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). 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.

The 78th Legislature in its Regular Session in 2003 created the Office of Inspector General (OIG) within HHSC, consolidating the OIE, the Office of Inspector General at the Texas Department of Human Services (DHS), and expanding the powers and jurisdiction of the office.

RECENT DEVELOPMENTS

Among its several accomplishments, 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. A major focus of the bill is the consolidation and streamlining of services currently provided by 12 health and human services agencies into five, under the direction of the HHSC. House Bill 2292 also creates the Office of Inspector General within the HHSC, consolidating compliance and enforcement functions now within 12 agencies into one 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 that, when matched with federal grant funds, could expand from its current level of 36 staff to up to 236 staff.

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 will establish guidelines under which provider payment holds and exclusions from the Medicaid program are implemented. Timelines have been established for the HHSC Office of Investigations and Enforcement for making referrals to the MFCU. This will enhance the timely investigation of potentially fraudulent providers.

Staffing

During state fiscal year 2003, the OIE had an authorized staffing of 124 employees. They are investigators, registered nurses, nurse analysts, researchers, analysts, third party liability specialists, public health technicians, and administrative staff. OIE employees have been active in the Technical Advisory Group (TAG) for the Centers for Medicare and Medicaid Services (CMS), the Texas Medicaid and Public Assistance Fraud Oversight Task Force, the National Association of Surveillance Officers (NASO), and the Association of Certified Fraud Examiners.

As the result of the reorganization of functions within HHSC, the Utilization Review (UR) Department transferred from the OIE to the Deputy Commissioner for Health Services, HHSC, effective September 1, 2003, reducing the authorized staffing by 64 employees. As part of the same reorganization, the Third Party Liability (TPL) section transferred from the OIE to the Medicaid-CHIP Division of HHSC, effective September 1, 2003, reducing authorized staffing by an additional 6 employees. These transfers were done in preparation of the creation of the Office of Inspector General, and in accordance with the functional review and reorganization of HHSC.

Staffing for the OIG will be established within the first semester of state fiscal year 2004 and will include remaining OIE positions, positions transferring from the Office of Inspector General at DHS, and positions transferring from other areas of the health and human services system.

National Recognition

The OIE has been recognized by the United States General Accounting Office (GAO), the U. S. Department of Health and Human Services, the Texas Comptroller of Public Accounts (CPA), and private entities such as the National Association of Surveillance Officers (NASO) for promoting program integrity, implementing advanced fraud and abuse technology, and assuring access to financial and medical assistance for persons in need.

The Centers for Medicare and Medicaid Services (CMS) selected Texas as one of four states to serve in the national Program Integrity Council, which is charged with developing strategies to prevent fraud, abuse, or waste in the Medicare and Medicaid programs. CMS

has also selected Texas as one of 10 states to serve in the pilot for a national Payment Accuracy Measurement (PAM) study for Medicaid.

Most recently, CMS selected Texas to be the second state to participate in a Medicare/Medicaid Data Match Project. The Texas Project will be funded by the U. S. Department of Health and Human Services and will include staff from CMS, OIE, and the Medicare Program Safeguard Contractor for Texas. A computer matching agreement, statement of work, and work protocols have been completed and agreed upon by both agencies.

To fight fraud, abuse, and waste in the Texas Medicaid program, the OIE has increasingly turned to technology, scientific research, and sampling techniques. The OIE has formulated innovative approaches and tools for improving the detection and prevention of fraud, abuse, and waste. The Detection, Research, and Analysis (DAR) staff within OIE focuses on vulnerabilities and solutions in the Medicaid payment system. When vulnerabilities are identified, OIE works with the Medicaid-CHIP staff and the Claims Administrator to implement policy or system initiatives that remove these vulnerabilities. OIE has representatives in the various policy workgroups within Medicaid-CHIP, as well as within the appropriate workgroups that interact with the claims administrator.

New Initiatives

Third Party Liability Program

On September 1, 2001, two programs previously managed by the Texas Department of Health, under the Health Care Financing function, became functions of OIE. These programs are Third Party Liability and Recovery (TPR) and Recipient Utilization Assessment (RUA), also called the Medicaid Limited Program.

The TPR program is a federally mandated program, at 42 CFR Part 433, State Fiscal Administration, Part D. The CFR and the State Medicaid Plan require HHSC to take reasonable measures to determine the legal liability of third parties who are liable to pay for services furnished under the State Medicaid Plan.

The TPR program achieves cost savings and recoveries through a prospective review of claims, as well as through retrospective recovery. In fiscal year 2003, TPR achieved $541,196,884 in cost avoidance and recoveries for the acute care program. Total recoveries increased by $11.3 million to $64,190,449.

These increases were realized by implementing new initiatives and technology that allowed the State and its vendor to improve the identification of liable third parties.

Recipient Utilization and Assessment

Recipient Utilization Assessment (RUA) is also required by Federal regulation, as part of the state's Medicaid utilization control program. Through automated systems and processes, RUA identifies Medicaid recipients who exhibit aberrant or potentially abusive patterns of utilization.

The OIE reviewed the rules governing RUA in Texas and, after coordination with the Medicaid operating agencies, consumers, and providers, OIE promulgated new rules that expedite and strengthen limitations and sanctions. The RUA process has been moved to the neural network platform and is now based on a client-based unsupervised neural model designed for the Texas Medicaid program. The neural model takes into account the different medical needs of Medicaid recipients, and compares utilization only within the program and recipient type, rather than across all recipient types.

Investigative Audits for Pharmacies

As part of the new procurement for the Medicaid Fraud and Abuse Detection System (MFADS), a fraud detection system based on neural network and learning technology, HHSC received a proposal that included, as a value add option, an investigative audit program for pharmacies enrolled in the Texas Medicaid program. The vendor that included this option, Electronic Data Systems (EDS), was awarded the contract effective September 1, 2002, and HHSC advised the vendor that it wished to exercise the pharmacy option through the subcontractor included in the proposal, Heritage Information Systems. Heritage Information Systems has conducted this type of audit activity in other states, most recently in Florida, with good financial results for the states. HHSC and EDS agreed on a six-month pilot to determine the value of the option for the State of Texas before committing to a more permanent arrangement. HHSC and EDS agreed that the pilot would be limited to 500 mail audits and 100 on-site investigative audits.

The pilot includes the following activities:

- **Statistical Provider Risk Ranking:** Heritage Information Systems ranked all pharmacies enrolled in the Texas Medicaid program through a confidential tool. This tool ranks pharmacies based on a combination of factors and assesses a risk score. At this step, 805 pharmacies, of approximately 2,400, ranked as high risk for fraud or abuse and would warrant investigative audits.
- **Direct Mail Audit:** Out of the 805 pharmacies ranked as high risk, the top five hundred of the top-ranking pharmacies were selected for a direct mail audit. The direct mail audit involved contacting each Medicaid recipient who, according to our systems, had received at least one prescription through the Medicaid program at one of these pharmacies during the 12-month period preceding the pilot.

- **Investigative Audits:** Based on the combination of risk score and negative responses to the direct mail audit, 100 pharmacies were selected for on-site investigative audits.

HHSC will evaluate the results of the pilot for statewide implementation in fiscal years 2004 and 2005.

MEDICAID FRAUD, WASTE & ABUSE STATISTICS

HHSC's MEDICAID FRAUD, ABUSE AND WASTE STATISTICS

For the third and fourth quarters of fiscal year 2003, the Office of Investigations and Enforcement achieved the following:

RECOUPMENTS BY OIE FOR FISCAL YEAR 2003 (3rd and 4th Quarters)

Office of Investigations and Enforcement Divisions	3rd Quarter FY2003	4th Quarter FY2003	TOTAL FY2003
Medicaid Program Integrity	$1,083,901	$8,838,453	**$9,922,354**
Civil Monetary Penalties	$114,596	$6,497,074	**$6,611,670**
Utilization Review (DRG-hospitals)	$3,187,512	$1,597,085	**$4,784,597**
TEFRA Claims – Children's Summary	$188	$0	**$188**
TEFRA Claims – Psychiatric Summary	$1,994	$3,206	**$5,200**
Case Mix Review (Nursing Homes)	$3,342,646	$3,402,213	**$6,744,859**
Surveillance and Utilization Review Subsystems (SURS)*	$49,689	*	**$49,689**
Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered*	$1,117,783	$288,801	**$1,406,584**
TOTAL	**$8,898,309**	**$20,626,832**	**$29,525,141**

Note: Total recoupment dollars reflect all active cases within OIE.

*SURS Recoveries in the 4tth quarter of FY2003 are included in the MPI recovery amount.

THIRD PARTY RECOVERIES FOR FISCAL YEAR 2003 (3rd and 4th Quarters)

Office of Investigations and Enforcement Divisions	3rd Quarter FY2003	4th Quarter FY2003	TOTAL FY2003
Third Party Liability and Recovery:			
Recoveries (Provider):			
• Other Insurance Credits*	$77,961,917	$70,973,488	**$148,935,405**
• Provider Refunds	$1,160,212	$1,785,309	**$2,945,521**
• Texas Automated Recovery System (TARS)	$4,805,409	$3,778,675	**$8,584,084**
• Recipient Refunds	$0	$0	**$0**
• Pharmacy	$1,183,718	$1,741,190	**$2,924,908**
Recoveries (Recipient):			
• Credit Balance Audit	$3,522,282	$5,441,024	**$8,963,306**
• Amnesty Letter	$0	$0	**$0**
• Tort	$4,226,173	$5,528,883	**$9,755,056**
TOTAL	**$92,859,711**	**$89,248,569**	**$182,108,280**

* Other insurance credits are estimated pending the completion of a data repair project.

MEDICAID FRAUD AND ABUSE DETECTION SYSTEM (MFADS) PERFORMANCE MEASURES

Performance Measures	FY03	FY04	FY05
Number of cases opened			
1st Qtr	415		
2nd Qtr	97		
3rd Qtr	532		
4th Qtr	593		
Total Cases Opened for the FY	**1,637**		
Dollars identified for recovery			
1st Qtr	$182,635		
2nd Qtr	$108,287		
3rd Qtr	$446,050		
4th Qtr	$2,189,638		
Total dollars identified for recovery	**$2,926,610**		
Actual Dollars Recovered:			
1st Qtr	$611,135		
2nd Qtr	$455,593		
3rd Qtr	$1,117,783		
4th Qtr	$288,801		
Total Recoveries	**$2,473,312**		

RECOUPMENTS FOR FISCAL YEAR 2003 (3rd and 4th Quarters) BY OTHER HHSC DIVISIONS

Health and Human Services Divisions	3rd Quarter FY2003	4th Quarter FY2003	TOTAL FY2003
Medicaid Audits (cost settlement based on cost reimbursement methodology)*	$5,946,819*	$15,036,791*	**$20,983,610***
Vendor Drug:			
• Recoveries	$21,990,566	$19,843,906	**$41,834,472**
• Manufacturer Rebates	$101,655,198	$101,352,840	**$203,008,038**
Customer Services/Provider Resolutions	$37,792	$26,788	**$64,580**
TOTAL	**$129,630,375**	**$136,260,325**	**$265,890,700**

* Overpayments for Medicaid Audits are reported as net based on Cost Settlements. Managed care payment settlements are excluded from the calculation. Overpayments are calculated based on the difference in total interim payments and cost, less any previous settlements completed during the period.

OIE WORKLOAD STATISTICS FOR THE 3RD AND 4TH QUARTERS OF FISCAL YEAR 2003:

Action	3rd Quarter FY2003	4th Quarter FY2003	Total FY2003
Medicaid Program Integrity:			
• Cases Opened	246	191	**437**
• Cases Closed	325	156	**481**
• Providers Excluded	233	69	**302**
Utilization Review:			
• Case Mix (Nursing Homes) - Cases Closed	334	310	**644**
• Case Mix (Nursing Homes) - # of Reviews	7,005	6,895	**13,900**
• Hospitals - Cases Closed	45	203	**248**
• Hospitals - # of Reviews	1,737	1,119	**2,856**
Medicaid Fraud & Abuse Detection System:			
• # of Cases Opened	532	593	**1,125**

Action	3rd Quarter FY2003			4th Quarter FY2003		
LOCK-IN*:	03/03	04/03	05/03	06/03	07/03	08/03
• Fee-for-Service (FFS)	510	530	527	522	521	489
• STAR	299	297	295	292	289	282
• STAR+PLUS	74	71	67	62	61	39
TOTAL	**883**	**898**	**889**	**876**	**871**	**810**

***LOCK-IN:** CFR, Title 43, Volume 3, Section 431.54 (e) requires "Lock-in of recipients who over-utilize Medicaid services. If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict that recipient for a reasonable period of time to obtain Medicaid services from designated providers only." The Texas Administrative Code, Title 45, Part I, Chapter 43 outlines the Texas Utilization Control Methods. Fee-for-Service clients can be limited to a doctor and/or pharmacy. Managed Care Organization members can be limited to a pharmacy. STAR+PLUS members were added to the Lock-in process on September 1, 2001.*

Health and Human Services Agencies Fraud, Waste and Program Abuse Activities

The Medicaid Fraud, Waste and Program Abuse work group was formed in 1996 with the primary focus of exchanging information relevant to Medicaid fraud, waste or abuse activities across health and human services operating agencies. Agencies in the Health and Human Services system utilize the workgroup members to develop joint investigative strategies, operating policies, and provide technical assistance across agencies as it relates to the prevention, detection, and investigation of fraud, abuse, and waste in health and human services programs.

Activities in the third and fourth quarters of fiscal year 2003 by the health and human services operating agencies have resulted in Medicaid recoupments totaling $268,831,305 ($249,511,873 in provider recoveries and $19,319,432 in recipient recoveries) and civil monetary penalties, fines, or liquidated damages totaling $209,619,708.

In addition to Medicaid recoveries, $12,289,519 was recovered in Title XX, the Temporary Assistance for Needy Families (TANF), and Food Stamp programs.

The tables in Appendix A on pages 21-22 provide a detailed summary of program integrity activities by the health and human services agencies.

OIE Cost Savings to the Texas Medicaid Program for Fiscal Year 2003[1]

Background

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 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. OIE 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 OIE and the HHSC to increase cost avoidance activities, improve quality of care, and sustain improved relationships with the Medicaid 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 state fiscal year 2003 was 13.3%. This is the first fiscal year that has seen an increase in error rate for long-term care services reviewed by OIE. The increase in error rate is attributed in part to higher turnover and increased difficulty in recruiting and hiring experienced nursing staff at the facility level. UR staff have revised the training programs offered to nursing home staff, as well as increased its interaction with representatives of the industry to improve the collection of information, as well as the completion of the assessment tools by nursing home staff.

The error rate for the long-term care program is collected through on-site reviews of nursing facilities. During the on-site review, registered nurses observe the patient and review medical records maintained by the facility. The nurses' on-site review and observations are compared with the assessment form submitted by the facility to the Department of Human Services. The assessment form documents the level of effort required to care for the patient, based on the assessment of nursing facility staff. When the review conducted by the HHSC nurse differs from the facility's assessment, the assessment form and level of

[1] Cost savings in this report are actual savings computed on 12 months of data.

effort index are changed to reflect the state's decision. This action is counted as an error against the facility.

Cost savings in the acute care program are defined as estimated savings to the state Medicaid program, which arise from administrative actions and/or sanctions.

Cost savings for the acute care program are computed differently based on the function under review or investigation. For cost savings resulting from fraud, abuse, or waste investigations undertaken by the Medicaid Program Integrity (MPI) division of OIE, cost savings are based on sanctions against providers. When a sanction is taken against a provider, the savings take into consideration the level and duration of the sanction. For example, when a provider is excluded from the Medicaid program, the cost savings are estimated based on the provider's billing history prior to the exclusion, the error rate or fraud rate found by the investigation, and the length of the exclusion. In fiscal year 2003 MPI reflected $19,964,210 in cost savings.

COST AVOIDANCE/PROGRAM SAVINGS:

Office of Investigations and Enforcement Divisions	TOTAL FY2003
Third Party Liability and Recovery:	
• Cost Avoidance	$203,499,956
TOTAL	**$203,499,956**

Office of Investigations and Enforcement Divisions	TOTAL FY20032
Medicaid Audits - TPL	$13,633,529
TOTAL	**$13,633,529**

MEDICAID FRAUD DETECTION & ABUSE PREVENTION TRAINING PLAN

Under the provisions 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 OIE 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 OIE 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, 2002-August 31, 2003 are as follows:

Type of Course	Total Enrolled
TILE Nursing Home Correspondence	1098
TILE Nursing Home On-Line Computer Training	668
Community Base TILE Correspondence	611
Community Based TILE On-Line Computer Based Training	326
Medicaid Fraud only –Computer based training	11
TOTAL	**2,714**

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-OIE. The Educational Institute on Aging and the Texas healthcare Association conducted five (5) MDS workshops between May 2003 and August 31, 2003 with a total audience of 253 participants representing 144 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
March 1-August 31, 2003

Presentation Date	Presentation Audience	Presentation Subject	Presenter
3/4/2003	Medicaid/CHIP External Quality Review Organizations [EQROs]	Preventing Fraud, Abuse, or waste in Federal Medical Programs	Juanita Henry
8/13/2003 Two (2) Sessions	Affiliated Computer Systems, Inc. (ACS)	Fraud and Abuse Training **Morning Session** Medicaid Program Integrity Fraud Referrals and Investigations	[Morning Session] D Ward
		Afternoon Session The Texas Perspective on Medicaid Fraud, Abuse, and Waste	[Afternoon Session] A LeBrun
		Role of MPI/OG Relationships Between OIE/OIG and Claims Administrator	S Thompson
		Medicaid Program Integrity Fraud Referrals and Investigations	D Ward

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."

Within HHSC 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 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 TEXAS DEPARTMENT OF HUMAN SERVICES

Texas Government Code, Section 531.108, requires the Health and Human Services Commission (HHSC) to compile and disseminate accurate information and statistics relating to fraud prevention. These requirements include:

- Develop a cost-effective method of identifying applicants for public assistance 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); and
- Submit a semiannual report to the Governor and Legislative Budget Board on results of computerized matching with other states and TDCJ.

The Texas Department of Human Services (DHS) has worked closely with HHSC to comply with these requirements.

Quality Control

Food Stamps

DHS reviews food stamp eligibility and benefit amounts to develop a payment error rate (PER). The U.S. Department of Agriculture awards enhanced federal funding to states achieving a 5.9 percent or lower PER and also have a negative case error rate lower than the national average. In federal fiscal year (FFY) 1998, Texas had a 5.27 percent PER and was the first large-issuance state to earn enhanced funding. To date, DHS has earned more than $135 million in enhanced funding:

Federal Fiscal Year	Payment Error Rate	Enhanced Funding Amount
1998	5.27%	$19.7 million
1999	4.56%	$27.9 million
2000	4.14%	$28.6 million
2001	3.73%	$29.8 million
2002	4.85%	$29.1 million

FFY 2002 is the final year for enhanced funding. The Farm Security and Rural Investment Act of 2002 replaces enhanced funding with performance bonuses in four areas: payment accuracy, negative error rate, participation rate and application processing timeliness.

Temporary Assistance for Needy Families (TANF)

Federal welfare reform converted the Aid to Families with Dependent Children (AFDC) program into a state block grant known as Temporary Assistance for Needy Families (TANF) and removed the federal requirement to maintain a quality control system. However, since the program is a state block grant, DHS continues to operate a quality control system for TANF, as required by state law and funds saved by the quality control system and error reduction activities are state savings.

Fraud Prevention Initiatives (September 2002 to August 2003)

Enhanced funding and successful progress in lowering the PER for both programs could not have been achieved without implementing innovative fraud prevention and detection programs.

Electronic Benefits Transfer (EBT) Trafficking

DHS Office of Inspector General (OIG) conducted 46 criminal investigations and 17 administrative investigations totaling $37,773 in theft. District Attorneys obtained 44 criminal court convictions based on OIG investigations conducted in prior years. In addition, OIG obtained 32 administrative dispositions in trafficking cases. The total established theft amount for convictions and administrative dispositions was $45,936.

Fraud Investigations

OIG completed 10,611 investigations; 1,548 referred for prosecution, 2,596 referred for administrative disqualification hearings (ADH), and 3,499 ADH waivers were processed. District Attorneys obtained 1,642 convictions based on OIG investigations conducted in current and prior years. Dispositions were obtained in 5,764 administrative hearings. Texas collected $17,280,091 in Food Stamp funds, $4,057,169 in TANF funds, and $1,078,735 in Medicaid funds.

State-to-State Matches (September 2002 to May 2003)

Section 531.108 requires matching with bordering states. The following potential matches were identified: 1,426 cases from Louisiana, 1,914 cases from Oklahoma and 2,058 cases from New Mexico. After verification, benefits were denied or lowered in 142 Louisiana cases, resulting in $127,416 savings. Benefits were denied or lowered in 262 Oklahoma cases, resulting in $280,182 savings. Benefits were denied or lowered in 191 New Mexico cases, resulting in $194,703 savings. Cases are still under investigation and the number of denied or lowered cases, associated savings, and number of referrals may increase.

DHS has reached agreement with Arkansas regarding a cooperative data match, and is working on technical aspects of executing the match.

Motor Vehicle Information

Section 531.108 requires using motor vehicle data for eligibility determination to ensure correct client resource information is available to Texas Works Advisors. DHS has included motor vehicle registration and value information in its Data Broker initiative, allowing Texas Works Advisors to obtain information on client vehicle and property ownership when certifying or re-certifying clients.

Criminal Justice Matches (September 2002 to August 2003)

The TDCJ match identified 1,897 clients who may be ineligible due to state incarceration. Thirty-three percent are still under investigation and the number of denied or lowered cases, associated savings, and number of referrals for this period may increase. Analysis of completed investigations indicates benefits were denied or lowered in 270 cases, resulting in $268,086 savings. In 264 cases, clients were referred to OIG for $92,364 in estimated fraud or non-fraud overpayments.

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 Education and Staff Development Department 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 Program 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.

Texas Health and Human Services Agencies 3rd and 4th Quarters FY03 Fraud, Waste and Program Abuse Activities:

Agency Name	Overpayments				Monetary Penalties, Fines, or Liquidated Damages			
	Provider/Contractor/ Vendor		Recipient/Client		Provider/Contractor/ Vendor		Recipient/Client	
	Other $	Medicaid $	Other $	Medicaid $	Other $	Medicaid $	Other $	Medicaid $
Health & Human Services Commission:								
• Medicaid Program Integrity	NA	$9,922,354	NA	NA	NA	$6,611,670	NA	NA
• Utilization Review: hospitals	NA	$4,784,597	NA	NA	NA	NA	NA	NA
- nursing homes	NA	$6,744,859	NA	NA	NA	NA	NA	NA
• Surveillance & Utilization Review Subsystems	NA	$49,689[1]	NA	NA	NA	NA	NA	NA
• Tax Equity & Fiscal Responsibility Act Claims (TEFRA)	NA	$5,388	NA	NA	NA	NA	NA	NA
• Medicaid Fraud & Abuse Detection System (MFADS)	NA	$1,406,584	NA	NA	NA	NA	NA	NA
• Customer Services/Provider Resolution	NA	$64,580	NA	NA	NA	NA	NA	NA
• Third Party Resources	NA	$163,389,918	NA	$18,718,362	NA	NA	NA	NA
• Vendor Drug	NA	$41,834,472	NA	NA	NA	$203,008,038[2]	NA	NA
• Bureau of Children's Health	NA	NA	NA	NA	NA	NA	NA	NA
Texas Department of Human Services:								
• Office of Inspector General	NA	NA	$11,891,617[3]	$601,070	NA	NA	NA	NA
• Office of Programs – Long Term Care Services	$4,091[4]	$7,613	NA	NA	NA	NA	NA	NA
• Long Term Care Regulatory	Info not provided	Info not provided	Info not provided	Info not provided	Info not provided	Info not provided	Info not provided	Info not provided
Texas Interagency Council on Early Childhood Intervention – Provider Funding	$151,644	NA	NA	NA	NA	NA	NA	NA
National Heritage Insurance Company – Medicaid Audits	NA	$20,983,610[5]	NA	NA	NA	NA	NA	NA
Texas Department of Mental Health & Mental Retardation – Medicaid Administration	$212,227[6]	$318,209[7]	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	$29,940	NA	NA	NA	NA	NA	NA	NA
Texas Rehabilitation Commission[8]	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	**$397,902**	**$249,511,873**	**$11,891,617**	**$19,319,432**	**NA**	**$209,619,708**	**NA**	**NA**

[1] SURS recoveries in the 4th quarter of FY2003 are included in the MPI recovery amount.
[2] Amount recovered through Manufacturer Rebates.
[3] Includes the following programs: Food Stamp, Temporary Assistance for Needy Families.
[4] Title XX monies.
[5] Overpayments for Medicaid Audits are reported as net based on Cost Settlements. Managed Care Payment Settlements are excluded from the calculation. Overpayments are calculated based on the difference in total interim payments and cost, less any previous settlements for any settlements completed during the period.
[6] These dollars are all recovered state dollars.
[7] Medicaid dollars recouped resulted from onsite waiver reviews, HHSC review of fiscal accountability reports, and billing and payment reviews conducted for Case Management Health Rehabilitation.
[8] Effective 9/1/99, this program was transferred to TDHS.

Texas Health and Human Services Agencies 3rd and 4th Quarters FY03 Fraud, Waste and Program Abuse 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	302	NA	481	NA	NA	NA	NA	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
• Customer Services/Provider Resolution Services	NA	NA	6,721	NA	NA	NA	20	NA
Texas Department of Human Services:								
• Office of Inspector General	NA	4,271[1]	NA	5,660[2]	2,410[3]	NA	NA	3,125[4]
• Office of Programs – Long Term Care Services	192	NA	NA	NA	NA	0	0	NA
• Long Term Care Regulatory	Info not provided	Info not provided	Info not provided	Info not provided	Info not provided	Info not provided	Info not provided	Info not provided
Texas Interagency Council on Early Childhood Intervention – Provider Funding	0	NA	NA	NA	NA	NA	NA	NA
Texas Department of Mental Health & Mental Retardation – Medicaid Administration	0	NA	NA	NA	NA	NA	35	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	6	NA	372	NA	1	NA	NA	0
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	**500**	**4,271**	**7,574**	**5,660**	**2,410**	**0**	**55**	**3,125**

[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