
**Albert Hawkins, Executive Commissioner**

# Office of Inspector General Semi-annual Report

## September 2004

**Brian Flood, Inspector General**

**OIG Mission Statement**

*To protect the integrity of health and human services programs in Texas, as well as the health and welfare of the recipients of those programs.*

**OIG Vision Statement**

*Through synergies of purpose and efficiencies of scale, the Office of Inspector General will identify and correct waste, abuse, and fraud in the state's Health and Human Services programs.*

HEALTH AND HUMAN SERVICES COMMISSION

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HEALTH AND HUMAN SERVICES COMMISSION

# Executive Summary

## OCTOBER 1, 2004

The Office of Inspector General (OIG) is pleased to issue the semi-annual report for the first full year of operation, which ended August 31, 2004. This report contains a synopsis of OIG recoveries and cost-avoidance activity for state fiscal year (SFY) 2004, provides an overview of our organizational transformation, details the optimization phase of the transformation, and summarizes key projects.

The OIG has successfully absorbed the fraud and abuse prevention and detection functions for all legacy agencies. Several lines of business, with an over-riding focus on protecting the integrity of health and human services programs in Texas, as well as the health and welfare of the recipients of those programs, have been integrated into a streamlined organizational structure. This organizational structure promotes clarity of task ownership, facilitates information sharing, and provides flexibility to perform a variety of tasks quickly and efficiently. We have demonstrated these organizational traits in our expedited responses to investigation requests made by the both the Governor and Executive Commissioner. We can deploy a variety of skill sets quickly, efficiently, without hesitation, and in a way that maximizes taxpayer dollars.

In SFY 2004, OIG recovered $349,500,000 and achieved cost avoidance of $389,500,000. All recoveries and cost avoidance activity directly assists our neediest citizens. As these funds are directed back into the program, we know that the $739,000,000 provided needed healthcare and other state-funded assistance to these Texans. Further, OIG exceeded outputs from the last five years of measures.

In addition to our organizational transformation and recovery success in SFY 2004, we have developed new policies and procedures, cash collection and tracking processes, case management tools, and interagency agreements, and created a variety of other program and administrative tools, that will enable OIG to mature and grow with the needs of the Health and Human Services enterprise.

We look forward to serving the State of Texas and its leadership, and providing a clear sense of value to the Texas taxpayer.

Brian Flood
Inspector General

# Background

In 1997, the 75th Legislature directed the Texas Health and Human Services Commission (HHSC) to create the Office of Investigations and Enforcement (OIE). The 78th Legislature strengthened HHSC's authority to combat fraud, abuse, and waste in health and human services programs by creating the new Office of Inspector General (OIG). House Bill 2292 and its companion, HB1743, contained 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.

In addition to the maintenance of OIE activities, OIG absorbed fraud and abuse detection and prevention functions for all health and human services (HHS) agencies. The OIG provides program oversight of HHS activities, providers, and recipients through its compliance, enforcement, and chief counsel divisions, which are designed to identify and reduce waste, abuse, or fraud, and improve HHS system efficiency and effectiveness.

The OIG has clear objectives, priorities, and performance standards 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 monetary recovery; and
- maximizing the opportunities for referral of cases to the Office of the Attorney General.

In addition to its detection and investigative activities, the OIG supports the goals of HHSC, including:

- reducing abuse, neglect, and exploitations of elderly people and adults with disabilities;
- reducing child abuse and neglect;
- reducing family violence;
- increasing services to truants and runaways, children at risk of truancy or running away, and their families;
- reducing crime and juvenile delinquency;

- reducing community health risks; and
- improving regulations of human services providers.

OIG has also performed large-scale and special investigations at the request of the Governor and Executive Commissioner.

The OIG routinely takes proactive measures to reduce errors in the billing, payment, and adjudication of claims for Medicaid services. These measures include fraud and abuse prevention training to Medicaid providers, health maintenance organizations, staff of the claims administrator, and provider organizations.

Other proactive measures undertaken by the OIG include workgroups with major provider associations, increased use of professional medical consultants, and a number of pilot projects designed to improve provider communication and education. OIG staff actively participates in the design of medical and program policy, to reduce erroneous payments while maintaining or improving quality of care to the Medicaid beneficiary. These proactive efforts have allowed OIG and HHSC to increase cost-avoidance activities, improve quality of care, and sustain improved relationships with the Medicaid providers.

# OIG Recovery and Cost Avoidance Statistics

## Overview

The total recovery and cost avoidance for SFY 2004 for OIG was $739,000,000 (all funds). All recoveries are deposited into the program to pay for program medical care.

This number appears lower than SFY 2003. However, in SFY 2003, the legacy OIE, included $470,278,443 for recoupment activity by other HHSC divisions. This figure was predominately related to Medicaid Vendor Drug rebates and Medicaid hospital cost settlement activity. During the optimization phase these program savings were determined to be unrelated to fraud and abuse activities and are no longer included in any OIG report. Taking into account this reduction and by comparing last year's recoveries by program (e.g. general investigations, Medicaid Program Integrity, etc.), OIG achieved a 23% increase in recoveries over SFY 2003. (See appendix C for past years comparisons)

## OIG Recovery Activity

Total recoveries reflect all dollars collected during the period. Due to the nature of audit activities, figures are approximate. Because Third Party Resources (TPR) other insurance credits represent a direct reduction to Medicaid claims expense and are hard dollar savings to the program, the OIG includes them as a recovery in lieu of a cost-avoided figure.

## Recoupment/Recovery

| OIG Program | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Medicaid Program Integrity | $2,699,051 | $18,523,944 | $337,201 | $1,797,902 | **$23,358,098** |
| Civil Monetary Penalties | $893,237 | $13,071,164 | $115,556 | $104,193 | **$14,184,150** |
| Utilization Review (DRG-hospitals) | $2,153,633 | $4,821,062 | $6,034,310 | $9,128,344 | **$22,137,349** |
| TEFRA Claims – Children's Summary | $0 | $0 | $0 | $2,601 | **$2,601** |
| TEFRA Claims – Psychiatric Summary | $0 | $0 | $4,575 | $0 | **$4,575** |
| Case Mix Review (Nursing Homes) | $3,222,915 | $2,231,457 | $2,527,429 | $258,984 | **$8,240,785** |
| Third Party Resources | $79,031,617 | $49,505,122 | $67,313,167 | $56,669,299 | **$252,519,205** |
| Surveillance and Utilization Review Subsystems (SURS) | $388,419 | $608,729 | $248,136 | $284,313 | **$1,529,597** |
| Medicaid Fraud and Abuse Detection System (MFADS) - *dollars recovered* | $452,432 | $373,502 | $480,995 | $1,163,271 | **$2,470,200** |
| General Investigations | $4,622,061 | $4,825,880 | $8,720,634 | $4,448,705 | **$22,617,280** |
| WIC Monitoring & Investigation | $1,534 | $3,585 | $3,617 | $18,711 | **$27,447** |
| Audits | $1,001,876 | $135,037 | $886,157 | $478,891 | **2,501,961** |
| **Total** | **$94,466,775** | **$94,099,482** | **$86,671,777** | **$74,355,214** | **$349,593,248** |

## OIG Cost Avoidance

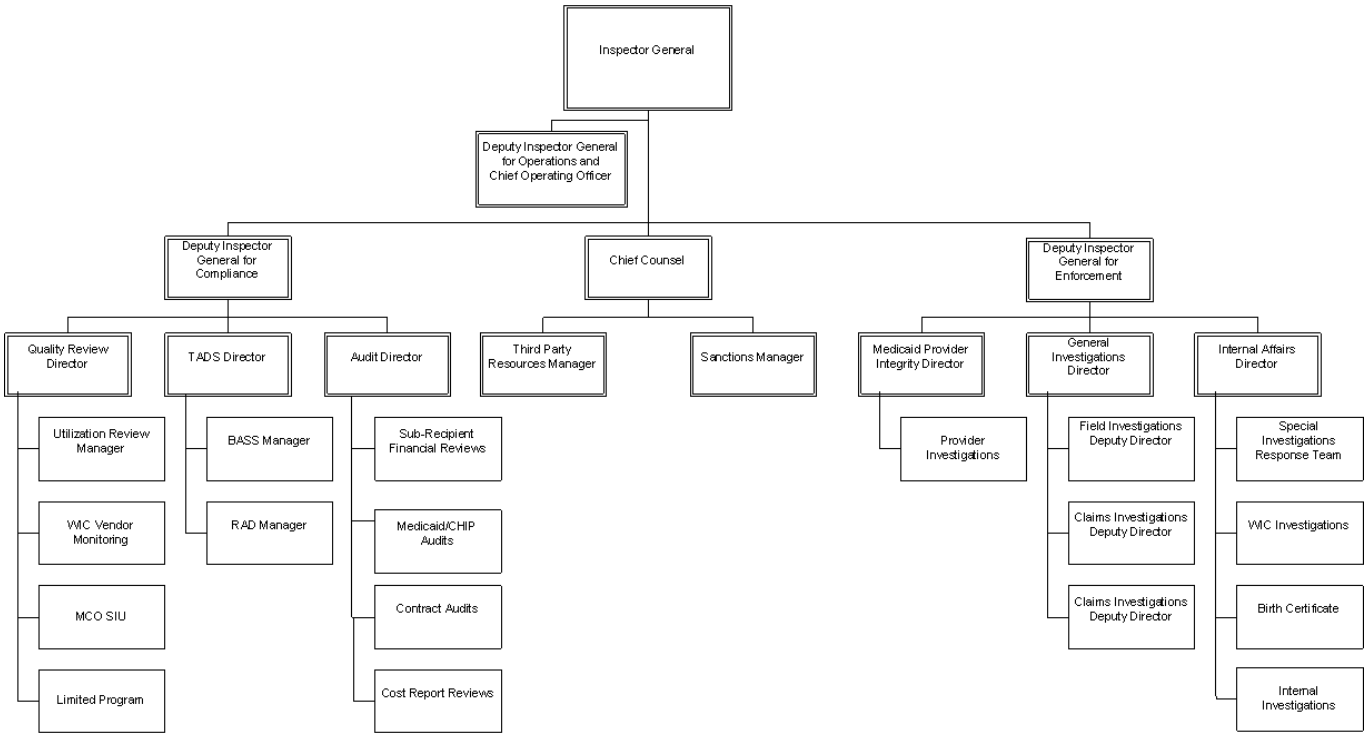
Cost avoidance is a reduction to a state expenditure that would have occurred, or was anticipated to occur, without OIG intervention.

### Cost Avoidance

| OIG Departments | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Medicaid Provider Integrity | $10,791,002 | $28,630,614 | $4,703,117.11 | $944,104 | **$45,068,837** |
| Audits | $45,123,059 | $22,073,745 | $14,071,814 | $12,104,416 | **$93,373,034** |
| Third Party Resources | $53,154,581 | $70,457,268 | $65,908,342 | $58,281,813 | **$247,802,004** |
| General Investigations | $718,962 | $670,376 | $977,316 | $899,472 | **$3,266,126** |
| **Total** | **$109,787,604** | **$121,832,003** | **$85,660,589** | **$72,229,805** | **$389,510,001** |

# Key Accomplishments and Recent Developments

Following is the organizational chart for the Office of Inspector General.




## 1. OIG Transformation Project

To ensure operational effectiveness, eliminate duplicate administrative functions, establish clear lines of authority and responsibility, and enable streamlined operations within business units, the newly formed OIG embraced the detailed assessment of existing organizational structures and business units. In addition to the legacy OIE, OIG folded in investigative, audit, medical, and other related functions from the Texas Department of Health, Texas Department of Mental Health and Mental Retardation, the Department of Human Services, and other state agencies.

The consolidation of legacy agencies into a single OIG and the corresponding assessment of business functions is the Transformation Project. Brian Flood, Inspector General, directed the transformation effort for OIG. Ann-Marie Price, optimization project manager, managed daily project activities and enabled the team to complete all

scope deliverables within targeted timeframes. In less than one year, the OIG transformation has successfully created a new division of HHSC, with documented policies and procedures, measurable results, and streamlined business processes, all of which target the containment of fraud, waste, and abuse within the HHS enterprise.

The transformation effort contained four distinct phases:

1. **Consolidation** – Merging of legacy agency personnel, budgets, and other resources to form the new OIG;
2. **Integration** – Enabling working relations between legacy agency staff to perform the mandates of the new office;
3. **Optimization** - Ensuring efficient, productive, and cooperative working relations and operations; and
4. **Transformation** - Operating under the new structure.

Although each phase was critical in achieving the legislature's transformation goals, the optimization phase yielded the most significant structural changes to operations. The OIG established clear optimization goals to

- utilize the knowledge of legacy agency staff to identify appropriate and necessary OIG activity;
- employ organizational design tools to identify and review OIG roles, processes, and mandates;
- identify areas of improvement within OIG, including improvements to the organization, business processes, and existing technology support systems; and
- implement change based upon the findings from organizational tools and other analytics.

**Optimization Section I - Phase Summary**

Consulting with the inspector general and deputy inspector generals, Deloitte Consulting began working with OIG on March 1, 2004. The objective was to evaluate the OIG organizational structure and seek third-party assistance in identifying areas for improvement.

Following were key components of the Deloitte Consulting effort:

- to facilitate and define the baseline scope of optimization, as well as to identify structural improvement opportunities, Deloitte helped OIG develop administrative and program process models, which originated from a functional review of the existing organizational structure;
- to enable a clear direction, Deloitte helped the OIG team to define a working vision to guide the transformation;
- to ensure project deadlines were achieved, Deloitte consultants helped established a project management structure;
- to clarify organizational roles, responsibilities, activities, and internal and external interactions, organizational and process assessment tools were deployed;
- to provide communication between OIG departments and front-line employees, the Deloitte team helped OIG develop and conduct workshops and seminars; and
- to establish an implementation hierarchy for identified opportunities, projects were prioritized by implementation ability and organizational importance.

**Optimization Section II - Customized Analysis Tools**

To assist the OIG in assessing organizational roles, structure, scope, and opportunity, Deloitte provided three analytical tools. These tools included:

1. **The Programmatic Matrix –**to assess program-related processes/sub-processes currently performed by OIG functional areas;
2. **The Administrative Matrix –**to assess what administrative processes/sub-processes currently performed by OIG functional areas; and
3. **The Organizational Analysis Table –**to assess the activities of each functional area, including the staff skill sets, statutory and regulatory authority, tasks and duties, and a listing of all external entities with which OIG interacts.

The Programmatic and Administrative Matrix tools were customized to capture OIG roles and functions through an in-depth analysis of new and existing OIG functions, interviews with subject matter experts, and conferences with Deloitte consultants.

To educate OIG staff and utilize these tools, an OIG lifecycle was devised. The lifecycle was a simple depiction of what occurs at OIG:

1. An event of suspected fraud, waste, or abuse is referred to OIG.
2. OIG researches, detects, and fully identifies these events.
3. Once the event has been fully identified and understood, OIG can manage the event by, for example,
   - providing education to providers and clients;
   - referring the event to an outside entity, like the Attorney General's Office; or
   - investigating the event with utilization review nurses, auditors, and/or investigators.
4. Depending on the event, OIG can issue sanctions or perform other corrective actions to stop the fraud, waste, and abuse.

Throughout the lifecycle, OIG provides education, technical assistance, and training to providers and clients.

The term "event" is defined as:

- an activity (i.e., conducting audits or routine reviews) to detect, identify, and address fraud, waste, or abuse;
- an instance, or series of instances, committed by a provider, client, contractor, employee, or other person that is considered to be suspicious, aberrant, or attention-worthy as it relates to fraud, waste, or abuse;
- an action, including research, investigations, and/or auditing, taken to correct or mitigate against fraud, waste, and abuse; and/or
- the disposition(s) of a fraud, waste, or abuse.

Nine processes were identified from the OIG lifecycle that describe specific OIG functions. OIG processes are numbered, while their corresponding sub-processes are lettered.

1. **Provide education and technical assistance**
   a. manage training (development, maintenance, and conduct); and
   b. manage technical assistance materials (development and maintenance of technical assistance materials).

2. **Develop strategies and analysis**
    a. develop fraud and abuse theories,
    b. develop algorithms and queries, and
    c. conduct validation of tests and theories.
3. **Perform intakes of complaints**
    a. receive complaints,
    b. analyze complaints, and
    c. develop complaint dispositions.
4. **Conduct investigations and audits**
    a. develop strategies for investigation,
    b. collect data,
    c. conduct analysis,
    d. develop case dispositions, and
    e. develop recommended corrective actions or sanctions (damages and/or penalties).
5. **Manage referrals**
    a. refer to an external entity, or
    b. refer to an internal entity.
6. **Manage quality assurances**
    a. develop quality assurance strategies for hospitals, nursing facilities, and/or sub-contractors;
    b. conduct hospital or nursing facility reviews;
    c. develop review reports;
    d. conduct provider reviews; and
    e. monitor compliance (corrective action).
7. **Manage recoupment**
    a. develop settlement agreements,
    b. manage payment holds,
    c. manage receipt of payments,
    d. develop order of payment from providers and recipients,
    e. monitor reimbursements and fees,
    f. manage asset seizure, and
    g. monitor settlement agreements.

8. **Manage qualifications of clients and providers**
    a. manage client exclusions,
    b. manage provider exclusions, and
    c. manage reinstatements.
9. **Monitor program policy**
    a. monitor and evaluate policies, and
    b. interpret policies, standards, and procedures.

The Programmatic Matrix encompasses the lifecycle, process, and sub-process work.

Staff also completed an Administrative Matrix according to the same specifications as the Programmatic Matrix. The team then configured the corresponding Programmatic and Administrative Mapping Indexes. The Administrative and Programmatic Mapping Indexes required several hundred FTE hours to complete.

The third tool developed was the Organizational Analysis Table. This table expands upon the Programmatic Matrix, and documents:

- the statutory and regulatory authority for each process and sub-process,
- identified cross organizational/agency relationships, and
- identified staff skill sets.

There were three goals for reviewing the statutory and regulatory authority for each sub-process:

1. Completing the table helped staff to recognize whether the sub-processes they were performing were actually mandated. All staff for all sub-processes could justify their performance with reference to specific statutes or Texas Administrative Code rules.
2. Seeing internal and external staff interactions helps OIG ensure consistent coordination and communication with necessary individuals and agencies. For example, if an external agency was identified that OIG works with frequently, but for which formal relations have not yet been established, OIG may initiate a memorandum of understanding (MOU). Currently, OIG has MOUs with the Office of Attorney General, the Texas State Board of Medical Examiners, the Texas State Board of Dental Examiners, and the Texas State Board of Pharmacy.

3. Listing the general skill sets involved with the performance of sub-processes ensures that OIG is utilizing the correct FTEs in its respective divisions, sections, and units.

**Optimization Section III – Meetings and Key Projects**

Several workshops, seminars, and presentations were required to develop and refine the Programmatic Matrix, the Administrative Matrix, and the Organizational Analysis Table.

- **March 15, 2004** – Forty-seven OIG staff attended a three-hour session to learn about the OIG lifecycle, the processes and sub-processes, the analytical tools, and to begin identifying ownership or participation of the processes and sub-processes. Staff had until March 19 to complete both the Administrative and Programmatic Matrixes.
- **March 22, 2004** – Fifty-two OIG staff attended a three-hour session to discuss the results from their March 19 submissions. To explain organizational limitations discovered by use of the tool, Inspector General Flood provided a detailed review of the Programmatic Matrix. Studying the matrix revealed that certain processes and sub-processes lacked clear lines of accountability. With this information, transformation team members were challenged to review their initial submissions and re-submit the Programmatic Matrix. Staff had two weeks to complete their second pass at the Programmatic Matrix.
- **April 12, 2004** – Directors and top-level managers reviewed the second submission of the Programmatic Matrix. The second submission identified clearer lines of responsibility for processes and sub-processes, and would provide the final baseline from which the inspector general and deputy inspector generals would finalize the organizational structure, define functional unit responsibilities, and establish unmistakable lines of accountability within each business unit. In addition to enabling the structural integrity of the OIG, this analysis yielded 16 organizational conclusions. After further scrutiny, these conclusions yielded 10 specific optimization projects:

  **1. Event Outcome Metrics, and 2. Cost-Avoidance and Cash-Savings Tracking Procedures**

  These two projects pursued three objectives. Achievement of the objectives ensured that the OIG could quantify its activities, and all legacy agencies folded into OIG were included in OIG's re-designed reporting system.

Objectives:

- develop guidelines on how to compute cost-savings, as each OIG department and legacy agency does this differently;
- develop tracking procedures so that OIG can verify recoupment claims; and
- establish recoupment protocols between OIG and legacy agencies to ensure recoupment is accomplished.

The project redesigned the internal quarterly report card, developed report category definitions, established submission guidelines, and enabled the new reporting formats to be effective for SFY 2005. The internal quarterly report card is Appendix A to this report.

**3. Sanctions Processes**

The sanctions process reviewed the various consolidated functions within OIG and identified a variety of meanings for the term "sanctions."

Objectives:

- define sanctions, and
- develop internal and external sanctions procedures.

Two definitions of sanctions were developed:

1) OIG Sanctions: Sanctions are administrative enforcement interventions or adverse actions imposed on providers of various state health care programs in accordance with the Texas Administrative Code rules Title I, Part 15, Chapter 371. The administrative sanction action depends on the program violation, the providers' previous history, evidence of the provider's knowledge and intent, and other relevant factors. These actions may range from education, to referrals, to licensing boards, to payment hold or program exclusion.

2) HHSC Agency Program Sanctions: Sanctions are interventions or adverse actions taken by the OIG against providers or recipients who receive benefits or reimbursement from state health care and other state-administered

programs under HHSC authority. These interventions or adverse actions are administered in accordance with federal and Texas statutes, rules, policies, procedures, and applicable contracts.

**4. Case Management Systems**
This project pursued four initial objectives.

Objectives:
- coordinate an approach or strategy to event development;
- consolidate risk management systems across legacy agencies;
- consolidate case management systems across legacy agencies; and
- identify systems that track cash recovered and saved.

Attainment of these objectives enabled OIG to coordinate a focused approach to event development, enabling investigators, nurses, and auditors to share information and synchronize efforts for investigations and audits.

The current OIG systems infrastructure supports our Case Management System, which tracks many OIG events. Initial discussions focused on modifying the Case Management System to meet project objectives. However, in addition to a required redesign of the Medicaid Fraud and Abuse Detection System (MFADS), modifying the Case Management System to accommodate each area's business rules and complex tracking and reporting needs was determined to be impractical, given time and budgetary constraints.

As a result, the project scope was adjusted from a Case Management System Redesign Solution to a Coordinated Case List solution, which will allow investigators, nurses, auditors, and other staff to share information and coordinate efforts for investigations and audits. The Coordinated Case List is searchable, simple, updated weekly, and will link from the OIG page on the HHSC intranet site. Because confidentiality of investigations is important and required by law, access to the list is restricted to authorized employees with a password and user ID.

The Coordinated Case List solution achieved the project objective of allowing a coordinated event-development business process that provides shared information and synchronized efforts for investigations and audits.

**5. Work Flow Diagrams**

This optimization project had four objectives and provided a "snapshot" view of the activities performed within each OIG division, section, and unit.

Objectives:

- clarify OIG staff roles and procedures, and identify policy loopholes;
- chart work-flow for each department;
- develop standardized work-flow procedures, so that continuous policy development is possible using that baseline; and
- coordinate with agencies on workflow processes and intake.

By creating the workflows of these activities, it is possible to see how interactions occur within and throughout the organization. The ultimate goal was to increase efficiency and decrease redundancy.

**6. Referral Forms**

The referral forms project pursued a single objective: to develop a variety of forms to enhance referral effectiveness for OIG. The newly created incoming referral system provides a central point of entry into OIG and a reporting mechanism to track referrals, and educates users on what OIG investigates.

Objective:

- develop forms to clarify and coordinate events between OIG departments and with external stakeholders.

A referral form system was necessary to provide a consistent format for state employees and the public to refer cases to OIG. Incoming and outgoing referral forms are being developed. The two-part incoming referral form is now available. The outgoing referral form should be complete in the fall of 2004.

The system is anticipated to generate additional OIG referrals, which may translate into a positive fiscal impact.

**7. External Entities Index**

The purpose of this project was to identify communication events occurring between OIG and any external entity.

Objective:

- determine every entity with which OIG communicates, to ensure coordination of event activities.

A list of all agencies, organizations, offices, etc., with which OIG interacts was compiled to ensure coordination of event activities. The index will also help OIG develop its external referral form and process.

**8. Policies and Procedures**

The policies and procedures project was a comprehensive effort to review, analyze, and write or rewrite all existing procedures. The policies and procedures manual is central to OIG operations. It is the document everyone can rely upon to comprehend what OIG does and how it is done.

Objectives:

- develop a policies and procedures manual for OIG staff;
- develop a procedural feedback loop between OIG and legacy agencies;
- provide a guide for legacy agency efforts, so they are better coordinated with OIG missions and goals;
- delineate a method of communication with agencies about OIG events that impact agency programs; and
- develop a method of feedback between OIG and legacy agencies about recouped monies, to verify recoupment was accomplished.

The project created documented guidelines that facilitate OIG functions and coordinate communication with agencies outside of OIG. The on-line policies and procedures manual is accessible to all OIG employees.

Staff dedicated thousands of hours to documenting their roles and responsibilities at OIG.

**9. Conflicting Codes, Terms, and Definitions**
The purpose of this project was to identify and rectify conflicting, missing, and/or redundant language in statutes and codes that affect OIG and its legacy agencies. With the help of the Organizational Analysis Table, OIG identified the state and federal statutes, and TAC rules that affect them.

Objectives:
- identify conflicting code language and propose revisions; and
- identify terms and develop common definitions.

The list must be evaluated and analyzed to ensure that statues and codes within OIG and across the HHSC organization still apply. This large project will take many months.

**10. Education and Training Coordination**
The project focused on several key objectives for OIG. Due to the transition from a conglomeration of disparate parts to a unified and consolidated agency, training was an important aspect of the OIG transformation.

Objectives:
- hire a coordinator;
- coordinate OIG training among staff;
- improve sharing of expert knowledge between staff;
- develop educational opportunities for OIG staff from legacy agencies; and
- develop educational opportunities for staff still in legacy agencies.

Providing coordinated, continuing training opportunities is an invaluable tool in maintaining an effective and motivated workforce.

- **April 20, 2004 –** An OIG Optimization Phase Progress Report presentation was presented to Executive Commissioner Albert Hawkins and all OIG staff for review.

- **May-June 2004**– The Inspector General and his executive management team discussed how to address visible organizational structural issues made apparent by the Programmatic Matrix. One outcome of their meetings was the "To Be" matrix, the third and final iteration of the Programmatic Matrix, which would bring the organizational responsibilities within business units to finality.
- **July 14, 2004** – The OIG executive management team presented 48 OIG staff with the "To Be" matrix. The matrix was explained in detail to ensure staff understood expectations for each process and sub-process. The final matrix delineated clear lines of accountability for each business unit.

  The final stage of the policies and procedures project could then be initiated. All business units are currently amending policies and procedures to comply with the "To Be" matrix and address the identified processes and sub-processes. Staff has until October 4, 2004, to submit those changes for final approval by executive management. Upon approval, the changes will be incorporated into the OIG Policies and Procedures Manual.

**Optimization Section IV - Summary of Outcomes**

OIG has realized many changes throughout its Transformation Project, which aid the State of Texas in containing fraud, waste, and abuse in the HHS enterprise. OIG has

- **secured the transfer of over 400 legacy-agency FTEs**. Primarily auditors and investigators, these individuals performed OIG activities and duties in legacy agencies. Now these individuals coordinate their efforts and cooperate with each other toward achieving common goals.
- **secured a single building site for all Austin-based OIG staff**. While the Office of Inspector General was established with legislation effective September 2003, it was not possible to gather all affected FTEs from various legacy agencies into one building until September 2004. Austin-based staff were scattered in as many as 11 different buildings, which presented obvious challenges to coordination.
- **redesigned its organizational structure**. With the transfer of legacy agency staff, certain OIG divisions were inundated with staff from disparate organizational and functional cultures. OIG needed to carefully consider how to efficiently utilize these new resources. In particular, the Audit division needed to redesign its method of work. With the help of Audit's deputy of compliance, key managers from legacy agencies, and hundreds of hours of meetings and

dialogue, the Audit division successfully restructured itself from individualized legacy agency roles to unified functional responsibilities.

- **invested in its cultural transformation**. Before the institution of a unified and coordinated Office of Inspector General, roles and duties previously performed in legacy agencies were typically "stove piped." That is, people performed their jobs with little or no communication with others. Now that nurses, auditors, and investigators work under the same roof, they can more easily coordinate their efforts. The many hours staff spent in optimization seminars and workshops created some of the first opportunities for people to get acquainted. Staff will continue to nurture their working relationships by their continued interactions in the new building.
- **created OIG mission and vision statements**. Through the Transformation Project, it was possible to work together to create these statements.
- **realized optimization project goals**. The 10 optimization projects have improved OIG's business processes and expected outcomes. These projects will be monitored to ensure their potential is realized and will be hallmarks for the improvement projects that follow.

The OIG Transformation Project has proved a useful model for consolidating a state office with a single focus. The project has structured OIG changes and enhanced OIG abilities to meet its objectives. While the effort required thousands of FTE hours and unwavering dedication from staff, OIG is now well prepared to move forward as a professional, consolidated, and unified state agency.

## 2. Adult Protective Services Investigation

Pursuant to Governor Rick Perry's Executive order, RP33, issued April 14, 2004; OIG General Investigations began the investigation of Adult Protective Services (APS). The executive order mandated a comprehensive statewide investigation of the In-Home Program. OIG has completed the scheduled 30- and 90-day reports required by the order, and is nearing completion of the final report.

The investigation has consisted of several different aspects:

- reviews of thousands of cases from every region of the state;
- interviews with hundreds of APS employees from every region of the state;

- interviews of members of community organizations and stakeholders in every region of the state; and
- limited reviews of policy and statutes, management structure, personnel records, and APS internal reports and data.

The statewide offices of General Investigations have assisted this investigation.

## 3. Child Protective Services Investigation

On July 1, 2004, Governor Perry ordered a statewide investigation into the practices and procedures of Child Protective Services (CPS), citing discrepancies in casework documentation, concerns over casework management and inaction when children have been exposed to abusive situations. On July 2, 2004, HHSC Executive Commissioner Albert Hawkins ordered the immediate investigation of CPS programs, which are managed by the Department of Family and Protective Services (DFPS).

OIG is conducting the investigation and is focusing on all aspects of the CPS program, including existing laws, policies and procedures, the intake and triage of reported complaints, CPS investigations, assessment and determinations for placement and resolutions, and other services provided by the agency. The investigation is anticipated to take about six months and contain the same aspects as the APS investigation.

## 4. National White Collar Crime Center

The National White Collar Crime Center (NW3C) provides a nationwide support system for agencies involved in the prevention, investigation, and prosecution of economic and high-tech crimes, and supports and partners with other appropriate entities in addressing homeland security initiatives, as they relate to economic and high-tech crimes.

NW3C is a federally funded, non-profit corporation whose membership primarily consists of law enforcement agencies, state regulatory bodies with criminal investigative authority, and state and local prosecution offices.

The NW3C conducted training for over 120 OIG staff in the summer of 2004. The four classes focused on the practical skills, insights, and knowledge necessary to successfully complete a financial investigation.

The 36-hour training session covered identifying and addressing complex, criminal activities, organizing and documenting critical evidence, and techniques for case prosecution. OIG employees from different investigative disciplines (auditors, claims investigators, fraud analysts, nurse reviewers, and research specialists), as well as staff from the Department of Public Safety and Attorney General's office participated.

A fifth class (40 hours) scheduled for September 20 to 24, 2004, will educate participants on successful ways to use intelligence analysis and its overall effectiveness.

## 5. Historic Medicaid Fraud Case

OIG participated in the investigation and testified in the 177th Harris County District Court regarding one of Texas' most severe criminal cases involving Medicaid fraud. A husband and wife, operating a company named D&H Christian Case Management, which allegedly provided mental-health care counseling to children, were convicted of Medicaid fraud. These individuals received a combined 98 years in prison for $630,000 in inappropriate Medicaid billings. OIG staff was in Houston when the guilty verdict was read and sentencing took place.

## 6. Technology Analysis, Development, and Support (TADS)

This OIG section directs and monitors the development, implementation, and coordination of policies and procedures for the management of OIG electronic systems. These systems include the Medicaid Fraud and Abuse Detection System (MFADS), the Surveillance Utilization Review Subsystem (SURS), the ASOIG (primarily used by OIG General Investigations staff and multiple HHSC and enterprise systems involving third party resources [TPR]), Client Limited Program, and hospital and nursing facility utilization review. TADS consists of

- the Business Analysis and Support Services (BASS) unit, and
- the Research Analysis and Detection (RAD) unit.

The BASS unit implemented the new data matches that include the FBI felony and missing persons file, the Texas DPS wanted and missing persons match, and the National Center for Missing and Exploited Children (NCMEC) file. The first completion of the FBI felony and DPS wanted file matches identified over 35,669 individuals who had Medicaid, TANF, or Food Stamp eligibility. The FBI missing persons, DPS missing persons, and the NCMEC file matches identified 2,894

individuals who had Medicaid, TANF, or Food Stamp eligibility. Additional accomplishments include

- the migration of the inpatient hospital utilization review application from the old mainframe system to the MFADS platform, and
- the development and implementation of the case mix utilization review application using the MFADS platform.

The RAD unit is composed of nurse analysts and research specialists who develop cases from the MFADS targeted queries and model results, and SURS. For the Medicaid program during the last two quarters of this fiscal year, this staff

- opened 937 cases;
- closed 671 cases;
- identified $1,009,795 in potential overpayments; and
- recovered $1,376,830 for the Medicaid program.

## 7. Utilization Review

The Nursing Facility Utilization Review section began implementing a fully automated review process. Through the MFADS platform, nurse reviewers can use Department of Aging and Disability Services (DADS) provider claims services data for payments to nursing homes in the field on a laptop computer. All documentation and data for the claim period is entered directly into the laptop during the review and sent back to DADS for claims adjustments. This new process will facilitate unannounced visits, as the reviewers will have claims data before arriving. Other advantages include decreased manpower requirements and enhanced reporting capabilities. OIG anticipates full implementation in September 2004.

## 8. Third Party Resources (TPR)

SFY 2004 post-payment recovery operations showed an increase of 8% over SFY 2003.

TPR completed a successful transition of TPR vendors with no disruption to recovery activity. In addition to the vendor, banking requirements, systems, staff, and file transfers necessary to maintain a successful TPR program, transition activities included business integration testing (BIT). BIT verified that the Texas Medicaid and HealthCare Partnership (TMHP) operational staff and systems could operate manual and automated functions according to contractual and business requirements. Tests confirm the following:

- TMHP staff was trained in the documented processes and procedures and could execute the necessary tasks for both systematic and manual data-entry for TPR, Tort, and Health Insurance Premium Payment (HIPP) operations;
- the Compass21 system can ensure that Medicaid is the payer of last resort, coordinate benefits with other payers, and recover funds due the Medicaid program; and
- the business requirements outlined in the RFP were correctly addressed in the policies and procedures used to include the Electronic Online Procedures Manual (eOPM) and the TPR Procedures Manual.

In addition to a seamless transition that resulted in no degradation to recovery activity in SFY 2004, OIG executed a contract with the Office of Attorney General Medical Support Division. This contract provides to HHSC third-party insurance information on Medicaid recipients identified during Attorney General Child Support Enforcement operations. In a continuing effort to increase the identification of third-party insurance, OIG is pursuing data-match contracts with pharmacy benefit managers.

## 9. Managed Care Organization Special Investigative Units

HB2292 mandated that all Medicaid managed care organizations (MCO) establish and maintain a special investigative unit (SIU) by September 1, 2004, to investigate fraudulent claims and other types of program abuse by recipients and service providers.

The bill also requires that each MCO adopt a plan to prevent and reduce fraud and abuse, and that the plan be filed annually with OIG for approval. OIG published the approved rules to accomplish this section of HB2292. The MCOs were to submit fraud and abuse prevention and reduction plans for approval by July 1, 2004. OIG is pleased to report that as of August 25, 2004, all MCOs fraud and abuse plans have been approved per HB2292 requirements.

## 10. National Insurance Crime Bureau (NCIB) Claim Search

In February 2004, OIG received access to the NCIB-ISO claim search database, which is the most comprehensive all-claims database for the insurance industry. Before OIG was established, HHSC could not obtain access to this tool. OIG completed training in

August 2004, and intends to use the database to identify, investigate, and prosecute insurance-related fraud and abuse, as related to state and federally funded Health and Human Services programs. Use of the database is limited to:

1. identifying Medicaid recipients who have not reported subrogation cases or other insurance information in accordance with Chapter 32 of the Texas Human Resources Code §32.033. Unreported access to third-party coverage and/or receipt of insurance settlements without proper reimbursement to the program are referred for investigation and may result in the loss of Medicaid benefits;
2. identifying Medicaid providers who have become delinquent on settlement agreements or have otherwise gone missing to avoid investigation and/or prosecution;
3. determining if the perpetrator has received insurance settlements, which will aid in making asset determinations to establish repayment plans, settlement agreements, or evidencing assets in court; and
4. determining if the provider or client may be involved in other insurance-related illegalities, and to coordinate prosecution efforts with other interested parties.

## 11. OIG Intern Program

With the assistance of the University of Texas at Austin, the OIG sponsored two summer interns. The OIG internship program educates students and enhances OIG's ability to achieve operational responsibilities. This summer, the two law school interns assisted with an optimization project. The individuals identified legislation, which impacts OIG. The result of their effort is in Appendix B.

The length of internships varies, but students usually prefer semester-length assignments, between 12 and 14 weeks. OIG is working with schools around the state to cultivate more internship opportunities for students of nursing, law, accounting, and finance. In particular, OIG is receiving degree candidates from the University of Texas at Dallas.

The internship benefits both the State of Texas and young students seeking real-world experience. The interns learn about OIG through their interaction in monthly meetings, networking opportunities, and skill development. They can work with data to produce work that is truly relevant to state policy. They may produce reports, white papers, masters thesis, and Ph.D. dissertations that OIG can use to meet its mission and myriad directives.

## 12. OIG and Attorney General Interagency Coordination

Pursuant to the requirements of Senate Bill 30 (75th Legislature), a memorandum of understanding (MOU) was executed in April 1998 between the HHSC Medicaid Program Integrity Department (MPI) and the Office of Attorney General (OAG) Medicaid Fraud Control Unit (MFCU). The MOU was updated and expanded in November 2003, in accordance with House Bill 2292, which required OIG and the OAG to enter into a new MOU no later than December 1, 2003.

MFCU and MPI are moving 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. MPI and MFCU hold meetings as needed to share information, and several joint investigation projects have been initiated.

The HHSC and the OAG have established guidelines under which provider payment holds and exclusions from the Medicaid program are performed. Timelines and minimum standards for case referrals have been established, which will enhance the timely investigation of potentially fraudulent providers. And, roles and expectations of each agency have been documented.

Additionally, matched federal grant funds were approved, which could expand the MFCU to as many as 236 staff by the end of federal fiscal year 2005. The MFCU has increased its staff by 98, and has opened field offices in Dallas, Houston, Lubbock, Tyler, El Paso, McAllen, San Antonio, and Corpus Christi. Additionally, the MFCU has opened a Houston-based a task force. OIG referred 257 cases to the AG this year vs. 104 cases last year.

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. Thanks to a renewed cooperative spirit and the efforts of both agencies, both agencies continue to achieve the following:

- 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; and
- 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.

## 13. Investigative Data Matching

OIG is currently operating five data matches:

1. the Texas-wide DPS data match (wanted file and missing persons file),
2. the national FBI Wanted Felon data match (wanted file and missing person file), and
3. the National Center for Missing and Exploited Children data match.

As codified in Texas Government Code §531.115 and the Governor's Executive Order RP36, dated July 12, 2004, OIG is required to pursue these data matches.

OIG completed the first run of the Texas-wide DPS data match and the Nation-wide FBI Wanted Felon data match. OIG identified 10,116 distinct client numbers on the FBI Wanted Felon match, and 25,553 distinct client numbers on the DPS match. OIG intends to run these data matches monthly. In summary, OIG now has at least 35,669 distinct client numbers that have outstanding arrest warrants.

The data match process for each match is as follows:

1. **DPS Data Match:** (involving Texas-only warrants and Texas missing persons) OIG performs the match
   a. DPS sends OIG a TCIC list of Texas-only warrants;
   b. OIG matches the list provided to OIG databases; and
   c. OIG discards multiple entries of the same client number

2. **Felony Data Match:** (involving warrants and missing persons) FBI performs the match
   a. OIG has a full list of three systems (full files):
      - Medicaid,
      - TANF, and
      - Food Stamp.
   b. OIG extracts an "eligible" list [ages 14 and older] and send it to the FBI;
   c. FBI matches the list to their National Crime Information Center list, and sends OIG the matches; and
   d. OIG discards multiple entries of the same client number.
3. **National Center for Missing and Exploited Children (NCMEC):** OIG performs the match
   a. NCMEC sends us three lists:
      - Missing Children List,
      - Suspected Abductors List, and
      - Law enforcement entity.
   b. OIG has a full list of three systems (full files) to match against the NCMEC data:
      - Medicaid,
      - TANF, and
      - Food Stamp.

## 14. Audit Activities

The Audit section consists of four units:

- Sub-recipient Financial Review,
- Medicaid/CHIP Audit,
- Contract Audit, and
- Cost Report Review.

Consolidation efforts began in January 2004 and continued for the remainder of SFY 2004. The Audit section is prepared to ensure coverage for transferred functions. Additionally, high-risk areas such as Medicaid/CHIP and Vendor Drug Program (VDP) contractors will also be audited.

**Sub-recipient Financial Review Unit**

The Sub-recipient Financial Review Unit consists of single audit reviews and financial on-site and desk reviews of legacy agency sub-recipients. Fiscal WIC Monitoring will move to this unit effective September 1, 2004.

**Medicaid/CHIP**

The OIG Audit section is developing a risk-based system for auditing HHS system contracts and grants. Information will be gathered from audit reports, information systems, contract monitoring, and other related activities. The risk assessment results will be used to plan on-site audits.

Work is underway on an audit to determine the setting of payment rates for federally qualified health centers (FQHCs). This audit entails determining if

- supervising organizations are performing oversight and review procedures to ensure that FQHCs are paid at the proper rates, and
- TMHP is performing proper audit procedures for FQHCs.

The second part of this audit will also be used as a pilot test to determine oversight procedures for the contracted Medicaid/CHIP audit process. By piloting oversight audits, the Medicaid/CHIP Audit unit will have a system in place before the contracts are executed, which will prevent a lag in proper contract oversight.

**Vendor Drug Audits**

Vendor drug audits ensure pharmacy compliance with state and federal guidelines and regulations. The objectives are to

- express an opinion based on the results of the procedures performed,
- determine whether a pharmacy complied with the HHSC Vendor Drug Program (VDP) Contract requirements, and
- determine 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.

In July 2004, an MOU was executed between OIG and Texas State Board of Pharmacy. The MOU ensures cooperation and coordination between the agencies in issues involving potential fraud and abuse by a pharmacist or pharmacy. The vendor drug program completed 11 audits during June and July 2004, and identified $1,099,796.26 of potential findings.

According to TAC Title 1, Part 15, Chapter 354, subchapter F, §354.1891, "Vendor Drug Providers Subject to Audit," if the provider disagrees with the initial audit findings, the provider can request an informal hearing or desk review by the VDP. The VDP manager appoints reviewers for the informal hearing or desk reviews. From March 2004 through July 2004, the Contract Audit unit participated in 20 informal hearings.

# Medicaid Fraud Detection and Abuse Prevention Training

## 1. Texas State University Training

Under the provisions of the Texas Government Code, §531.105, HHSC provide Medicaid fraud and abuse training to Medicaid contractors, providers, and their employees, and to state agencies associated with the Medicaid program. In cooperation with Texas State University (TSU) HHSC has developed this training. Continuing education units are available through TSU.

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 as a seminar. The seminar 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.

## 2. Distance Learning Program

The distance-learning program was developed in collaboration with OIG and TSU. It provides the most efficient and economical training on Medicaid fraud and abuse detection and prevention training to Medicaid contractors, providers, and their employees. The module is available from TSU on-line or by correspondence.

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 March 31, 2004 – August 31, 2004**

| Type of Course | Total Enrolled |
|---|---|
| TILE Nursing Home Correspondence | 432 |
| TILE Nursing Home On-Line Computer Training | 350 |
| Community Base TILE Correspondence | 191 |
| Community Based TILE On-Line Computer Based Training | 202 |
| **Total** | **1,175** |

## 3. Fraud Prevention Training

HHSC believes that provider education is an integral element of any fraud, abuse, and waste prevention plan. OIG met with the Texas Medicaid HealthCare Partnership (TMHP), to discuss the OIG role within the HHS enterprise. OIG also met with key management staff, including provider representatives, to ensure the new Claims Administrator/Primary Care Case Management vendor was acutely aware of OIG fraud and abuse activities, and the role OIG expected the vendor to play. To ensure operational interfaces were not jeopardized during transition, OIG conducted several additional meetings with key TMHP departments.

As a requirement of SB30, OIG provides free training to Medicaid providers, contractors, their employees, and staff from other state agencies that administer health and human services programs, on the identification and referral of abuse, waste or fraud in the Medicaid Program.

The objectives of HHSC/OIG training are to educate and inform about:

- what constitutes Medicaid fraud, abuse, or waste;
- the obligation to report Medicaid fraud, abuse, or waste;
- how to identify potential Medicaid fraud, abuse, or waste; and
- how to report potential Medicaid fraud, abuse, or waste.

**Training March 1, 2004 – August 31, 2004**

| Date | Audience | Subject | Presenter |
|---|---|---|---|
| March 01, 2004 | Texas Board of Medical Examiners | Waste, abuse, and fraud | Juanita Henry |
| March 18, 2004 | Regency Nursing Home | Waste, abuse, and fraud | Juanita Henry |
| March 20, 2004 | First Care | Waste, abuse, and fraud | Juanita Henry |
| April 8, 2004 | US Department of Labor | OIG Consolidation | Bart Bevers |
| April 16, 2004 | Andrews Center | Waste, abuse, and fraud | Juanita Henry |
| May 25, 2004 | Travis County Bar Association | Office of Inspector General | Brian Flood |
| July 7, 2004 | Evercare STAR + Plus | Waste, abuse, and fraud | Juanita Henry |
| July 22, 2004 | Capital City MGMA Group | OIG Consolidation | Bart Bevers |
| August 10, 2004 | North Texas Healthcare Compliance Professionals Association | Waste, abuse, and fraud | Charlotte Dokes |

## 4. Specialized Medicaid Fraud Detection Training for Toll-free Hotline Operators

To meet the provisions of Texas Government Code, §531.108, the HHSC developed an agreement with the Texas Department of Health to utilize its existing toll-free hotline and operators to ensure that such a line for reporting Medicaid fraud and/or abuse is maintained and promoted. The OIG conducts specialized 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 Department.

**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 1-800-925-9126
- 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
- Limited Program hotline 1-800-252-8141
- CHIP/TexCare partnership 1-800-647-6558

Hotline numbers are publicized through recipient and provider mailings, posters in appropriate offices of the operating agencies, and publications of the operating agencies and HHSC.

# Appendix A – OIG Detailed Statistics

## Recoupment and Recovery

| OIG Program | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Medicaid Program Integrity | $2,699,051 | $18,523,944 | $337,201 | $1,797,902 | **$23,358,098** |
| Civil Monetary Penalties | $893,237 | $13,071,164 | $115,556 | $104,193 | **$14,184,150** |
| Utilization Review (DRG-hospitals) | $2,153,633 | $4,821,062 | $6,034,310 | $9,128,344 | **$22,137,349** |
| TEFRA Claims – Children's Summary | $0 | $0 | $0 | $2,601 | **$2,601** |
| TEFRA Claims – Psychiatric Summary | $0 | $0 | $4,575 | $0 | **$4,575** |
| Case Mix Review (Nursing Homes) | $3,222,915 | $2,231,457 | $2,527,429 | $258,984 | **$8,240,785** |
| Third Party Resources | $79,031,617 | $49,505,122 | $67,313,167 | $56,669,299 | **$252,519,205** |
| Surveillance and Utilization Review Subsystems (SURS) | $388,419 | $608,729 | $248,136 | $284,313 | **$1,529,597** |
| Medicaid Fraud and Abuse Detection System (MFADS) *- dollars recovered* | $452,432 | $373,502 | $480,995 | $1,163,271 | **$2,470,200** |
| General Investigations | $4,622,061 | $4,825,880 | $8,720,634 | $4,448,705 | **$22,617,280** |
| WIC Monitoring & Investigation | $1,534 | $3,585 | $3,617 | $18,711 | **$27,447** |
| Audits | $1,001,876 | $135,037 | $886,157 | $478,891 | **2,501,961** |
| **Total** | **$94,466,775** | **$94,099,482** | **$86,671,777** | **$74,355,214** | **$349,593,248** |

## Cost Avoidance

| OIG Departments | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Medicaid Provider Integrity<br>**based on total dollars identified* | $10,791,002 | $28,630,614 | $4,703,117 | $944,104 | **$45,068,837** |
| Audits | $45,123,059 | $22,073,745 | $14,071,814 | $12,104,416 | **$93,373,034** |
| Third Party Resources | $53,154,581 | $70,457,268 | $65,908,342 | $58,281,813 | **$247,802,004** |
| General Investigations | $718,962 | $670,376 | $977,316 | $899,472 | **$3,266,126** |
| **Total** | **$109,787,604** | **$121,832,003** | **$85,660,589** | **$72,229,805** | **$389,510,001** |

## Medicaid Fraud and Abuse Detection System (MFADS) Performance Measures

| Performance Measures | | FY03 | FY04 |
|---|---|---|---|
| Number of cases opened | 1st Quarter | 415 | 451 |
| | 2nd Quarter | 97 | 353 |
| | 3rd Quarter | 532 | 143 |
| | 4th Quarter | 593 | 795 |
| **Total cases opened for the FY** | | **1,637** | **1,742** |
| Potential dollars identified for recovery | 1st Quarter | $182,635 | $1,459,840 |
| | 2nd Quarter | $108,287 | $1,308,507 |
| | 3rd Quarter | $446,050 | $2,165,070 |
| | 4th Quarter | $2,189,638 | $690,752 |
| **Total potential dollars identified for recovery** | | **$2,926,610** | **$5,624,169** |
| Actual dollars recovered | 1st Quarter | $611,135 | $452,432 |
| | 2nd Quarter | $455,593 | $373,502 |
| | 3rd Quarter | $1,117,783 | $480,995 |
| | 4th Quarter | $288,801 | $1,163,271 |
| **Total Recoveries** | | **$2,473,312** | **$2,470,200** |

## Third Party Resources

| OIG Program | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Cost Avoidance | $53,154,581 | $70,457,268 | $65,908,342 | $58,281,813 | **$247,802,004** |
| Other Insurance Credits | $58,271,124 | $33,312,499 | $45,125,472 | $42,312,139 | **$179,021,234** |
| Provider Refunds | $1,596,801 | $1,308,830 | $1,310,515 | $1,473,950 | **$5,690,096** |
| Texas Automated Recovery System (TARS) | $5,119,654 | $4,065,875 | $3,796,239 | $3,406,596 | **$16,388,364** |
| Pharmacy | $3,307,849 | $1,705,048 | $3,600,098 | $2,541,853 | **$11,154,848** |
| Credit Balance Audit | $5,034,135 | $2,086,340 | $4,647,412 | $892,935 | **$12,660,823** |
| Cash Medical Support | $1,132,386 | $1,201,913 | $2,365,503 | $1,760,380 | **$6,460,182** |
| Tort | $4,569,667 | $5,824,616 | $6,467,925 | 4,281,446 | **$21,143,654** |
| **Total** | **$132,186,197** | **$119,962,389** | **$133,221,506** | **$114,951,112** | **$500,321,404** |

## Summary for General Investigations

| Description | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Claims Established | $7,043,807 | $6,314,168 | $7,142,954 | $4,526,814 | **$25,027,743** |
| Collections* | $4,622,061 | $4,825,880 | $8,720,634 | $4,448,705 | **$22,617,280** |
| Disqualification Cost Savings** | $718,962 | $670,376 | $977,316 | $899,472 | **$3,266,126** |
| Referrals/Complaints Received | 22,963 | 18,749 | 16,968 | 18,758 | **77,438** |
| Cases Completed | 23,752 | 23,598 | 22,827 | 15,456 | **85,633** |
| % of Cases Completed w/in 180 Days | 93.8% | 94.5% | 95.1% | 94.2% | **94.4%** |
| Cases Referred for Prosecution | 1,097 | 771 | 1,195 | 762 | **3,825** |
| ADH Cases Completed | 1,846 | 1,952 | 1,947 | 959 | **6,704** |
| Cases Adjudicated | 339 | 379 | 440 | 388 | **1,546** |
| Civil Disqualifications | 1,751 | 1,565 | 1,864 | 1,798 | **6,978** |
| IEVS Matches Cleared*** | 53,629 | 44,689 | 60,034 | 58,318 | **216,670** |
| Other Data Matches Cleared | 4,966 | 4,394 | 3,871 | 0 | **13,231** |

*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. Monthly cost savings updated effective 3/1/04 to $106 for Food Stamps and $112 for TANF.
*** Income Eligibility and Verification System data source matches.

## Food Stamp Investigations

| Description | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Claims Established | $5,045,203 | $4,624,006 | $5,124,687 | $3,190,196 | **$17,984,092** |
| Collections | $3,661,507 | $3,855,976 | $7,489,823 | $3,581,056 | **$18,588,362** |
| Disqualification Cost Savings | $675,484 | $612,406 | $910,116 | $836,976 | **$3,034,983** |
| Cases Referred for Prosecution | 590 | 392 | 640 | 466 | **2,088** |
| ADH Cases Completed | 1,534 | 1,613 | 1,610 | 785 | **5,542** |
| Civil Disqualifications | 1,381 | 1,223 | 1,443 | 1,388 | **5,435** |

## TANF Investigations

| Description | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Claims Established | $1,246,046 | $1,180,029 | $1,453,645 | $999,553 | **$4,879,273** |
| Collections | $671,864 | $665,436 | $858,164 | $597,399 | **$2,792,863** |
| Disqualification Cost Savings | $43,477 | $57,970 | $67,200 | $62,496 | **$231,143** |
| Cases Referred for Prosecution | 268 | 190 | 277 | 146 | **881** |
| ADH Cases Completed | 307 | 337 | 334 | 172 | **1,150** |
| Civil Disqualifications | 370 | 342 | 421 | 410 | **1,543** |

## Medicaid Investigations

| Description | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Claims Established | $752,558 | $510,133 | $564,622 | $337,065 | **$2,164,378** |
| Collections | $288,689 | $304,467 | $372,648 | $270,251 | **$1,236,055** |
| Disqualification Cost Savings | N/A | N/A | N/A | N/A | **N/A** |
| Cases Referred for Prosecution | 239 | 189 | 278 | 150 | **856** |
| ADH Cases Completed | 5 | 2 | 3 | 2 | **12** |
| Civil Disqualifications | N/A | N/A | N/A | N/A | **N/A** |

## Income Eligibility and Verification System

| Description | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| IEVS Food Stamp Matches | 33,016 | 34,555 | 49,709 | 48,821 | **166,101** |
| IEVS TANF Matches | 3,293 | 1,952 | 1,870 | 1,932 | **9,047** |
| IEVS Medicaid Matches | 17,320 | 8,182 | 8,455 | 7,565 | **41,522** |
| **Total** | **53,629** | **44,689** | **60,034** | **58,318** | **216,670** |

## CHIP Investigations

| Description | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| CHIP Investigations | N/A | N/A | N/A | N/A | N/A |

## Other Matches

| Description | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| Other Data Matches Cleared | 4,966 | 4,394 | 3,871 | 0 | **13,231** |

## Summary for Audit Activities

| Audits Summary for HHS Agencies | Number of Audits | Number of Site Visits | Number of Reviews | Recoupment & Recovery | Cost Avoidance | Dollars Identified | Recipient Refunds | Rejected Single Audits |
|---|---|---|---|---|---|---|---|---|
| **Vendor Drug Audits** | | | | | | | | |
| 1st Quarter | 19 | N/A | N/A | $163,345 | N/A | $1,424,497 | N/A | N/A |
| 2nd Quarter | 31 | N/A | N/A | $110,820 | N/A | $2,300,405 | N/A | N/A |
| 3rd Quarter | 5 | N/A | N/A | $861,773 | N/A | $78,635 | N/A | N/A |
| 4th Quarter | 9 | N/A | N/A | $437,943 | N/A | $1,099,796 | N/A | N/A |
| **SFY Total** | **64** | **N/A** | **N/A** | **$1,573,883** | **N/A** | **$4,903,333** | **N/A** | **N/A** |
| **Medicaid/CHIP Audits** | | | | | | | | |
| 1st Quarter | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 2nd Quarter | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 3rd Quarter | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 4th Quarter | N/A | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| **SFY Total** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** | **N/A** |
| **Single Audit** | | | | | | | | |
| 1st Quarter | N/A | N/A | 112 | N/A | N/A | N/A | N/A | 1 |
| 2nd Quarter | N/A | N/A | 159 | N/A | N/A | N/A | N/A | 25 |
| 3rd Quarter | N/A | N/A | 192 | N/A | N/A | N/A | N/A | 35 |
| 4th Quarter | N/A | N/A | 192 | N/A | N/A | N/A | N/A | 26 |
| **SFY Total** | **N/A** | **N/A** | **655** | **N/A** | **N/A** | **N/A** | **N/A** | **87** |

*N/A = Not an applicable metric. Medicaid/CHIP Audits are in the development phase.

## Summary for Audit Activities

| Audits Summary for HHS Agencies | # of Audits | # of Site Reviews | # of Reviews | Recoupment & Recovery | Cost Avoidance | Dollars Identified | Recipient Refunds | Rejected Single Audits |
|---|---|---|---|---|---|---|---|---|
| **Texas Commission on Alcohol and Drug Abuse (TCADA)** | | | | | | | | |
| 1st Quarter | N/A | 3 | 40 | $29,351 | $174,787 | $313,173 | N/A | N/A |
| 2nd Quarter | N/A | 8 | 19 | $16,169 | $21,174 | $62,930 | N/A | N/A |
| 3rd Quarter | N/A | 4 | 0 | $24,142 | $778,893 | $371,484 | N/A | N/A |
| 4th Quarter | N/A | 2 | 0 | $26,106 | $126,281 | $107,683 | N/A | N/A |
| **SFY Total** | **N/A** | **17** | **59** | **$95,768** | **$1,101,135** | **$855,270** | **N/A** | **N/A** |
| **Texas Department of Health Financial Compliance (TDH)** | | | | | | | | |
| 1st Quarter | N/A | 18 | 4 | $273,478 | $174,787 | $279,318 | N/A | N/A |
| 2nd Quarter | N/A | 12 | 5 | $8,048 | $21,174 | $156,628 | N/A | N/A |
| 3rd Quarter | N/A | 14 | 2 | $242 | $778,893 | $77,013 | N/A | N/A |
| 4th Quarter | N/A | 10 | 1 | $14,842 | $126,281 | $800,408 | N/A | N/A |
| **SFY Total** | **N/A** | **54** | **12** | **$296,610** | **$1,101,135** | **$1,313,367** | **N/A** | **N/A** |
| **Texas Department of Human Services (DHS)** | | | | | | | | |
| 1st Quarter | 80 | N/A | 801 | N/A | $42,903,380 | $10,045,364 | $153,012 | N/A |
| 2nd Quarter | 66 | N/A | 553 | N/A | $21,148,909 | $9,083 | $134,815 | N/A |
| 3rd Quarter | 153 | N/A | 1,075 | N/A | $11,552,522 | $1,332 | $31,067 | N/A |
| 4th Quarter | 115 | N/A | 842 | N/A | $14,079,001 | $1,451,467 | $38,669 | N/A |
| **SFY Total** | **414** | **N/A** | **3,271** | **N/A** | **$89,683,812** | **$11,507,246** | **$357,563** | **N/A** |
| **Texas Mental Health and Mental Retardation (MHMR)** | | | | | | | | |
| 1st Quarter | 22 | 3 | 170 | $535,702 | $2,044,892 | $1,015,777 | $65,315 | N/A |
| 2nd Quarter | 3 | 2 | 169 | $0 | $903,662 | $534,081 | $52,056 | N/A |
| 3rd Quarter | 0 | 1 | 109 | $0 | $1,740,399 | $243,610 | $34,503 | N/A |
| 4th Quarter | 6 | 76 | 57 | $0 | $-2,100,866 | $1,909,858 | $21,523 | N/A |
| **SFY Total** | **31** | **82** | **505** | **$535,702** | **$2,588,087** | **$3,703,326** | **$173,397** | **N/A** |
| **Totals** | **509** | **153** | **4,502** | **$2,501,961** | **$93,373,034** | **$22,282,542** | **$530,960** | **87** |

*N/A = Not an applicable metric.

## Other OIG Statistics

| Action | 1st Quarter | 2nd Quarter | 3rd Quarter | 4th Quarter | Total FY2004 |
|---|---|---|---|---|---|
| **Medicaid Provider Integrity**: | | | | | |
| Cases opened | 354 | 285 | 299 | 211 | **1,149** |
| Cases closed | 329 | 243 | 270 | 348 | **1,190** |
| Providers Excluded | 240 | 124 | 159 | 102 | **625** |
| **Utilization Review**: | | | | | |
| Case Mix (Nursing Homes) – Facilities Visited | 336 | 298 | 311 | 27 | **972** |
| Case Mix (Nursing Homes) - Forms Reviewed | 7,079 | 6,604 | 7,929 | 941 | **22,553** |
| Hospitals – Facilities Reviewed | 116 | 189 | 286 | 357 | **948** |
| Hospitals - Chart Reviews | 5,072 | 5,860 | 6,688 | 9,248 | **26,868** |
| **Medicaid Fraud & Abuse Detection System:** | | | | | |
| Cases opened | 451 | 353 | 143 | 795 | **1,742** |
| Cases closed | 559 | 415 | 235 | 465 | **1,674** |

| Action | 1st Quarter FY2004 | | | 2nd Quarter FY2004 | | | 3rd Quarter FY2004 | | | 4th Quarter FY2004 | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Limited Program** | 09/02 | 10/02 | 11/02 | 12/02 | 01/03 | 02/03 | 03/03 | 04/03 | 05/03 | 06/03 | 07/03 | 08/03 |
| Fee-for-Service (FFS) | 416 | 384 | 345 | 325 | 314 | 304 | 312 | 316 | 322 | 318 | 306 | 315 |
| STAR | 209 | 205 | 188 | 168 | 176 | 173 | 166 | 151 | 145 | 141 | 141 | 151 |
| STAR+PLUS | 37 | 32 | 32 | 31 | 31 | 34 | 36 | 35 | 36 | 38 | 39 | 37 |
| TOTAL | **662** | **621** | **565** | **524** | **521** | **511** | **514** | **502** | **503** | **497** | **486** | **503** |

# Appendix B – OIG Legislative Analysis

| Legislative Session | Bill | Chapter | Applicable Section(s) |
|---|---|---|---|
| **78(R) - 2003** | HB 2292 | 198 | 1.03, 1.05(c)(2), 1.06, 1.18, 2.05, 2.06, 2.07, 2.17 – 2.28, 2.35, 2.37, 2.44, 2.46, 2.57, 2.60, 2.85, 2.88, 2.97, 2.99, 2.103 - 2.111, 2.136 - 2.139, 2.141 – 2.143 |
| | HB 1743 | 257 | 2 – 8, 11, 12 |
| **77(R) – 2001** | SB 789 | 1255 | 3 |
| **76(R) – 1999** | HB 2641 | 1460 | 9.06 |
| | SB 1587 | 1289 | 1, 3, 4 |
| | HB 1514 | 215 | 1, 2 |
| | HB 875 | 206 | 1 |
| | SB 1588 | 493 | 1 |
| | SB 11 | 12 | 1, 2 |
| | SB 1248 | 88 | 1, 2 |
| | SB 368 | 556 | 74 |
| **75(R) – 1997** | SB 30 | 1153 | 1.01 - 1.11, 2.01 – 2.09, 3.01 - 3.04, 4.01 – 4.10, 5.01, 6.01 - 6.02, 7.01, 8.01 – 8.03 |
| | HB 2777 | 1116 | |
| | HB 2123 | 322 | 1, 2 |
| | SB 898 | 165 | 6.53, 14.03, 14.10, 14.16 |
| | SB 290 | 147 | 1 |
| | HB 2913 | 1262 | 1, 2 |
| | SB 910 | 827 | 2, 3 |
| **74(R) – 1995** | HB 1863 | 655 | 2.02, 8.03, 8.04, 8.08 |
| | SB 969 | 76 | 8.002(a) |
| | SB 1162 | 531 | 3 |

# Appendix C – Recoupments, Cost Avoidance, and Savings

**Office of Inspector General**
**1999-2004**

| | 1999[b] | | 2000 | | 2001 | | 2002 | | 2003 | | 2004 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Recoup-ments | Cost Avoidance and Savings | Recoup-ments | Cost Avoidance and Savings | Recoup-ments | Cost Avoidance and Savings | Recoup-ments | Cost Avoidance and Savings | Recoup-ments | Cost Avoidance and Savings | Recoup-ments | Cost Avoidance and Savings |
| **Compliance** | | | | | | | | | | | | |
| *Quality Control* | | | | | | | | | | | | |
| Utilization Review | | | | | | | | | | | | |
| Hospitals (DRGs) | $40,424,668 | | $31,508,661 | $31,500,000 | $28,352,157 | $11,365,244 | $20,960,086 | $28,352,156 | $19,838,443 | $15,720,066 | $22,137,349 | g |
| Nursing Homes (Case Mix Review) | $7,544,699 | | $7,090,259 | $7,056,000 | $9,378,194 | $65,413,046 | $7,758,268 | $9,378,196 | $13,463,106 | $5,818,701 | $8,240,785 | g |
| TEFRA Claims | $45,025 | | $362,341 | | $143,719 | | $26,688 | | $59,413 | | | |
| Children's Summary | | | | | $28,429 | | $23,854 | | $21,743 | | $2,601 | f |
| Psychiatric Summary | | | | | $115,290 | | $2,834 | | $37,670 | | $4,575 | f |
| Compliance Monitoring and Referral[b] | $15,127,601 | | $12,546,475 | $12,546,475 | $9,247,210 | $9,247,210 | $4,326,484 | $9,247,212 | | | | |
| *Technology, Analysis, Development, and Support* | | | | | | | | | | | | |
| RADS | | | | | | | | | | | | |
| Surveillance and Utilization | $2,023,644 | | $1,426,859 | $1,426,859 | $1,143,499 | $1,143,500 | $1,002,106 | $1,143,500 | $101,467 | $155,334 | $1,529,597 | g |
| Medicaid Fraud and Abuse | $734,792 | | $3,418,564 | $3,418,564 | $1,854,123 | $1,900,000 | $2,200,648 | $1,854,124 | $2,310,113 | $1,650,486 | $2,470,200 | g |
| *Audit*[c] | | | | | | | | | | $13,633,529 | $2,501,961 | $93,373,034 |
| **Enforcement** | | | | | | | | | | | | |
| *Medicaid Provider Integrity* | $5,722,536 | | $8,719,952 | $13,802,760 | $3,565,975 | $6,347,920 | $8,296,834 | $26,714,974 | $11,661,741 | $19,964,211 | $23,358,098 | $45,068,837 |
| *General Investigations*[d] | | | $32,584,083 | | $25,930,896 | | $26,924,518 | | $22,415,995 | | $22,617,280 | $3,266,126 |
| *Internal Affairs* | | | | | | | | | | | | |
| WIC investigation Recoveries[e] | | | | | $600 | | $4,508 | | $5,170 | | $27,447 | f |
| **Chief Counsel** | | | | | | | | | | | | |
| *Sanctions* | | | | | | | | | | | | |
| Civil Monetary Penalties | $160,979 | | $324,470 | | $55,827 | | $2,072,841 | | $7,224,987 | | $14,184,150 | |
| **TOTAL Recoupments without Third Party Recoveries** | **$71,783,944** | | **$97,981,564** | | **$79,825,919** | | **$73,601,469** | | **$77,139,848** | | **$97,074,043** | |
| **Savings without Third Party Recoveries** | | | | **$69,750,658** | | **$95,416,920** | | **$76,690,162** | | **$56,942,327** | | **$141,707,997** |

a = Data for cost avoidance and savings not available.
b= Function discontinued in 2003.
c= Data captured by legacy agencies until 2003.
d= Data for cost avoidance and savings captured by legacy agencies until 2004
e= Unreported data not available from legacy agency.
f= Cost avoidance and savings methodology under review.
g = OIG has taken a more conservative approach to the calculation of cost avoidance, and therefore a comparison to prior years is not possible. After a review of all OIE cost avoidance methodologies during the Optimization Phase of Transformation, OIG has removed cost avoidance savings for UR, MFADS, and SURS. We believe that including cost avoidance, in addition to recovery activity, for these areas was too agressive of a measure.

Blue represents an OIG Division
Green represents an OIG Section
Pink represents an OIG Unit

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