

OIG - Fiscal Compliance's mission is to ensure stewardship of funding for prevention, intervention, and treatment services across the state by operating an efficient and effective financial compliance division that holds providers fiscally accountable to federal and state regulations and Texas Commission on Alcohol and Drug Abuse (TCADA) rules.

This responsibility is mandated by a Legislative key performance measure, which requires the TCADA to conduct 95 on-site financial and programmatic reviews of funded programs annually for compliance. Additionally, 45 CFR 74.51(a)(2003) (Codification of OMB Circular A-110 (Sec. _51(a)), OMB Circular A-133 (Sec. _.225 and Sec. _.400(d)), 31 USC 7502(f)(2) (Single Audit Act Amendments of 1996 (Pub. L. No. 104-156)), and 45 CFR 92.37 and 92.40(a)(2003) (Codification of former A-102 Common Rule (Sec._.37 and _.40(a)) require pass-through entities to monitor the activities of sub-recipients as necessary to ensure compliance. Likewise, 45 CFR 96.123(a)(16)(2003) (Implementing regulations for Substance Abuse Prevention and Treatment Block Grant) and Texas Health and Safety Code, Sec. 461.012(a)(9)(Vernon Supp. 2004) requires consistent monitoring of expenditure of funds by all grant and contract recipients.

From December 2003 through February 2004, OIG – Fiscal Compliance questioned $263,682.67 of reported expenditures of which $127,541.37 was recovered through provider corrections and $41,755.53 was disallowed and must be refunded by the providers. Prior disallowed costs in the amount of $16,169.71 were collected from providers during this same period.

Texas Department of Health (TDH) Financial Compliance

Contracts monitored by the Compliance staff are cost reimbursement agreements under which a sub-recipient partners with the Texas Department of Health (TDH) to carry out a program administered by TDH. Sub-recipients submit vouchers and financial reports and receive reimbursement without submitting any financial supporting documentation. A primary function of the Compliance staff in conducting a financial compliance review is to determine that amounts reimbursed are supported by verifiable documents. In addition, the review objectives are to evaluate the sub-recipient's compliance with requirements of the state and/or federal program, applicable laws and regulations, the provisions of the contract agreement and that performance goals are achieved. Financial compliance monitoring includes the review of internal controls to determine if the financial management and accounting system are adequate to account for program funds in accordance with state

and/or federal requirements. It also includes an examination of cost information to ensure that all costs comply with applicable state and/or federal cost principles, laws and regulations, and are reasonable and necessary to achieve program objectives.

The following is a report of questioned and/or disallowed costs identified in reports issued during the quarter ended February 29, 2004 and refunds collected for the same period:

Questioned/Disallowed Costs *	$156,628
Refunds Collected	$ 8,048
Voucher Reductions	$ -0-

* The amount of questioned/disallowed costs may be reduced during the resolution process. References:

Texas Department of Human Services

Cost Audits

In accordance with the State Plan for Providing Medicaid Services to eligible recipients in Texas, and as mandated by 42 CFR Chapter IV, 447.253(g), HHSC OIG Audit Department audits Medicaid Cost Reports to ensure accurate and reliable data is submitted. The CFR and State Medicaid Plan require rates to be related to actual costs of the providers of LTC Facility Services and Community Care Services. During the second quarter of fiscal year 2004, cost audits removed $ 21,332,043 of unallowable costs by field auditing 51 cost reports and desk-reviewing 523 cost reports. Cost avoidance savings are generated by the removal of these costs and the resulting lower reimbursement rates.

Annual Compensation Cost Report Audits

HHSC OIG Audit Department conducts field audits and desk reviews of Attendant Compensation Rate Enhancement Cost Reports. These cost reports are required by House Bill 2292 section 2.102 and House Bill 1 of the 78th Legislature. Medicaid providers are required by statute to spend these funds on certain staffing enhancements. The failure to meet expenditure requirements results in the recoupment of funds from these providers. During the second quarter of fiscal year 2004, audits and desk reviews of these added $183,134 of expense. The recoupments based on these cost reports would have been incorrect had these expenses not been included. Recoupments are made annually and were approximately $ 10,000,000 for fiscal year 2002.

Compliance Audits

HHSC OIG Audit Department does audits and reviews to determine whether nursing homes, community care and other contracted providers complied with the requirements of their contract agreements. These audits are required by Texas Administrative Code and

Program Requirements as part of the monitoring requirement for contractors. During the second quarter of fiscal year 2004, fifteen audits and reviews were completed resulting in $9,083 of vendor overpayments and $134,815 of erroneous expenditures of client funds. Vendor overpayments are recouped and erroneous client expenditures are refunded to the clients.

Texas Mental Health and Mental Retardation (MHMR)

The Cost and Compliance audit section performs compliance audits on the Intermediate Care Facilities for Mental Retardation as mandated in the Texas Administrative Code §419.269 to monitor compliance with §419.219 relating to provider reimbursement and Division Six relating to personal funds. Audits are performed to reasonably assure that program funds were properly used to provide contracted services to eligible recipients, to ensure that recipient funds were adequately managed and to serve as a deterrent to fraud and abuse within the program.

The Cost and Compliance audit section performs audits and desk reviews on Medicaid Provider cost reports, as mandated by TAC, Title 1, Part 15, chapter 355, subchapters D and F. HHSC-OIG conducts desk reviews of all provider cost reports to ensure that the financial and statistical information submitted in the cost reports conforms to all applicable rules and instructions. Unallowable costs are removed from the cost report and ultimately from the HHSC data base that is used to determine the reimbursement rates.

The Cost and Compliance audit section performs audit oversight on the Community Mental Health and Mental Retardation centers as mandated by the Single Audit Act-OMB Circular A-133 and the Texas Single Audit Circular. Oversight is performed to ensure compliance with rules, regulations and proper expenditure of state and federal funds.

Program	# of Reviews	Expense Adjustments Added	Deducted	Recoupments Verified or Identified
2001 HCS Cost Reports	18	$58,860	$692,509	$37,682
2002 ICF Cost Reports	72	$720,359	$990,372	$496,399

Program	# of Reviews	Net Overpayment Identified	Consumer Funds Protected	Corrective Action Plans
ICF Compliance Audits	1	-	$1,181	
Quality	16	$4,056	Quality	16

Assurance Fee Audits			Assurance Fee Audits	
Community Center Onsite Audits	2			2
Trust Funds Reviewed	79		$50,875	Trust Funds Reviewed

MAINTENANCE AND PROMOTION OF A TOLL-FREE HOTLINE

To meet the provisions of Texas Government Code, §531.108, the HHSC 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 HHSC's Office of Inspector General conducts specialized Medicaid fraud detection training for Medicaid hotline operators who receive calls with information on suspected Medicaid fraud and/or abuse and refer the information to the HHSC's Medicaid Provider Integrity (MPI) Department.

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

Available Toll-free 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
- Kidney Health Care Provider hotline – 1-800-222-3986
- Third Party Liability and Recovery hotline – 1-877-511-8858
- Recipient Utilization Assessment hotline – 1-800-252-8141
- CHIP/TexCare partnership – 1-800-647-6558

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 HHSC.