Office of Inspector General

Annual Report

Fiscal Year 2007

Bart Bevers, Inspector General

OIG Mission Statement

We protect the integrity and ensure accountability in the health and human services programs, as well as the health and welfare of the recipients of those programs, by identifying, communicating and correcting activities of waste, fraud or abuse in Texas.

OIG Vision Statement

The Office of Inspector General (OIG) is the nationally recognized model for leveraging technology and collaborative partnerships to eliminate waste, fraud, and abuse. The value the OIG provides to ensure the health, safety and welfare of all Texans is universally realized.

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HEALTH AND HUMAN SERVICES COMMISSION

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HEALTH AND HUMAN SERVICES COMMISSION

Executive Summary

I am pleased to issue the Office of Inspector General's (OIG) report for State Fiscal Year (SFY) 2007, which ended August 31, 2007. This report provides a synopsis of SFY 2007 OIG recoveries and cost avoidance, an overview of our key accomplishments and projects, and presents a look at future OIG activities. During SFY 2007, OIG recovered $61.9 million through sanctions penalties and recoupments. Third-party payments and reimbursements were in excess of $356 million.

OIG issued a "Provider Self-Reporting Guidance" to encourage health care providers to voluntarily investigate and report matters involving the possible waste, abuse, fraud, or inappropriate payment of funds under state administered programs. It is OIG's intention to work collaboratively with providers who proceed in accordance with the Guidance. We anticipate the number of self-reports to increase as more health care providers become aware of the potential benefits of working cooperatively with OIG.

The Medicaid CHIP Division and OIG continue to work collaboratively in the planning, implementation, and monitoring of medical policy changes that may result in cost avoidances or cost savings. In addition, the Benefits Management Workgroup and OIG are working to ensure that reimbursement is disallowed when services are used in a manner that is inconsistent with nationally accepted coding standards.

An increase in staffing was approved by the 80th Legislature for SFY 2008. This will aid in providing additional staff to assist with overpayment recoveries and audit, investigation, and compliance functions.

Since SFY 2007, OIG continues to assess and enhance policies and procedures, and streamline the integrated fraud and abuse prevention and detection functions. We are devoted to enhancing our computer programs and technical infrastructure to enrich the quality of work papers, improve the ability to recoup overpayments and increase efficiency.

We look forward to providing continued service to the State of Texas, and its leadership, and assuring accountability and integrity to Texas taxpayers.

Bart Bevers
Inspector General

Background

The 78th Texas Legislature created the Office of Inspector General (OIG) in 2003 in order to strengthen the Health and Human Services Commission's (HHSC) authority to combat abuse, and fraud in health and human services (HHS) programs.

Authorized by section 531.102 of the *Texas Government Code*, OIG is responsible for the investigation of fraud and abuse in the provision of heath and human services. OIG fulfills its responsibility through the following activities:

- Issuing sanctions and performing corrective actions against program providers and clients, as appropriate;
- Auditing the use of state or federal funds including contract and grant funds administered by a person or state agency receiving the funds from an HHS agency;
- Researching, detecting, and identifying episodes of abuse, and fraud to ensure accountability and responsible use of resources;
- Conducting investigations, reviews, and monitoring cases internally, with appropriate referral to outside agencies for further action;
- Recommending policies that enhance the prevention and detection of abuse, or fraud and promoting economical; and
- Providing education, technical assistance, and training to promote cost avoidance activities and sustain improved relationships with providers.

Overseen by a Governor-appointed Inspector General, OIG is a modern investigative arm with extensive expertise and diverse resources capable of rapidly and objectively responding to emerging HHS issues.

OIG has successfully strengthened its stakeholder relationships, including those with the State Auditor's Office, Texas Comptroller of Public Accounts, and Office of the Attorney General, enabling the state to achieve cost savings in a variety of HHS areas. To ensure quality, OIG operates in accordance with the National Association of Inspectors General Principles and Standards, and all audit activity is performed in accordance with United States General Accounting Office Government Auditing Standards.

Advancing the HHS mission and the Governor's Executive Order RP 36, dated July 12, 2004, OIG initiates proactive measures and deploys advanced information technology systems to aggressively reduce, pursue, and recover expenditures that are not medically necessary or justified. These measures and automated systems enhance the ability of OIG to identify inappropriate patterns of behavior and allow investigative resources to target cases with the strongest supporting evidence and greatest potential for monetary recovery.

OIG maintains clear objectives, priorities, and performance standards emphasizing:

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

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 for Medicaid providers, health maintenance organizations, staff of the claims administrator, and provider organizations.

Other proactive measures undertaken by OIG include workgroups with major provider associations, increased use of professional medical consultants, and a number of 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 and sustain improved relationships with Medicaid providers.

Key Accomplishments and Recent Developments

Compliance Division

The Compliance division reviews providers, vendors, and contractors to ensure compliance with all state and federal rules, regulations, and guidelines related to payment for reimbursable services; collects all identified overpayments for reimbursable services; educates providers, vendors, and contractors on submitting accurate information for reimbursable services; and refers providers, vendors, and contractors for suspected waste, abuse and fraud when appropriate. The Compliance division has three sections: Quality Review; Technology Analysis, Development and Support; and Audit.

Quality Review

The Quality Review section consists of three units:

- Limited Program;
- Utilization Review; and
- WIC Vendor Monitoring.

Limited Program

To prevent the inappropriate use of medical services and to promote quality of care, the Medicaid program may restrict a Medicaid recipient to designated providers, through the Limited Program. The Limited Program assigns selected recipients to designated primary care providers and/or pharmacies.

Recipients are assigned a designated provider when:

- The recipients receive duplicative, excessive, contraindicated, or conflicting health care services including drugs; or
- Review indicated abuse, misuse, or suspected fraudulent actions related to Medicaid benefits and services.

In February 2007, program processes were streamlined to maximize efficiency and increase the number of new limited recipients. Initial monitoring of the effect of these changes shows that the average number of new limited recipients has increased 236% from 10.9 to 25.7 per month.

Simultaneously, though, due to changes in program requirements effective September 2003, recipients were limited either to a Primary Care Provider (PCP) or pharmacy or both for a period of 36 months. As these recipients become compliant and are released, the total number of limited recipients in any given month has generally decreased. Limited Program clients also decline when they enter Managed Care, lose eligibility for over 6 months, or transfer to TIERS.

Provider participation in the Limited Program is voluntary. The Limited

Program continues to struggle with the lack of PCPs willing to participate.

Utilization Review

The Utilization Review (UR) unit currently reviews nursing facility services rendered to Medicaid recipients using the 3652 Client Assessment Review and Evaluation form to determine the appropriateness of the Texas Index for Level of Effort (TILE) submitted for payment. Under House Bill 867, the 74th Legislature mandated unification of State and Federal methods for the assessment of and payment for nursing facility services. In 2006, the Health and Human Services Commission ordered that this transition to a single method should occur by September 1, 2008. On this date, Texas Medicaid will begin using the federal Minimum Data Set (MDS) assessment to validate the Resource Utilization Group (RUG) III 34 group assigned as payment for the services rendered for nursing facility residents. In preparation of the conversion, UR has drafted rules to address program changes and requirements, evaluating necessary policy and procedures, and assessing statewide impact. To meet the implementation deadline and ensure an effective outcome and work products, stakeholder input will be obtained and considered. UR looks forward to working with both the provider community and the Department of Aging and Disability Services to coordinate efforts toward a successful conversion.

WIC Vendor Monitoring

During this reporting period, the WIC Vendor Monitoring unit utilized a technique of conducting coordinated simultaneous compliance activities at four locations, and requesting purchase invoices of said stores, in order to address issues of potential fraud. These stores are owned and operated by multiple parties with familial or other known business connections. This approach was used to ensure purchase invoices obtained by one store could not be used to substantiate the sales of the other locations during subsequent invoice audits.

Technology Analysis, Development and Support

The Technology Analysis, Development and Support (TADS) section is responsible for directing and monitoring the development, implementation, and coordination of policies and procedures encompassing OIG information technology systems. TADS is also responsible for working the results of the Texas Medicaid Fraud and Abuse Detection System (MFADS) generated targeted queries and models. This section provides oversight and direction on cases identified by the Medicaid claims administrator, Affiliated Computer Services (ACS) TMHP, through the federally required Surveillance and Utilization Review Subsystem (SURS).

During this period the contract amendment to extend the MFADS contract for the last option period was executed. The contract will terminate on August 31, 2009. In the

upcoming year TADS and other OIG staff will be involved in the competitive bid process for the new MFADS contract.

TADS staff has continued with the following technology developments:

- *Create a secure environment for OIG data and applications* – OIG has made strides for added network security and controls by:
  - Installing additional servers for software development, testing, and system administration for secure and non-secure data.
  - Coordinating with Internal Affairs for Disaster Recovery/Offsite storage space at the Department of State Health Services located at 1001 W. 49th Street, Room 1055.
- *Installation of third party applications that include*:
  - Feedback Server application – gives OIG the ability to create dynamic and professional looking surveys for internal and external use.
  - Evidence Tracker – application for tracking evidence for OIG in Texas.
  - Code Manager 2007 and quarterly updates – used by OIG for Current Procedural Terminology (CPT®) code registered with the American Medical Association (AMA).
  - ACL – used by OIG Compliance/Audit
- *Development and deployment of an OIG Public Homepage* – Additional development work has taken place to allow a secure liaison between OIG and the public. The website will be compliant with *Texas Administrative Code*, Title 1, Chapter 206 and section 508 of the Rehabilitation Act (36 CFR § 1194 (2006)).
- *Continued Upgrades to the OIG internal portal homepage* – The official internal homepage for the Office of Inspector General.
- *Continued development and internal testing of Phases I, II, and III of the Internal Affairs case management system* – It is a web-based, centralized, security–driven case management system to streamline the current OIG Internal Affairs paper-based operation.
- *Improvements to the external Waste, Abuse and Fraud Electronic Reporting System (WAFERS) website* – This application allows any state employee or private citizen to report waste, abuse, and fraud to the Office of Inspector General.
- *Continued development of the new internal complaint tracking system* – This system will be used for all external referrals that are received (via Hotline, e-mail, letter, fax, etc.) and for internal referrals from one OIG area to another.
- *Additional improvements to the internal project request application that is accessed via the OIG portal* – This application will be used by designated OIG staff to request TADS assistance.
- *Gathering requirements for the Payment Error Rate Measurement (PERM) tracking application* – The purpose of this application is to track the claims and eligibility cases pulled for review and the expected benefit is compliance with multiple pieces of legislation that affect all HHS agencies and programs that

receive Medicaid, CHIP, or Managed Care funding. As of September 1, 2007, PERM functions were transferred to HHSC Internal Audit.

- *OIG Minimum Data Set* – Federal system based on the Minimum Data Set Resident Utilization Group (MDS RUG). The Business Analysis and Support Services (BASS) staff was involved with several workgroups and the creation of the project charter.
- *Development and deployment of a BASS Timekeeping system* – This system is used by BASS to track time for work that will be associated with the various OIG areas. This information will be sent to HHSC Financial services so the proper funding source can be determined.
- *Development and deployment of an OIG Portal File sharing application* – This allows OIG staff to share files even when they belong to different domains.
- *Improvements to the Single Audit Sub-recipient Website* – Additional design requests for the Single Audit determination web form have been implemented for the OIG Single Audit unit.

Audit[1]

The Audit section consists of five units:

- Subrecipient Financial Review Unit;
- Medicaid/CHIP Audit Unit;
- Outpatient Hospital/MCO Audit Unit;
- Contract Audit Unit and
- Cost Report Review Unit.

The Audit section continues to implement enhancements to existing processes and is incorporating new audit processes to achieve its mission.

Subrecipient Financial Review Unit

The Subrecipient Financial Review Unit (SFRU) is responsible for Single Audit Desk Reviews of reports submitted by subrecipients, quality control reviews of Certified Public Accountant (CPA) firms who conduct single audits[1] of subrecipients, and the limited–scope audits of subrecipients. The quality control reviews conducted on the CPA firms and the limited-scope audits are based on a risk assessment process, while desk reviews are conducted on all single audit reports submitted by subrecipients of health and human services agencies.

Desk Reviews - The SFRU completed a total of 706 desk reviews in fiscal year 2007. In addition to the routine desk reviews, the SFRU has continued to find ways to enhance accountability on waste, abuse, and fraud, by maintaining consistency and/or continually modifying our internal processes and procedures in the following ways:

- Modifying our desk review audit programs to include additional audit steps to evaluate the subrecipient's single audit reports.
- Working with the KPMG auditors (external auditors) to ensure proper audit

[1] The audits are conducted in accordance with the Single Audit Act of 1984, and the related amendments of 1996 - Office of Management and Budget (OMB) Circular A-133, *Audits of State, Local Government and Non-Profit Organizations;* and/or State of Texas Single Audit Circular.

of HHSC compliance with the single audit requirements during the preliminary phase of the SFY 2007 Statewide Audit.

Quality Control Reviews - The SFRU completed a total of 87 Quality Control Reviews in fiscal year 2007. Also, the SFRU completed its risk assessment for the SFY 2008 Quality Control Reviews in August 2007, from which it developed an annual audit plan for the quality control review of selected CPA Firms. There are approximately 91 quality control reviews of CPA firms located across the state of Texas, planned for SFY 2008.

Medicaid/CHIP Audit Unit

The Medicaid/CHIP Audit Unit (MCAU) has concluded one major audit engagement and is in the process of concluding several other audit engagements that are expected to positively impact the operation of the Medicaid program. The audit of the current Medicaid claims administrator provider enrollment function has been completed. The audit of the close out of the risk stabilization reserve maintained by the prior Medicaid claims administrator is nearing completion. Additionally, the Information Technologies (IT) audit team has completed fieldwork on its audit of the Vendor Drug claims system, which will assist Medicaid program management by identifying opportunities to improve the system.

The MCAU is in the process of completing the planning for the Hospice Drug Audit project mandated by section 531.084(a)(6) of the *Texas Government Code*. The purpose of the project is to develop and implement a system for auditing the Medicaid hospice care system that provides services in long-term care facilities to ensure correct billing for pharmaceuticals.

The IT audit team began a limited audit of the implementation of system improvements to the Compass 21 Medicaid claims system through amendments to the claims administrator contract and a limited audit of the Disease Management contract.

In the next fiscal year, the MCAU will begin performing quality assurance reviews of the audits of Managed Care Organizations (MCOs) and Medicaid contractors, which were performed under contract by outside accounting firms.

Outpatient Hospital/MCO Unit

The Outpatient Hospital/MCO Unit (OMAU) has finalized the development of a cost report audit methodology and completed fieldwork on four of eight providers. These engagements encompassed individual audits of the cost reports submitted over a four-year period. The OMAU is finalizing the associated reports on those completed audits. In addition, OMAU is in its final phase of fieldwork on audits of the four remaining providers identified in the annual audit plan, which will be completed the early part of SFY 2008. Furthermore, one additional provider has been notified of an impending audit for which the formal planning work has begun.

Contract Audit Unit

The Contract Audit Unit (CAU) is primarily responsible for auditing contract compliance to ensure program funds are properly used to provide contracted services, to ensure recipient funds are adequately managed, and to serve as a deterrent to abuse and fraud within programs. The CAU performs audits in the following areas:

A risk assessment for the Vendor Drug Program (VDP) was completed and pharmacies were selected and included in the unit's SFY 2007 Audit Plan. One audit is in review stage and three audits are in the draft report stage.

For the period March 2007 through August 2007, Intermediate Care Facility for Persons with Mental Retardation (ICR/MR) audits identified recipient refunds of $10,710.26, recoupments and recoveries of $13,182.17, dollars identified for recovery of $7,942.60, and underpayments of $3,628.30. The unit completed 12 ICF/MR audits.

Cost Report Review Unit

The Cost Report Review Unit (CRRU) conducts field audits and desk reviews of provider cost reports and provides other requested non-audit services. Field audits and desk reviews are designed to meet OIG's goal to identify and correct waste, abuse, and fraud in the Medicaid and non-Medicaid programs and are performed in accordance with applicable sections of the *Texas Administrative Code*, Title 1, Chapter 355.

The results of field audits and desk reviews are used by HHSC's RAD in its rate setting responsibilities. RAD uses the adjusted statistical and financial information to recommend future reimbursement rates for program services to the Texas Legislature. For the period March 2007 through August 2007, CRRU completed a total of 2,527 enhanced and limited desk reviews and field audits, and cost avoided $99,512,443.

CRRU has made changes designed to enhance the efficiency and effectiveness of its audit processes. CRRU has completed development of the risk assessment methodology used in selecting samples of cost report projects to be conducted for each type of review stated above. Related sample projects have been selected and field work has begun.

Chief Counsel

The Office of Chief Counsel provides general legal services to OIG, rendering advice and opinions on HHS programs and operations, and provides all legal support in OIG's internal operations. This office imposes penalties on healthcare providers and litigates those actions. The Office of Chief Counsel includes two sections: Sanctions and Third Party Resources.

Provider Self-Reporting Guidance

The Office of Chief Counsel has issued a "Provider Self-Reporting Guidance" (Guidance) to encourage health care providers to voluntarily investigate and report matters involving the possible waste, abuse, or fraud or inappropriate payment of funds under state administered programs.

The Guidance was distributed to numerous external stakeholders, including the Texas Medical Association, the Texas Dental Association, and law firms specializing in health care law. In addition, the Guidance is posted on the OIG's external website for quick reference by individual health care providers seeking information as to how best to report instances of suspected non-compliance with program requirements.

In issuing the Guidance, it is OIG's intention to work collaboratively with providers who choose to proceed in accordance with the letter and spirit of the Guidance. Chief Counsel's Office has received numerous self-reports since the Guidance was issued in March 2007. OIG expects the number of self-reports to increase as more health care providers and their legal counsel become aware of the potential benefits of working cooperatively with OIG in resolving possible waste, abuse, and fraud of state health care programs.

Sanctions

As a result of the distribution and posting of the Guidance, OIG Sanctions is successfully working with health care providers, including hospital's providing Medicaid services, to resolve self-reported issues. In several instances, resolution of the issues has included substantial refunds of overpaid dollars back to the Medicaid program.

In addition to recovering overpaid funds, Sanctions works with self-reporting providers to develop appropriate corrective action plans to ensure the providers' future compliance with the specific Medicaid program requirements at issue. Sanctions also encourages each provider to develop and maintain an active compliance program that includes, among other elements, auditing and monitoring designed to prevent, detect, and remedy all program violations.

Third Party Resources

Third-party payments and reimbursements for SFY 2007 exceeded $356 million. To further increase recovery efforts, HHSC continues to search for new methods of identifying and pursuing liable third

parties. As a result, HHSC is working on a contract amendment that will enhance and/or expand the follow TPR activities:

- *Pharmacy Accounts Receivables (AR) claim level posting* – Historical-posting practices relied on the posting of payments at a client level and did not include the posting of claims denials. Under this amendment, a more automated and comprehensive approach to AR posting and follow-up will be utilized.
- *Medicare Identification and Recovery Initiatives* – Supplemental Medicare data matching and recovery initiatives will be performed to ensure full utilization of Medicare as a source for other available insurance to Medicaid clients.
- *Medicare Part D Gap Recoveries* – Efforts will be in place to recover pharmacy claims paid by Medicaid when not paid by Medicare Part D as designed.
- *Third Party Liability (TPL) Verifications Work* – Office of the Attorney General (OAG) excluded populations will be included under a new verification and recovery process.
- *Overpayment Recovery Services (ORS)* – Additional contacts will be made to insurance companies that provide benefits to Medicaid eligible clients.
- *Provider Audit Recoveries* – A subcontract will be entered into to recover credit balances from providers, who due to the size of the provider, have not been selected by the current credit balance recovery subcontractor.
- *Medicare Part D* – A workgroup for Medicare Part D has been formed to discuss recent findings that Part A & B dates are not consistently formatted in System for Application, Verification, Eligibility, Reports and Referrals (SAVERR) and TIERS. This impacts Medicaid payments on claims when another payer already exists. The discussions focused on current Medicare A & B dates in our eligibility systems, concerns about current source file (Bendex), costs associated with missing A/B dates, and the feasibility of using the Medicare Enrollment Database instead of, or in addition, to the current Bendex process.

  The workgroup is finalizing an analysis of the current Bendex processing and has recently obtained a copy of a possible alternate source of Medicare data, CMS' Medicare Enrollment Database. Once conclusions are developed about the quality of current processes and the new data source, the workgroup will send a memo to the Executive Commissioner with recommendations about how we can improve the quality of Medicare Part A and Part B data in our current Medicaid eligibility systems.

Enforcement Division

The Enforcement division conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or by HHS beneficiaries and of unjust enrichment by providers. These investigative efforts lead to criminal convictions, administrative sanctions, or civil monetary penalties. The Enforcement division has three sections: General Investigations; Medicaid Provider Integrity; and Internal Affairs.

General Investigations

General Investigations (GI) staff conducts recipient eligibility fraud investigations in Food Stamps, Temporary Assistance for Needy Families (TANF), Medicaid, Children's Health Insurance Program (CHIP), and other HHS programs. GI also coordinates and conducts covert operations involving retailers who illegally exchange Food Stamps for money. GI units consist of Claims Investigators and/or Field Investigators who establish fraud and non-fraud overpayments claims for recovery that returns funds to the state treasury and agency programs. Fraud investigations are filed with local prosecutors or handled through an Administrative Disqualification Hearing (ADH).

GI is working with HHSC Enterprise Applications staff and contractors regarding issues with the TIERS application and development of a TIERS Historical Case Report application. General Investigations staff began using the TIERS Historical Case Report (THCR) application September 7, 2007 to process non-fraud overpayment claims and in October began conducting fraud investigations on TIERS cases. As problems are discovered, they are reported to the Help Desk and addressed by HHSC IT staff.[2]

To enhance its productivity, GI staff worked closely with HHSC's IT staff to develop an Investigations Module for the Automated System for OIG (ASOIG). This module was implemented on September 4, 2007 and replaces several outdated systems, including the Office of Program Integrity Claims Integrated System (OCIS), Case Management System (CMS), Themis, and the Pending District Attorney Cases (PDAC) system. Program development and user testing will continue during SFY 2008. This addition makes ASOIG a comprehensive system built to enable OIG General Investigations staff to effectively initiate referrals, assign and monitor workload, investigate referrals, dispose of referrals and investigations, generate correspondence, interface with other systems to receive and transmit information, and generate reports.

Medicaid Provider Integrity

The Medicaid Provider Integrity (MPI) staff is primarily devoted to the investigation of

[2] Since fiscal year 2007, the TIERS Historical Case Report application has been fully deployed, and OIG is currently establishing fraud claims on TIERS cases.

provider fraud in the Texas Medicaid Program. In addition to provider investigations, MPI staff also presents recommendations related to all Medicaid policies affecting providers, documentation requirements, and any program areas that affect providers and our ability to identify potential overpayments. This past fiscal year, OIG has taken a more proactive approach to provider enrollment issues to further ensure the integrity of the Medicaid program while continuing to protect the recipients of that program.

In December 2006, MPI began conducting criminal history background checks on all Medicaid providers currently enrolled through TMHP, the state's Medicaid claims administrator. From March 2007 through August 2007, MPI has conducted 11,178 criminal history checks on Medicaid provider applicants, those under investigation, and current Medicaid providers.

OIG and OAG Interagency Coordination

The OIG and the OAG have established guidelines under which provider payment holds and exclusions from the Medicaid program are implemented. Timelines and minimum standards have been established by the HHSC-OIG for making referrals between the OAG Medicaid Fraud Control Unit (MFCU) and the OIG. This has enhanced the timely investigation of potentially fraudulent providers.

The Governor's Executive Order RP-36, dated July 12, 2004, directed all state agencies to establish wide-ranging efforts to detect and eliminate fraud in government programs. OIG continues to strengthen and enhance coordinated efforts to execute the Governor's directive, and both OIG and the OAG recognize the importance of partnership and regular communication in this effort to fight fraud and abuse in the Medicaid program. Thanks to a renewed cooperative spirit and focused efforts, both agencies continue to achieve the following:

- An increased commitment to promptly send and/or act upon referrals, accomplished by improving turnaround time in addressing referrals;
- Regular case presentation meetings to introduce critical cases to MFCU staff, to conduct parallel investigations;
- Communication on cases through entire staff levels, ensuring all case resources are shared, and efforts are not duplicated; and
- Monthly and quarterly meetings are held between the appropriate OIG and OAG staff to discuss case information, Medicaid policies and issues, agency coordination and other related matters.

Periodic planning sessions have occurred to coordinate case-methodology guidelines that apply to all cases, regardless of type. Appendix B, Section IV under MPI, contains three charts, which provides the number of waste, abuse, and/or fraud referrals received and made by MPI between September 2006 and August 2007.

Managed Care Special Investigative Units

In accordance with section 531.113 of the *Texas Government Code*, all MCO's

contracting with the State of Texas are required to adopt a plan to prevent and reduce waste, abuse, and fraud and file their plan annually with OIG for approval. For the third and fourth quarters of SFY 2007, OIG received 11 complaint referrals from MCO's based on their mandated Special Investigative Units (SIU's).

The liaison function between OIG and contracted MCO SIU has been moved from OIG's Compliance division Quality Review section to OIG's Enforcement division MPI section.

MPI will lead OIG's coordinating efforts to assist MCOs in their mission of identifying, preventing, and reducing provider and client waste, abuse, and fraud within MCOs or their subcontractors as it relates to Medicaid Managed Care and CHIP.

OIG's Enforcement division expects to develop productive relationships with MCOs through mutual contributions of expertise and dedication in achieving this goal.

Internal Affairs

Effective September 1, 2007, the State Investigations Unit (SIU) section was changed to the Internal Affairs Section (IAS). The IAS will retain its current duties and responsibilities to identify and reduce fraud, waste, abuse, and misconduct involving contractors, vendors, service providers, and employees through independent, fact-based investigations, reviews, and analyses in accordance with applicable federal and state laws.

The IAS is comprised of five units: the Forensic Research and Analysis Unit (FRAU); Program Investigations Unit; Special Investigations Response Team (SIRT); Vital Statistics Investigations Unit; and Women, Infants and Children (WIC) Investigations Unit.

The section is in the final testing phase of the web based, centralized, security driven case management system. The system has been developed and is being tested for accuracy, user friendliness, workflow, and procedures of how information will be entered and captured for reporting. The new case management system will replace the current stand-alone Microsoft Access computer database inherited from the legacy agency operations.

The new system will automate and standardize most of the investigative logging, tracking, reporting, and writing tasks. The case management system will use the "wizard" approach to build a case record, guiding the user through case screens to create a case. This has the added benefit of ensuring that critical data is not left out of the information collection process.

Internal Affairs has experienced a significant increase in production during SFY 2007. The number of complaints received, cases referred, and investigations completed in Internal Affairs increased, along with the Women, Infants and Children (WIC) unit number of cases referred. However, the WIC unit has

experienced a slight decrease in cases adjudicated. When comparing first through third quarters of SFY 2006 to first through third quarters of SFY 2007 there is a significant increase in production:

The WIC Investigations team has experienced a decrease in production. This decrease is attributed to staffing issues experienced during SFY 2007. WIC Investigations has operated for the majority of SFY 2007 with less than full staff and has had as few as one investigator to handle the caseload. Considering this decrease in staff and training new personnel, WIC Investigations has managed an increase in Completed Cases. Prior to the end of SFY 2007, WIC Investigations hired two new investigators which will bring them to full staff.

In September 2005, HHSC purchased Encase Enterprise system, a network-enabled, multi-platform computer systems solution that enables immediate response to computer related incidents and thorough analysis of electronic media. In August 2006, Executive Commissioner Hawkins approved full deployment of Encase Enterprise[2]. Once fully deployed the Encase Enterprise system will enable IT and OIG staff to detect, prevent, document, and examine system breaches that compromise individual state computers and network systems. In addition, the Encase Enterprise system will assist HHSC and its umbrella agencies with HIPAA security requirements.

Upon full deployment of Encase Enterprise the existing Forensic Research and Analysis unit will have the latest technology to enable immediate response to incidents of computer misuse, thorough analysis of electronic media and efficiency in obtaining evidence. Utilizing this system will create substantial cost saving in staff time, computer down time and damaged hard drives.

Communications and Governmental Affairs

The Communications and Governmental Affairs division (Division) is structured in accordance with *Principles and Standards for Offices of Inspectors General* as issued by the Association of Inspectors General

The Division provides current and relevant information to public officeholders, other state bodies, stakeholders, and the public. Division tasks encompass informing appropriate officials through oral or written reports of the results of important OIG projects and any appropriate problems encountered that merit an official's attention. The Division is also involved in coordinating the production and distribution of a variety of reports to state and federal agencies.

A crucial component of the Division is developing and implementing external relations communication strategies and methods to effectively communicate with legislative bodies, interested parties, and the public regarding the mission of OIG.

Division Activities

The Division continued to refine its use of the Secured Issues Management System (SIMS) software during the 80th Legislative Session. This software, developed in-house, provided the capability to document, track, and report on the daily activities of the Division with a major focus on legislative issues such as assignments for bill tracking and legislative and constituent inquiries. SIMS was developed as a means to provide timely and accurate information in a user-friendly format.

The Division served in a number of roles while supporting OIG functions and activities. A Legislative Team was formed prior to the session from staff throughout OIG based on recommendations from the Deputies and served under the direction of the Division Chief. The team members served as subject matter experts for legal, compliance, investigations, operations, and audit activities. Legislative Team members were assigned to monitor and report on hearings related to their expertise, while also tracking and providing analyses of draft bills and filed bills that could impact the operations of OIG.

Legislative contacts focused on responding to legislative requests for assistance with developing talking points and discussion documents for the draft bills affecting OIG. Further, assistance was provided to legislative committee clerks based on their requests for matters relating to pending legislation and proposed changes in the draft language of bills. Responses to legislative and constituents inquiries were coordinated through the appropriate subject matter experts within OIG and then relayed to the requesting offices to ensure that all questions were resolved in a timely manner and any further issues were considered and discussed.

OIG Information Packet

The Division distributed OIG Information Packets during the 80th Legislative Session, containing information on each major component of OIG and all inspector general legislation filed during the session in a table format, listing the legislation by bill number, author, agency, and providing a synopsis of the major components of each bill.

Additional information in the packet included recommendations for the HHSC-OIG in the Senate Committee on Finance Interim Charge Recommendations to the 80th Legislature, the executive summary from the State Auditor's Office report on OIG, and news articles that related to matters of independence in performing the duties of an Inspector General.

Operations

The Operations division brings together the diverse functions that contribute to the overall organizational effectiveness of OIG. The Operations division consists of two sections: Quality Assurance, Risk Management, and Policy; and Business Operations and Support Services.

The two sections of Operations create consistency of purpose, uniform actions, and a stewardship of resources. This division is instrumental in keeping the flow of information open across divisions, developing and implementing program policies, and improving organizational capabilities.

Quality Assurance, Risk Management, and Policy

The Quality Assurance, Risk Management, and Policy (QARMP) section upholds OIG conformance to professional standards established by the Association of Inspectors General. This section exists to: 1) provide reasonable assurance that OIG processes and work performed adhere to the standards and established OIG policies, procedures, and performance criteria; and 2) enhance operational economy, efficiency, and effectiveness. To facilitate pursuit of these objectives, this office incorporates various business process risk management and policy review and development functions.

A summary of significant contributions of QARMP includes:

- Assessing the sufficiency, competence, relevance, validity, reliability, and presentation of case evidence.
- Developing and deploying policies, procedures, tools, and technical assistance to intra-and inter-agency project groups in standards compliance, issue scoping and materiality, quantitative and qualitative data acquisition and analysis, findings development, and reporting.
- Working on the long-term integration of OIG organization structure, strategic plan, budget, and performance measures.
- Developing and maintaining automated means for the collection, analysis, norming, trending, reporting, and integration of OIG division, section, and unit performance measures information.
- Standardizing the gathering, reporting, quality control, integrity, and retention of internally and externally reported performance information and auditing such information from OIG's inception to the present.
- Integrating and automating the gathering and reporting of OIG performance data in the Semi-Annual and Annual Reports.
- Drafting methodologies for the quantitative assessment of individual staff performance.
- Developing, deploying, and coordinating Risk Assessments for both Business Process Improvement and Auditing applications.

- Providing input on and coordinating OIG responses to internal and external requests for information, projects, and initiatives (e.g., state and federal policy impact studies, performance measures reporting, administrative rules, conflict of interest statements, Legislative requests, Interim Committee reports, Sunset Reviews, policies, special reports, and various contract provisions and amendments).
- Working with TMHP to develop processes for executing Mass Claims Adjustments.
- Advising and providing technical support to MCO-SIU's in sampling, data analysis, and reporting pertinent to waste, abuse, and fraud detection.
- Advising and providing technical support to HHSC agencies in their evaluation of vendor responses to Requests for Proposals.
- Training city and county auditors and investigators in gathering, sampling, testing, extrapolation, and reporting of quantitative and qualitative case information.
- Serving as State Liaison and/or (Sub)Committee Member with Centers for Medicaid and Medicare (CMS), the Federal Medicaid Integrity Project, and the National Association for Medicaid Program Integrity.
- Facilitating internal communications on health policy issues.
- Applying for a CMS Medicaid Transformation Grant to identify trends leading to waste, abuse, fraud, and improper payments in the Medicaid program.

Beyond these, QARMP staff continues to study and, where appropriate, standardize OIG's functions and operations, feed this information back to management and staff, and pursue production of office-wide quality assurance protocols.

Federally Mandated Payment Error Rate Measurement (PERM) Project

All Texas Medicaid disbursements will be subject to review during Fiscal Year 2007-2008, the third and final year of the first cycle of the federally mandated PERM project. Based on federally contracted reviews of claims and related payments in all States, PERM seeks to establish baseline national payment error rates in all Medicaid fee-for-service, managed care, and SCHIP programs. The PERM project will also include scrutiny of payment error rates associated with the eligibility components of Texas Medicaid and Texas SCHIP.

Staff in the QARMP section have expended great effort on the PERM project by:

- Reviewing and providing input on the audit programs proposed for use in the claims reviews.
- Participating in meetings and conference calls of the National Association of Medicaid Directors' Fraud and Abuse and PERM Technical Advisory Groups (TAG), the former of which is chaired by a QARMP staff member.
- Serving on the national PERM Dispute Resolution Process TAG Committee.

- Representing Texas in the National Association for Medicaid Program Integrity.
- Briefing and informing HHSC executives, management, and supervisors on PERM-related laws, policies, procedures, impacts and activities.
- Developing and delivering information and training on PERM across the HHSC Enterprise.
- Reviewing and providing input on PERM language for use in the TMHP's Medicaid Provider Bulletin, banner messages, and web- site for the purpose of informing Medicaid providers and stakeholders of PERM related initiatives, impacts, and requirements.
- Spearheading development of an automated system for tracking the status, resolution, trending, and analysis of PERM claim and payment errors.

As of September 1, 2007, PERM functions were transferred to HHSC Internal Audit.

Federally Mandated Medicaid Integrity Program

The Medicaid Integrity Program (MIP) provides federal oversight of each State's Medicaid program integrity efforts. The MIP is CMS' first national Medicaid waste, abuse, and fraud detection and prevention strategy and is bolstered by $75 million annual funding and 100 new employees. This oversight includes an annual State Program Integrity Assessment (SPIA) which will develop and deploy program integrity performance measures, share best practices, and recommend program integrity improvements. Moreover, MIP includes a Medicaid Integrity Audit Program (MIAP) under which federal contractors will audit Medicaid provider claims.

These audits will involve: (1) reviewing the actions of individuals or entities furnishing items or services in return for Medicaid payment to determine whether fraud occurred; (2) auditing claims for items or services rendered or administrative services, including cost reports, consulting contracts, and risk contracts; (3) identifying overpayments; and (4) educating providers, managed care organizations, and beneficiaries on payment integrity and quality.

It is vital to note that Congress views recovery of funds and return on investment (ROI) as key elements of the MIP program. Once federal auditors identify overpayments, the state has 60 days to collect the overpayment and return the federal share to Washington. If a state cannot collect some or all of the overpayment, the federal 60-day rule still requires the state to reimburse the entire federal share of the overpayment. Thus, the state is at risk of losing 100% of the identified overpayments.

Staff in QARMP is expending substantial time and effort related to MIP through:

- Serving on the Medicaid Integrity Program Advisory Committee.
- Serving as the Chair of the Performance Measures Workgroup of the Medicaid Integrity Program Advisory Committee.

- Serving on the Fraud and Abuse (F&A) Technical Advisory Group (F&A TAG).
- Serving as the Chair of the F&A TAG Workgroup responsible for MIP, PERM, Medi-Medi, National Provider Identifier (NPI), and Performance Metrics.
- Representing Texas on the Claims Dispute Resolution Subcommittee.
- Collaborating with Federal MIP staff and Federal contractors responsible for MIP Program administration to develop policies, processes, criteria, and performance measures.
- Working with Federal contractors to implement provider selections and audit processes.

Policy Initiatives

Policy improvement is vital in preventing and controlling waste, abuse, and fraud in health and human services. Toward these ends, OIG continually assesses and recommends policies, as mandated in section 531.102(h)(6) of the *Texas Government Code* which directs OIG to "recommend policies promoting economical and efficient administration of funds … and the prevention and detection of fraud and abuse in administration of those funds."

The HHSC Medicaid CHIP Division (MCD) leads the Benefits Management Workgroup (BMW) in defining medical policy for Medicaid Fee-For-Service and Managed Care programs. OIG Operations plays a key role in the BMW process, working collaboratively with MCD and other divisions in the planning, implementation, and monitoring of medical policy changes that may result in cost avoidance or cost savings by reducing waste, abuse, and fraud. OIG Operations works office-wide to ensure, when possible, that staff concerns identified through investigations and data analysis are addressed in medical policy.

The policies outlined below represent some of the Medicaid Fee-For-Service and Managed Care policies Operations participated in developing or implementing from March 1, 2007 to August 31, 2007.

The BMW and OIG are working to ensure that reimbursement is disallowed when services are used in a manner that is inconsistent with nationally accepted coding standards. Policy development includes review and alignment with the American Medical Association CPT®. The policy development process also includes review of the CMS National Correct Coding Initiative (NCCI) edits which outlines CPT procedure code combinations where one code denies and the other pays.

Policy development also includes development of standards for medical record documentation.

Policy development and implementation can be a lengthy process. The approximate start to sign-off approval or implementation time frame is included in parentheses.

Policies Implemented

Helicobacter pylori Testing

Effective March 1, 2007, changes to the Helicobactor Pylori Testing policy were implemented. Changes included clarification of when testing is appropriate, limiting testing frequency, adding pay/deny statements related to specific code combinations, and updating diagnosis restrictions.

Obstetrics and Prenatal Care - 3-D ultrasound

Effective May 7, 2007, obstetrical three-dimensional ultrasounds are not a benefit of the Texas Medicaid Program and will not be authorized. OIG identified the issue that although obstetrical three-dimensional ultrasounds are considered experimental they were a benefit of Texas Medicaid.

Outpatient Behavioral Health Services - Update

The cost savings for the following policy change reported in the last Semi-Annual Report was not available at that time.

Effective November 1, 2006, medical benefit policies related to psychiatric diagnostic interview examination, interactive psychiatric diagnostic interview examination, and pharmacological management procedure codes were modified to disallow reimbursement when these services are used in a manner that is inconsistent with nationally accepted coding standards. Uses of these procedures were clarified and standards for medical record documentation provided.

Policies with sign-off approval implementation pending that have projected cost savings

Brachytherapy

Medical benefit policy revisions included making Brachytherapy a new benefit of Texas Medicaid and updating provider types, places of service, and related limitations and restrictions. (7 months)

Flu Assay

OIG alerted HHSC/MCD that infectious agent antigen detection by immunoassay with direct optical observation influenza was currently not restricted in how many tests a provider can bill per client, per day. Medical benefit policy revisions included adding a system limitation of two per day per provider. (5 weeks)

Helicobacter pylori Testing

OIG alerted HHSC/MCD that specific breath test procedure codes were not included in the policy as previously approved for sign off on June 6, 2006, but are showing as a benefit in the Texas Medicaid claims processing system. Revisions to the policy included addition of the identified procedure codes, reimbursement language, systems limitations, provider types, and places of service. (5 weeks)

Hematopoietic Injections

OIG and the Texas Medicaid Claims Administrator discovered inconsistencies between the Texas Medicaid claims processing system and current medical policy restrictions involving diagnosis

codes for specific injection procedure codes. Medical benefit policy changes include updating the diagnosis restrictions, provider types, places of service, and medical documentation requirements. (5 weeks)

Obstetrics and Prenatal Care

Medical Benefit policy revisions included updating diagnosis restrictions, removing diagnosis restrictions, and adding clinical guidelines/conditions when testing can be accomplished. In addition the policy alerts providers that Texas Medicaid follows documentation requirements for Obstetric Ultrasounds as set forth in AMA CPT.

Outpatient Behavioral Health (continued revision)

Medical Benefit policy revisions included comprehensive modification to disallow reimbursement when all services are used in a manner that is inconsistent with nationally accepted coding standards, updating diagnosis restrictions and adding new diagnosis restrictions to services not previously diagnosis restricted. (One year)

Medicaid Fraud Detection and Abuse Prevention Training

Fraud Prevention Training

Provider education is an integral element of any waste, abuse, and fraud prevention plan.

The Operations division, through its MCO and Staff Development Training section, and in accordance with section 531.105 of the Government Code, provides 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 waste, abuse, and fraud in the Medicaid program. These highly interactive seminars last approximately two hours and discuss examples of actual schemes used to defraud the Medicaid program, ways to detect them, and measures to prevent them. 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.

The objectives of the training are to educate and inform about:

- What constitutes Medicaid waste, abuse, or fraud;
- The obligation to report Medicaid waste, abuse, or fraud;
- How to identify potential Medicaid waste, abuse, or fraud; and
- How to report potential Medicaid waste, abuse, or fraud.

MCO-SIU Training

In November 2005, HHSC MCD executed new joint procurement contacts with Medicaid/CHIP MCOs. Section 7.3.1.7 of this contract obligated MCOs to designate executive and essential personnel to attend mandatory training in waste, abuse, and fraud detection, prevention and reporting no later than 90 days after the operational start date.

OIG conducted waste, abuse, and fraud training sessions. These sessions addressed the mission of OIG and the scope of its investigations, specific beneficiary, provider, and MCO fraud issues, and developing organizational fraud controls.

Texas State University Training

OIG continues its contract with Texas State University - San Marcos (TSU) for the purpose of providing Medicaid fraud and abuse training. Under the provisions of section 531.105 of the Government Code, HHS provides Medicaid fraud and abuse training to Medicaid contractors, providers, their employees, and to state agencies involved in the administration of health and human services programs on the identification and referral of abuse, or waste in the Medicaid program. The TILE training incorporated the Fraud Prevention training as a separate module.

Individuals who are required to take the TILE training course may take the fraud-

training component as part of the TILE training course. The Fraud TILE course is intended for Long Term Care (LTC) nurses and other providers of long-term care in an institutionalized setting, and for nurses and providers associated with the Community Based Alternative (CBA) Waiver Program.

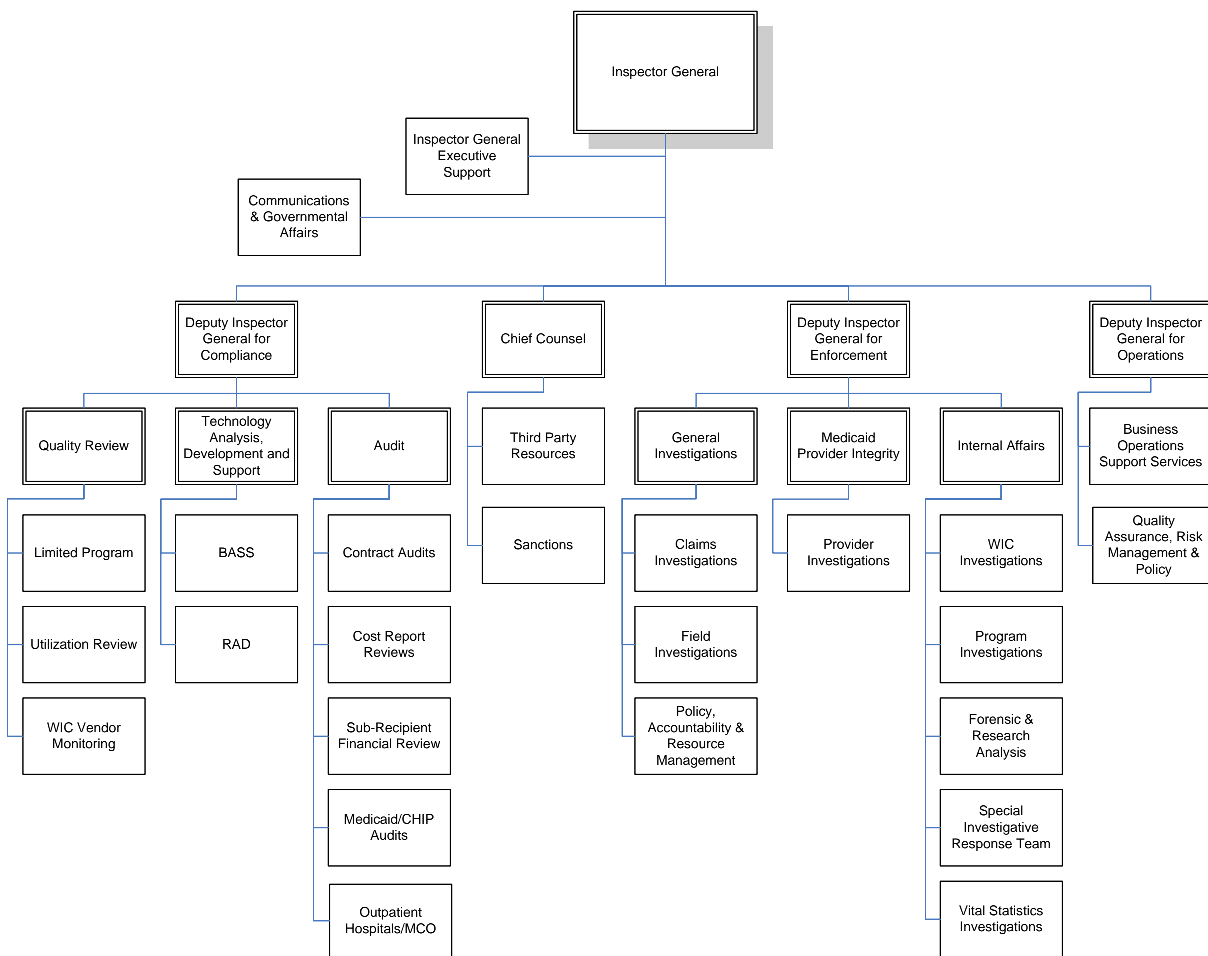
OIG, in cooperation with TSU, has made the Fraud TILE training available through its long-distance training program. The distance-learning program provides the most efficient and economical training on Medicaid fraud and abuse detection and prevention training to Medicaid contractors, providers, and their employees. The course may be taken through regular mail correspondence or on line at: http://www.txstate.edu/continuinged/

Nursing facilities reimbursement will be changing from the TILE reimbursement methodology to the RUG system. OIG is working with TSU to produce a distance-learning program for this material.

HEALTH AND HUMAN SERVICES COMMISSION

Appendix A—OIG Organizational Chart

Effective September 2007



Appendix B—OIG Recovery and Cost Avoidance Statistics

SANCTIONS, PENALTIES, AND RECOUPMENTS SFY 2007					
Category	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Sanctions	$6,593,747	$1,463,849	$1,764,638	$2,792,050	**$12,614,283**
Civil Monetary Penalties (CMP)	$48,508	$147,505	$227,874	$194,421	**$618,308**
Utilization Review (Hospitals)	$6,700,208	$2,023,356	$8,005,806	$6,565,816	**$23,295,186**
Utilization Review (Nursing Homes)	$3,279,257	$3,340,789	$2,417,748	$1,564,944	**$10,602,737**
Technology Analysis, Development & Support (TADS)	$497,905	$617,953	$618,527	$379,011	**$2,113,396**
General Investigations Collections (Food Stamps, TANF, and Medicaid Recipients)	$2,143,914	$3,083,912	$4,217,271	$3,263,575	**$12,708,671**
WIC Investigation Recoveries	$9,789	$6,105	$4,365	$1,770	**$22,028**
WIC Vendor Monitoring	$3,257	$96	$452	$969	**$4,774**
Audit Activities	$0	$0	$2,906	$10,276	**$13,182**
Internal Affairs Division	$0	$0	$0	$0	**$0**
Total	**$19,276,584**	**$10,683,564**	**$17,259,587**	**$14,772,830**	**$61,992,565**

THIRD-PARTY PAYMENTS AND REIMBURSEMENTS SFY 2007					
Category	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Provider Receipt of Other Insurance	$58,441,607	$65,547,230	$73,980,737	$57,665,967	**$255,635,542**
Provider/Recipient Refunds	$1,218,091	$1,083,310	$1,179,857	$1,073,110	**$4,554,368**
Texas Automated Recovery System	$6,472,944	$6,706,268	$6,957,949	$5,539,656	**$25,676,817**
Pharmacy	$5,049,821	$3,862,585	$3,494,155	$7,008,411	**$19,414,972**
PPRA	$254,809	$151,825	$275,935	$337,221	**$1,019,789**
Provider Audit Recoveries	$3,375,290	$4,279,598	$5,319,493	$1,460,921	**$14,435,302**
Tort	$3,395,407	$3,410,013	$3,801,506	$4,701,139	**$15,308,065**
Cash Medical Support	$3,396,314	$3,730,409	$8,097,318	$4,817,908	**$20,041,949**
Total	**$81,604,283**	**$88,771,238**	**$103,106,950**	**$82,604,332**	**$356,086,804**

COST AVOIDANCE SFY 2007					
Category	**1st Quarter**	**2nd Quarter**	**3rd Quarter**	**4th Quarter**	**Total**
Sanctions	$3,681,130	$3,636,355	$16,965,717	$4,885,200	**$29,168,402**
TADS Provider Prepayment Review Process	$64,571	$20,054	$58,780	$45,981	**$189,386**
Third Party Resources	$74,382,415	$95,577,540	$81,846,518	$72,065,790	**$323,872,264**
Disqualifications (Food Stamps & TANF Recipients)	$955,398	$870,858	$950,184	$1,182,144	**$3,958,584**
Income Eligibility Verification System (IEVS) Data Matches (Food Stamps, TANF and Medicaid Recipients)	$242,039	$251,489	$288,957	$197,900	**$980,385**
Recipient Data Matches (Food Stamps, TANF and Medicaid Recipients)	$69,725	$82,768	$169,342	$143,846	**$465,681**
Audit Activities	$16,763,503	$17,677,262	$0	$0	**$34,440,765**
WIC Vendor Monitoring	$1,006	$25	$790	$206	**$2,027**
Total	**$96,159,787**	**$118,116,351**	**$100,280,288**	**$78,521,068**	**$393,077,493**

Cost Recovery

Total recoveries[3] for State Fiscal Year (SFY) 2007 were $418,079,369 (all funds).

Recovery dollars are defined as actual collections, recoupments, or hard dollars saved by OIG. Recoveries, as reported by OIG, do not include any projects, dollars identified, or any other type of "soft-money" or future settlement payments.

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 dollars are calculated differently by business function. OIG takes a conservative approach in reporting these dollars. Following is a summary of the methodologies by business function, which is used for calculating cost avoidance.

Sanctions

Sanctions cost avoidance dollars are estimated savings to the state Medicaid program, which result from an administrative action and/or imposing a sanction against a Medicaid provider. These savings are computed as follows.

Recoupment of Overpayments Identified for a Provider with Exclusion:

The dollar amount reported is based on the overpayment determined by an investigation, review, or audit of a provider (as opposed to total provider billings) and the number of months in the resulting exclusion period. The provider's overpayment amount is divided by the number of months in which the overpayment occurred to render a monthly average. This figure is then multiplied by the number of months the provider is excluded to yield a dollar value for the given exclusion. All such products are then summed to valuate all exclusions ordered during the reporting period.

A maximum of 36 months is used for all exclusion cost avoidance calculations. This time period is both appropriate and conservative since it is the same as the mandatory re-enrollment period for Medicaid providers, sets a uniform exclusion period for both indefinite and permanent exclusions, and is 15 months less than the fifty-one-month average found in a census of indefinite exclusions recently conducted by OIG Sanctions staff.

The full amount of the dollar valuation of the given exclusion is reported as cost avoidance during the month in which the exclusion order is issued. Thus, the cost avoidance associated with a given

[3]Third Party Resources (TPR) other insurance credits represent insurance collections made by the provider as a result of known other insurance information. OIG includes this category of recoveries because these are actual savings which are measurable by TPR. A claim may still receive payment, unlike the cost-avoided figure, and we report other insurance credits as part of the recovery figures to the Centers for Medicare and Medicaid Services (CMS) on the federal CMS 64.9 report required quarterly. The Claims Administrator via automated reports from the Medicaid Management Information System (MMIS) provides the source data to populate the OIG recovery and cost avoidance figures for TPR.

provider's particular exclusion is taken only once. This approach both eliminates double counting and avoids the highly cumbersome process of tracking and valuating individual exclusions on a month-by-month basis.
When a provider is excluded from the Medicaid program and has a recoupment of overpayment identified, we do not include civil monetary penalties when computing cost savings.

Third Party Resources

Medicaid provider claims denied by Third Party Resources when there is other insurance – These are actual claims denials in which the client was identified as having other insurance for which the provider was required to bill prior to billing Medicaid.

General Investigations

Disqualifications Cost Avoidance – Disqualification cost avoidance dollars are calculated by multiplying the number of months each client is disqualified times the program-specific monthly allotment (presently $117.00 for Food Stamps and $122 for Temporary Assistance for Needy Families [TANF]) and then summing these individual products. The length of disqualification periods are based on federal regulations and state legislation and may be found in Section B-932 of the Texas Works Handbook. Disqualification periods for TANF intentional program violations occurring after September 1, 2003 are 12 months for the first offense and permanent for the second offense. TANF clients convicted of a state or federal offense for conduct that constitutes an Intentional Program Violation (IPV) or granted deferred adjudication or placed on community supervision for such conduct are permanently disqualified. Food Stamps clients are disqualified for one year for the first offense, two years for the second offense, and permanently for the third offense. Clients found guilty of an IPV in federal or state court or administrative disqualification hearing for making fraudulent statements or representations about residence or identity to receive multiple benefits simultaneously are barred for 10 years. When a client is found guilty of Food Stamp trafficking for $500 or more the disqualification is permanent.

Income Eligibility Verification System (IEVS) Data Match Cost Avoidance – In the process of investigating IEVS data matches, action notices are generated. These action notices alert Health and Human Services Office of Eligibility Services (HHSC-OES) staff to reduce or deny benefits based on income or resource information that may affect ongoing benefits. A sample of 141 cases with action notices were researched to validate the benefit and eligibility determinations and establish an average cost avoidance per action notice of $111.18. The total cost avoidance is the number of action notices generated multiplied by $111.18.

Recipient Data Match Cost Avoidance – Recipient data matches include Social Security Administration (SSA) Deceased Individual, Bureau of Vital Statistics (BVS) Deceased Individual, Prisoner Verification System, Texas Department of Criminal

Justice (TDCJ), Workers Compensation, and Border State matches (Louisiana, Oklahoma, and New Mexico). In the process of investigating these data matches, action alert notices are sent to HHSC-OES staff to reduce or deny benefits based on household composition, residence, income, and resource information that may affect ongoing benefits.

A sample of 351 matches was researched to validate the benefit and eligibility determinations and establish an average cost savings of $36.95 per match completed. The total cost avoidance is the number of recipient data matches completed multiplied by $36.95.

Technology Analysis, Development and Support

Dollars that are not paid based on the provider being placed on prepayment review – Providers on prepayment review must submit paper claims with supporting documentation. The information is then reviewed to determine if the service is payable.

Women, Infants and Children

Cost avoidance for Women, Infants and Children (WIC) investigations is found by using the following methodology:

- Identify cases where fraud was identified and the client stopped redeeming vouchers as a result of being notified of the investigation;
- Calculate an average amount of redeemed vouchers per month from the most recent three months available for that WIC participant; and
- Apply that average to the remaining months of the active certification period of that client.

Example: Client A stops redeeming vouchers after being notified that an investigation has identified fraud. Client A has two months of vouchers that are still active and does not spend them. The average amount of vouchers for the previous three months is $250. The cost avoided for this case would be $500 (2 months active vouchers x $250 average monthly-redeemed vouchers).

Audit

Cost avoidance results from four types of audit activities.

Cost Report Review (Desk Reviews/Performance Audits) – Cost Avoidance from cost report work represents the net of disallowed costs and added costs identified in desk reviews and field audits of long-term care provider Cost Reports, 24-Hour Residential Child Care Cost Reports, and Attendant Compensation Reports for Community Care and Nursing Facility providers.

The dollars removed from cost reports reduces the amount that flows into the rate-setting database maintained by HHSC's Rate Analysis Department (RAD). These dollars do not represent recouped amounts, because providers are paid a contract specified rate. The cost avoidance arises when this contractual rate is altered to account for audited disallowances.

Note, however, that as of the Third Quarter of FY 2007, OIG no longer includes these net of disallowed costs in its reported cost avoidance since these cost savings are highly indirect vis-à-vis OIG, arise over indeterminate and provider-specific time periods, and extremely difficult (if not impossible) to track.

Contract Audit – Represents unallowable costs and incorrect charges identified during an audit of unpaid contract claims and billings.

Medicaid/CHIP Audit (Oversight/Consulting) – Cost avoidance is achieved by providing consultation to program management, overseeing outside audit contracts to ensure all appropriate questioned costs are considered, and identifying wasteful practices that can be eliminated in future contracts and expenditures.

Outpatient Hospital/MCO Audit (Desk Reviews/Performance Audits) – The dollars removed from Medicaid Outpatient Hospital cost reports reduces the amount that flows into the rate-setting database maintained by Texas Medicaid and Healthcare Partnership (TMHP). These dollars do not represent recouped amounts, because providers are paid based upon a cost-to-charge ratio of Medicaid costs to all costs. The impact of these cost avoidance numbers are reductions reflected in the unit rate calculations used for interim payments to the hospitals and a savings through the time value of money.

End of Report