Albert Hawkins, Executive Commissioner

Office of Inspector General Semi-Annual Report

November 2006

Brian Flood, Inspector General

OIG Vision Statement

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

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.

HHSC-OIG Integrity Statement:

We, the members of the Office of Inspector General, know that none of us succeeds or fails alone. We acknowledge that if we succeed or fail we succeed together by doing what is just or fail together because we did not do justice. So whether we succeed or fail we should always seek to do what is right. We should, while effectively using our expertise and resources, work to assist others, staff and those that we serve, and not to simply improve our statistics or position. Therefore, all of us in the Office of Inspector General, through endurance and encouragement, will have a unified vision and mission that promotes courage, honesty and integrity, kindness and compassion, humility in service, justice and fairness for us and those we serve.

HEALTH AND HUMAN SERVICES COMMISSION

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HEALTH AND HUMAN SERVICES COMMISSION

Executive Summary

October 16, 2006

The Office of Inspector General (OIG) is pleased to issue our report for State Fiscal Year (SFY) 2006, which ended August 31, 2006. The report provides an overview of our key accomplishments, presents a look at future OIG activities, and contains a year-to-date synopsis of OIG recoveries and cost avoidance. In SFY 2006, OIG recovered $446,650,049 and cost avoided $411,105,767.

Under a January 2006 change to a prospective payment system for Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs), providers are compelled to minimize costs and use a "reasonable and necessary" standard when reviewing provider cost reports. In 2004, Medicaid paid CORFs/ORFs $99.5 million and $136 million in 2005. In SFY 2006, the Chief Counsel Division recovered $6,460,533 from CORFs/ORFs. Other positive and significant accomplishments include:

- The Third Party Recovery (TPR) Section cost avoidance and recovery for SFY 2006 exceeded $649 million, a $71 million increase over the previous year. As a result, Texas continues to be recognized as a national leader in TPR.
- SFY 2006 complaint referrals from Managed Care Organizations' (MCO) Special Investigative Units (SIU) increased 330% when compared to those received in SFY 2005.
- The Medicaid Provider Integrity Section realized 47% increase in opened cases over SFY 2005 and a 69% increase in OIG referrals to the Office of Attorney General's Medicaid Fraud Control Unit.
- The Audit Section conducts single audit reviews of subrecipient reports. No findings were issued by KPMG following their fieldwork of the SFY 2005 Statewide Audit of contracts issued by HHSC to subrecipients.
- In December 2005, OIG initiated criminal history background checks for all applicants seeking to enroll in the Medicaid, Medicaid Managed Care, and Children with Special Health Care Needs (CSHCN) Services programs through Texas Medicaid and Healthcare Partnership.
- In SFY 2006, OIG reinforced Texas' standing as the national model for other states' Medicaid fraud prevention programs. On March 28, 2006, U.S. Senator Tom Coburn complimented OIG, describing it as the national example for success. The state of New York on March 14, 2006, adopted and implemented the Texas model as the base of their Medicaid reform. Details of this and other public acclamations are described in Appendix D and F of this report.

We continue to assess and improve the quality of audits, investigations, reviews, advanced automated analysis tools, and monitoring through standardization of practices, policies, and ethics; encouragement of professional development by providing educational opportunities; and the establishment of a quality assurance function. To ensure quality, OIG operates in accordance to the National Association of Inspectors General principles and standards and United States General Accounting Office Government Auditing Standards. In addition, educational training for providers and claims administrator contractors continue to contribute to an increase in cost avoidance activities, improvement in quality of care, and a decrease in claim-processing errors.

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

Brian Flood
Inspector General

Background

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

Authorized by Section 531.102 of the Government Code, OIG provides program oversight of HHS activities, providers, and recipients through its compliance, enforcement, and chief counsel divisions. OIG fulfills its responsibility through the following activities:

- Issuing sanctions and performing corrective actions against program providers and clients as appropriate;
- Auditing the use and effectiveness 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 waste, 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 enhancing the prevention and detection of waste, abuse, or fraud and promoting economical and efficient administration of HHS funds; and
- Providing education, technical assistance, and training to improve quality of care, promote cost avoidance activities, and sustain improved relationships with providers.

Overseen by a Governor appointed, independent 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 to the National Association of Inspectors General principles and standards, and all audit activity is performed in accordance to 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 that emphasize:

- 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 to 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 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 Medicaid providers.

OIG Recovery and Cost Avoidance Statistics

Recovery

Total recoveries[1] for State Fiscal Year (SFY) 2006 were $446,650,049 (all funds). The details of OIG recovery activities by individual business function can be found in Appendix B, Section I.

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

OIG Cost Avoidance

Cost avoidance is a reduction to a state expenditure that would have occurred, or was anticipated to occur, without OIG intervention. The details of OIG cost avoidance activities by individual business function can be found in Appendix B, Section II.

Cost avoidance dollars are calculated differently by business function. The 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 recoveries.

CORF/ORF

Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Physical Therapy and Speech Pathology Facilities (ORFs) were reimbursed at an interim payment percentage applied to the provider's billed charges to determine the provider's allowed amount per claim detail. Applicable adjustments were then applied to result in the actual payment to the provider. HHSC proposed to reimburse CORFs and ORFs based on a Prospective Payment System (PPS) fee schedule, using the same methodology used for physicians and certain other practitioners within the Texas Administrative Code, which allows for resource-based fees or access-based fees. Senate Bill 1188, 79th Legislature, Regular Session, 2005, directed HHSC to examine and, if cost-effective, implement a PPS methodology for CORFs.

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

[1] 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.

Medicaid provider. These savings are computed as follows:

Recoupment of Overpayments Identified for a Provider with Exclusion:

- Exclusion periods must be converted to months, i.e., 5-year exclusion converts to 60 months.
- For an indefinite exclusion period, use 36 months for calculations.
- For a permanent exclusion period, use 240 months for calculations.

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 Recourses when there is other insurance. These are actual claim 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 disqualification months (Permanent disqualification=60 months) by $106.00 for Food Stamps and $112.00 for TANF and totaling the amounts.

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 Texas Works staff to reduce or deny benefits based on income or resource information that may affect ongoing benefits. A sample of 373 cases with action notices were researched to come up with an average cost avoidance per action notice of $74.92. The total cost avoidance is the number of action notices generated x $74.92.

Recipient Data Match Cost Avoidance:
Recipient data matches include Social Security Administration (SSA) Deceased Individual, Bureau of Vital Statistics (BVS) Deceased Individual, Nursing Home, Prisoner Verification, Texas Department of Criminal Justice (TDCJ), Workers Compensation, Teachers Retirement, and Border State matches (Louisiana, Oklahoma, and New Mexico). In the process of investigating these data matches, action alert notices are sent to Texas Works staff to reduce or deny benefits based on household composition, residence, income, and resource information that may affect ongoing benefits. During SFY 2004, 10,138 matches were researched to come up with an average cost savings of $29.02 per match completed. The total cost avoidance is the number of recipient data matches completed x $29.02.

TADS Provider Prepayment Review Process
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.

WIC

Cost avoidance for 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).

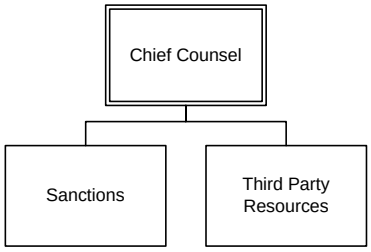
Audit

Cost avoidance results from four types of audit activities:

- Unallowable or incorrectly reported dollars identified and removed from cost reports that reduce the amounts that flow into the rate-setting database maintained by the HHSC's Rate Analysis Department. These dollars do not represent amounts that are received, because providers are paid under a unit-rate contract. The impact of these avoidance numbers would be reflected in the unit rate calculations.
- Unallowable costs and incorrect charges identified during a review of unpaid contract claims and billings.
- Consultation provided to program management overseeing outside audit contracts to ensure all appropriate questioned costs are considered and identifies wasteful practices that can be eliminated in future contracts and expenditures.
- Dollars removed from Medicaid outpatient hospital cost reports that reduce the amounts that flow into the rate-setting database maintained by Texas Medicaid Healthcare Partnership (TMHP). These dollars do not represent amounts that are recouped, because providers are paid based upon a cost-to-charge ratio of Medicaid costs to all costs. The impact of these avoidance numbers would be a reduction reflected in the unit rate calculations used for interim payments to the Hospitals, and a savings through the time value of money.

Key Accomplishments and Recent Developments

Chief Counsel



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

CORF and ORF Recoveries

The Office of Chief Counsel continues to be actively involved in recovering Medicaid overpayment dollars identified through audits and reviews of cost reports and cost information for the following two provider types—Comprehensive Outpatient Rehabilitation Facilities (CORFs) and Outpatient Rehabilitation Facilities (ORFs). CORFs and ORFs provide physical, speech and occupational therapies to Medicaid recipients.

During the last two quarters of this state fiscal year, Office of Chief Counsel, in conjunction with the Sanctions unit, recovered $2,051,767 from CORFs/ORFs. The total fiscal year recovery from these provider types comprised $6,460,533 of Sanction's total recoveries.

Sanctions

Sanctions is responsible for imposing administrative sanctions and/or actions against health care providers once an investigation has been completed. This includes placing providers on payment hold, recovering overpayment dollars, imposing administrative penalties, and excluding providers from the Medicaid program. In addition, Sanctions provides valuable input on policy issues important to the Medicaid program.

Sanctions has worked to strengthen OIG's relationship with the State's Managed Care Organizations (MCOs) by providing the MCOs with technical expertise and assistance in identifying and recovering overpayments. These overpayments have resulted from MCO health care providers' waste, abuse, or fraud in the Medicaid managed care program. As part of this effort, OIG has offered to provide all MCO Special Investigative Units with the statistical methodology and extrapolation tool developed and used by OIG. Use of this tool should minimize MCO investigative costs, while maximizing the amount of potential MCO overpayment recoveries.

Third Party Resources

Third Party Resources (TPR) cost avoidance and recovery for SFY 2006 exceeded $649 million. This is a $71 million increase over the previous year and sets another record for TPR. As a result of these figures, Texas continues to be recognized as a national leader in TPR.

As a result of Senate Bill 1188, 79th Texas Legislature, Regular Session, 2005, HHSC continues to lead the country in Pharmacy Benefit Manager (PBM) data matching contracts. HHSC has PBM agreements in place with six major PBMs, which will aid in OIG's post payment recovery operations and enhance OIG's cost avoidance efforts as Texas moves towards a cost avoidance system for Pharmacy. As a result of this achievement, the HHSC-OIG TPR Manager has been invited to present Texas' formula for success at the National Third Party Liability Conference in Orlando, Florida on September 13, 2006.

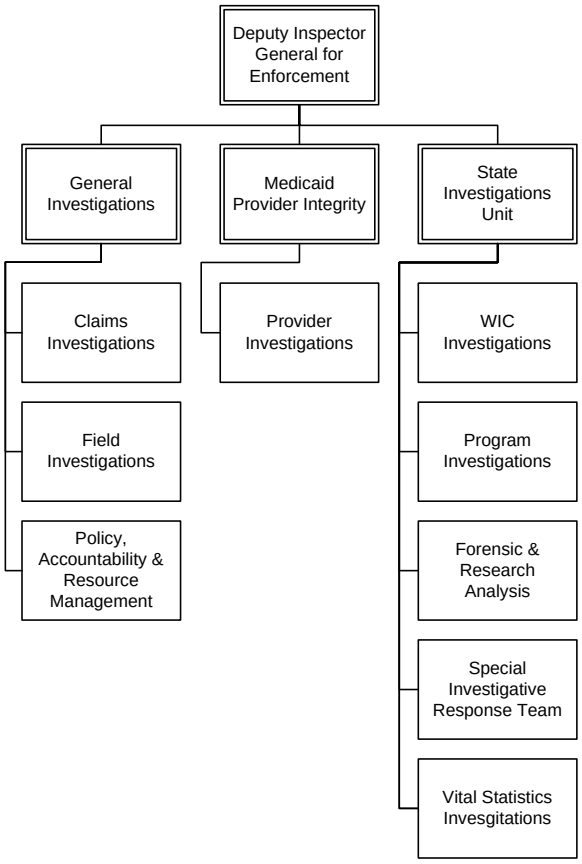
In a landmark case concerning Medicaid coordination of benefits, the Supreme Court ruled against the *Arkansas Department of Health and Human Services, et al v. Ahlborn*, 126 S.Ct 1752 (2006). In summary, the Ahlborn case limits Medicaid recovery to a medical portion of a settlement. Historically, Medicaid would negotiate its portion for medical expenses from the total case settlement. The implication is that the plaintiff's attorney can now negotiate or discount the medical portion of the settlement, keeping other damages intact. The resulting impact is that less money is available to the state to recover medical expenses.

In response to the court ruling, OIG is recommending specific changes to aid Texas in combating the potential loss to the state. Also, OIG has taken proactive countermeasures to limit the financial impact to Texas. Specifically, we have documented in our subrogation and 95-day notice letters that the state does not authorize any negotiation of the medical expenditures without prior written notification by the state or its designee.

The change OIG recommends is for any third party[2] to verify with HHSC or its designee, before dispersing an insurance settlement for medical costs, whether the insured is a Medicaid recipient. If the third party does not verify and have documentation of such and it is later determined that the client was a Medicaid recipient, the insurer remains liable for full reimbursement to Medicaid.

[2] Include health insurers, self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service.

Enforcement Division



The Enforcement division conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to 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 State Investigations Unit.

General Investigations

General Investigations (GI) staff primarily conducts recipient eligibility fraud investigations in Food Stamp, Temporary Assistance for Needy Families (TANF), Medicaid, and the Children's Health Insurance Program (CHIP). 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 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. Non-fraud investigations are handled for collection only. For SFY 2006, overpayment claims totaling $15,824,938 were recovered.

GI recoveries were negatively impacted by several events and factors occurring in SFY 2006. A majority of GI staff began the fiscal year by stepping out of their role as fraud investigations to assist the HHSC Hurricane Katrina relief efforts. Staff at all levels integrated with HHSC eligibility offices and relief shelters to aid Food Stamp and other benefit assistance certifications for evacuees. GI staff assisted in Houston, Dallas, Fort Worth, Arlington, Beaumont, Lufkin, Austin, San Antonio, Tyler, El Paso, and virtually all locations where the Louisiana, Mississippi, and Alabama residents were

evacuated in Texas. GI staff logged a total of 3,645 hours on hurricane assistance. This equates to approximately one-month's productivity for 10 percent of the GI workforce that was lost during the Hurricane Katrina relief effort in the first quarter of SFY 2006[3].

Shortly after the Hurricane Katrina efforts, GI was once again impacted by a hurricane. Hurricane Rita impacted GI with numerous GI offices being closed for varying lengths of time due to the threat and ultimate landfall of Hurricane Rita — from Corpus Christi north to Houston and into East Texas. In addition to the initial office closures, six GI employees in Beaumont and Lufkin were displaced from their homes for a month or more. The Beaumont GI office did not reopen for three weeks following the hurricane. Once again, the GI staff was called upon to provide assistance in the certification of evacuees and operation of the 2-1-1 call center; however, in this instance the scope of the involvement by GI was less than what it was following Hurricane Katrina.

The September 2005 Semi-Annual Report described the impact to GI of implementing "Streamlined Reporting," an optional provision of the Federal Farm Security and Rural Investment Act of 2002. Streamlined Reporting was implemented in March of 2003 and significantly changed the income reporting requirements for Food Stamp households. The result has been a dramatic decrease in the number of non-fraud overpayments being established over the last three years and a reduction in collections.

During the second half of SFY 2006, GI implemented new initiatives to increase the number of Food Stamp trafficking investigations. Eleven senior investigators were named as Food Stamp Trafficking Coordinators in each region to perform Food Stamp trafficking investigation activities.

GI staff worked closely with HHSC-IT staff to develop a new automation system. The Automated System for OIG (ASOIG) will replace several outdated systems currently used by GI. During SFY 2006 system requirements were finalized, a prototype was developed and approved, and programming began. The new system is expected to be implemented in SFY 2007, and improvements in employee productivity are expected.

Medicaid Provider Integrity

The Medicaid Provider Integrity (MPI) staff is primarily devoted to the investigation of provider fraud in the Texas Medicaid Program. The 79th Legislature, Regular Session, 2005, approved an exceptional item through the General Appropriations Act (GAA) granting an increase in MPI staffing levels by 16 additional FTE's. The staffing increase allowed MPI to place investigators in key areas of the state in order to more efficiently investigate issues related to Medicaid waste, abuse, and fraud. In addition to the Austin headquarters office, MPI now

[3] 3,645 hours divided by 40 hours = 91.13 weeks of assistance divided by 4 weeks = 22.78 staff which equates to 10% of the GI workforce.

has field investigators located in Dallas, Houston, San Antonio, and Edinburg.

In December 2005, MPI began conducting criminal history background checks for all potential Medicaid, Medicaid Managed Care, and Children with Special Health Care Needs (CSHCN) Services Program providers submitting an enrollment application through the Texas Medicaid and Healthcare Partnership (TMHP). Additionally, criminal background checks are performed for any person or business entity that meets the definition of "indirect ownership interest" as defined in 1 *Texas Administrative Code* (TAC) §371.1601 who are applying to become a Medicaid provider, or who are applying to obtain a new provider number or a performing provider number. Details of these changes were made available in the January/February 2006 *Texas Medicaid Bulletin*, No. 192 and the February 2006 *CSHCN Provider Bulletin*, No. 57.

From December 2005 through August 2006, MPI conducted 10,166 criminal history checks on Medicaid provider applicants and those under investigation. Of the criminal history checks conducted, 368 were either denied or are pending receipt of return information.

In October 2006, MPI will begin conducting criminal history checks on all Medicaid providers currently enrolled through TMHP, the state's claims administrator.

For SFY 2006, the number of provider complaints increased significantly from SFY 2005. In SFY 2005, MPI opened 545 cases. In SFY 2006, MPI opened 800 cases. This reflects a 47 percent increase in complaints. As a result of increased complaints, MPI referred 256 cases to the Office of Attorney General's Medicaid Fraud Control Unit (OAG-MFCU) for SFY 2006. This reflects a 69 percent increase over the number of cases referred to OAG-MFCU from SFY 2005.

In accordance with Section 531.113 of the Government Code, all Managed Care Organizations (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 SFY 2006, OIG realized a 330 percent increase in complaint referrals from MCO's based on their mandated Special Investigative Units (SIU's).

On March 10, 2006, the Office of Inspector General (OIG) notified the Health and Human Services Commission (HHSC) Medicaid/CHIP Division regarding problems in the provider enrollment process administered by Texas Medicaid and Healthcare Partnership (TMHP). Three areas of concern were noted including TMHP's (1) failure to verify required licensure information, (2) failure to check OIG's open investigations list, and (3) the erroneous enrollment of out-of-state providers. TMHP provided a response to OIG which included several lists of providers who were issued additional billing numbers while the providers were on OIG's open investigations list. To date, these "potential inappropriate payments" total in excess of $32 million. Currently, the OIG Audit Section is conducting

an audit of TMHP's provider enrollment process with an expected date of completion in December 2006.

OIG and OAG Interagency Coordination

The United States Department of Health and Human Services, Office of Inspector General, approved a staged expansion and match of federal grant funds to increase the OAG-MFCU to 208 employees by the end of SFY 2005. The grant application submitted for SFY 2006 requested staffing for 215 positions strategically located around the state. The OAG-MFCU is currently staffed with 208 employees, including more than 40 commissioned peace officers. Field offices are open in Dallas, Houston, Lubbock, Tyler, El Paso, McAllen, San Antonio, and Corpus Christi.

As required by Section 531.104 of the Government Code, the Memorandum of Understanding (MOU) between the OAG-MFCU and OIG was updated and expanded in November 2003, and continues to ensure the cooperation and coordination between the agencies in the detection, investigation, and prosecution of Medicaid fraud cases. This MOU has proven beneficial to both agencies.

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 OIG for making referrals between the OAG-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. OIG 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 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 recent referrals, and systematically revisiting older referrals;
- Regular case presentation meetings initiated by OIG to introduce critical cases to OAG-MFCU staff, in order to conduct parallel investigations;
- Constant communication on cases through entire staff levels, ensuring all case resources are shared, and efforts are not duplicated; and
- Monthly meetings are held between the appropriate OIG and OAG staff in order to share case information, including providing OIG with status updates for cases referred to OAG-MFCU by OIG.

Periodic planning sessions have occurred to coordinate case-methodology guidelines that apply to all cases, regardless of type. Appendix B, Section III under MPI, contains

three charts which provide the number of waste, abuse, and/or fraud referrals received and sent from MPI between March 2006 and August 2006.

State Investigations Unit

The OIG is restructuring its Enforcement Division to more efficiently respond to the expanding number of referrals involving contractor and vendor fraud involving HHS agency programs. Effective September 1, 2006, the Internal Affairs Section was changed to the State Investigations Unit (SIU). The SIU 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 SIU is staffed by OIG employees formerly assigned to the Enforcement Division's Internal Affairs Section, which includes the Research and Analysis Unit Team, Program Investigations Team, Special Investigative Response Team, and the Vital Statistics Team.

As of July 2006, development stages on the web based, centralized, security driven case management system for internal affairs investigations (CMSIA) began. CMSIA will replace the current stand-alone Microsoft access computer database approach inherited from legacy agency operations. The system is being developed by OIG's TADS section. Beta testing for deployment will commence in four to six months and will be fully operational during SFY 2007.

Once fully operational, the improvements offered by the new system will include:

- Complaints will be entered by any state investigations unit staff instead of a single intake investigator, decreasing the time from receipt of a complaint to determination to investigate;
- The system will accept a direct referral transfer from Waste, Abuse and Fraud Electronic Reporting System (WAFERS), which is available to the public as well as HHS staff, eliminating the need to manually re-enter complaint information;
- Documents can be scanned and inserted into the electronic case file, eliminating manual re-entering of information from hard copy documents;
- Complaints are reviewed and assigned for investigations on-line by management, eliminating the delay in initiating an investigation, and shipping documents folders;
- Investigation files are automated permitting real time review and comments by management;
- Management may encrypt highly sensitive cases with an encryption key, which increases security while permitting ongoing real time review by selected managers and executive staff holding the key; and
- Investigative caseload and various management summary reports will be available based on a range of selected criteria

that respond to executive management requests.

The new system will automate and standardize most of the investigative logging, tracking, reporting, and writing tasks. CMSIA will use the "wizard" approach to build a case record. That is, the system guides 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.

The Forensic Research, and Analysis Unit (FRAU) was created to handle the analysis of state-owned and leased electronics devices and peripherals associated with allegations of internal waste, abuse, and fraud received by OIG. The size of FRAU was increased in part to respond to the March 2005 revision of the Human Resources Manual. The revised policy on the use of state-owned computer resources and Internet connections was strengthened and standardized across the HHS Enterprise, and now requires that incidents of computer misuse be reported to OIG.

FRAU staff members utilize a new forensic machine called Forensics Recovery of Evidence Device (FRED SR) to assist with the anticipated increase in computer misuse referrals due to the revised policy. FRED SR is a more advanced forensic workstation with dual processors, integrated peripheral support, and increased memory and bandwidth. FRED SR, with four-gigahertz processors, dramatically reduces the time needed for evidence acquisition and forensic software processes during examinations.

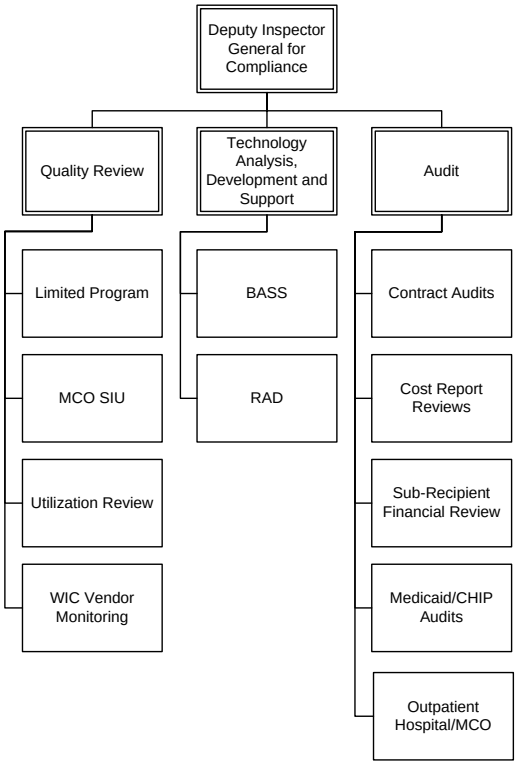
In September 2005, HHSC purchased the Encase Enterprise system. Encase Enterprise is a network-enabled, multi-platform computer systems solution that enables immediate response to computer related incidents and thorough analysis of electronic media.

In August 2006, Executive Commissioner Hawkins approved full deployment of Encase Enterprise. 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.

Full deployment and implementation of Encase Enterprises across the HHS Enterprise is anticipated to occur within three to twelve months. Due to the various agencies' IT infrastructure, several phases are required to build/distribute Encase Enterprise across the HHS Enterprise.

Upon the full deployment of Encase Enterprise and using the existing FRED SR, FRAU will have latest technology to enable immediate response to incidents of computer misuse, thorough analysis of electronic media and evidence collection more efficiently. Utilizing this system will create substantial cost savings in staff time, computer down time, and damaged hard drives.

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: Audit, Quality Review, and Technology Analysis, Development & Support (TADS).

Audit

The Audit section consists of five units:

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

The Audit Section has experienced growth in SFY 2006. The 79th Legislature, Regular Session, 2005, provided twenty-five new positions that were used to staff existing units. An additional fifteen positions were granted by Executive Commissioner Hawkins to staff the Outpatient Hospital/MCO Unit. These positions were filled in SFY 2006. The Audit Section filled the vacant positions that were frozen immediately following the consolidation.

The remainder of SFY 2006 was used to train new staff, and develop audit processes and fiscal year 2007 audit plans. The Audit Section successfully implemented enhancements to the existing processes and incorporated new audit processes during the fiscal year to achieve its mission.

Audits performed by the Audit Section include those described in the *Government Auditing Standards*, 2003 revision, issued by the Comptroller General of the United States (General Accounting Office), often referred to as Generally Accepted Govern-

ment Auditing Standards (GAGAS), or the "Yellow Book." Policies and procedures are in place to ensure work meets Yellow Book standards, including general, fieldwork, and reporting standards.

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 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.

A subrecipient is subject to a single audit when it receives and expends a minimum of $500,000 in state and/or federal government award or financial assistance. 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.

Desk Reviews - The SFRU completed a total of 804 desk reviews in fiscal year 2006. In addition to the routine desk reviews, the SFRU continues to find ways to enhance accountability on waste, abuse, and fraud, by continually modifying our approach in the following ways:

- Changing desk review audit programs to include additional audit steps to evaluate the subrecipient's financial statements, such as developing a template for ratio analysis (*e.g.*, calculation of liquidity ratios, ratio of administrative costs to total expenditures, ratio of payroll and related costs to total program expenditures), and other analytical considerations that might indicate evidence of financial hardship or growing concern. The information provided by these additional analyses is forwarded to funding agencies' program personnel for monitoring efforts, as they may indicate instances of waste, abuse, or fraud.
- Updating the Single Audit Web-Based System to track all subrecipients subject to single audit requirements, including "for-profit" subrecipients and other entities excluded from OMB Circular A–133 reporting requirements. The latest system update provides space to gather information on the amount of state and federal funds expended each fiscal year by the subrecipients.
- Updating the single audit database to track desk review deadlines. The updates allow SFRU to determine the timing for issuing reminder letters, delinquent letters, and/or following-up with subrecipients who do not comply with contract, grant agreements, and/or OMB circular A–133 reporting requirements.
- Working in collaboration with the funding agencies to ensure all new contracts are communicated to SFRU for input into the

single audit database and providing "read-only" access to the database.

- Collaborating and assisting specific programs, such as the Special Nutrition Program, (*i.e.*, responding to specific inquiries on technical matters related to OMB Circular A–133 reporting requirements, State of Texas Single Audit Circular, or interactions with external auditors).
- Working with the KPMG auditors in their fieldwork of the Statewide Audit (page 248) of SFY 2005 issued by HHSC to subrecipeints for compliance with OMB Circular A–133 reporting requirements. There are no findings regarding OIG's single audit reviews of the subrecipient reports. In addition, this unit was instrumental in resolving prior audit findings regarding insufficient monitoring efforts of subrecipients.[4]

Quality Control Reviews - The Single Audit Unit completed its risk assessment in June 2005, from which it developed an audit plan for the quality control review of selected CPA Firms for SFY 2006. The 67 initially planned quality control reviews of CPA firms located across the state of Texas for SFY 2006 were increased to 85. For future use, SFRU developed a Methodology Manual/Package covering the risk assessment process, documented the population and location of the CPA firms identified in the plan, and presented the overall approach used in performing the quality control risk assessment. Fieldwork for all 85 quality control reviews of CPA firms is complete. Reports for 16 quality control reviews were issued in SFY 2006. The remaining 69 reports will be released in SFY 2007.

The objective of a quality control review is to determine whether the selected CPA firms conducted the single audit of subrecipients in accordance with standards and other requirements set forth in the Yellow Book and/or OMB Circular A-133 – reporting requirements. To implement this program, OIG hired six new auditors.

Limited Scope Audit - This function of the SFRU is still in discovery stage. The risk assessment for this area was started and is ongoing. During this process, OIG plans to determine the amount of resources needed to proceed with the related responsibilities. The purpose of the limited scope audit is to audit subrecipients having the highest risk of non-compliance with the single audit requirements, quality control reviews, or monitoring requirements conducted by the funding agencies. The limited scope audit is designed to review both financial and non-financial information reported by subrecipients, and will be accomplished by conducting on-site audits of the subrecipients.

[4] Report number 03-434 pg. 104 (State of Texas Federal Portion of Statewide Single Audit Report for the Fiscal Year End August 31, 2002 (A Report by KPMG, LLP); finding number 03-21), issued April 30, 2003.

Report number 04-029 (An Audit Report on Texas Department of Health Monitoring of Program Service Contractors' Financial Operations), issued April 26, 2004.

Report number 05-319 (State of Texas Federal Portion of Statewide Single Audit Report for the Fiscal Year End August 31, 2004 (A Report by KPMG, LLP); finding number 05-20), issued March 29, 2005.

Medicaid/CHIP Audit Unit
In the six months ending August 31, 2006, the Medicaid/CHIP Audit Unit has undergone significant changes. As previously reported, this unit received authorization for 27 auditors in this fiscal year and during this period. The unit recruited the remaining positions and trained all of the new auditors to carry out audits as three: the Medicaid and CHIP audit team, the Information Technologies (IT) audit team, and Outpatient team. Due to the size and scope of the Medicaid Outpatient Hospital cost report project undertaken this fiscal year, the 15 positions in the Outpatient team were organized into a separate unit, the Outpatient Hospital/MCO Unit.

The Medicaid/CHIP Audit unit is carrying out audits of the Medicaid claims administrator contract, and the Texas Medicaid Administrative Services (TMAS) contract. It also initiated a close out audit of the risk stabilization reserve (RSR) maintained by National Heritage Insurance Company (NHIC) during its contract as the Medicaid claims administrator in accordance with Rider 16[5]. Additionally, the IT audit team is currently working on an audit of the newly contracted Vendor Drug system.

Outpatient Hospital/MCO Unit
The Executive Commissioner allocated 15 positions to the OIG Audit section in SFY 2006 to address a gap in the Medicaid program regarding the cost containment audit of Medicaid outpatient hospital costs. The Medicaid outpatient hospital program is the last cost-based reimbursement element in the Medicaid program. Medicaid outpatient hospital costs had been settled without audit since SFY 2001 when Medicare, which had provided audit coverage as the Medicaid Outpatient Hospital costs are reported on the Medicare Cost Reports, changed from a cost-based reimbursement system to a prospective payment system (PPS) and discontinued its in-depth audits of these cost reports.

As discussed earlier, these positions were originally organized as a team within the Medicaid/CHIP Audit Unit. This unit has undertaken an ambitious statewide initiative involving the audits of Medicaid Outpatient Hospital Cost included in Medicare Cost Reports for the past four years. Having completed development of an audit methodology for these cost reports, the unit began fieldwork on the initial round of audits and is continuing to identify facilities to be audited through an on-going risk assessment process.

Contract Audit
The Contract Audit Unit (CAU) provides audit coverage for all HHS contracts other than TMAS and subrecipient contracts.

To ensure needs and resources are balanced and the greatest impact and customer value is provided, an audit plan is being finalized based on a risk assessment that looks at current and past contracts within a given time period. Risk criteria along with external and internal business risks and auditor

[5] General Appropriations Act, HHSC Bill Pattern, Rider 16, 79th Legislature, Regular Session, 2005.

judgment will be used to identify those contracts with the greatest risk. A risk assessment for the Vendor Drug Program was completed.

Contracts included in the risk assessments include nursing home and hospice care, community care services, nutrition assistance, childcare, foster care, programs for the elderly, the Vendor Drug program, and various consulting and professional service contracts.

Audits are performed to ensure program funds are properly used to provide contracted services to eligible recipients, ensure recipient funds are adequately managed, and serve as a deterrent to abuse and fraud within the program.

The objectives of contract audits include:

- Compliance with federal and state laws, regulations, and rules;
- Final contract cost (cost settlement and close-out audits);
- Specific procedures performed on a subject matter (agreed upon procedures);
- The extent to which legislative, regulatory, or organizational goals and objectives are being achieved;
- Whether sound procurement practices are being followed; and
- Other audit objectives necessitated by the nature of the contracts.

Work performed in SFY 2006 by the CAU includes:

- Issuance of a final report on an attestation examination conducted on a long-term care provider that has potential recoupment of $283,705 in overpayments;
- Development of the audit program and process to conduct performance audits of pharmacies participating in the Vendor Drug Program. Vendor Drug pharmacy audits will begin in SFY 2007;
- Completion of 43 audits of Intermediate Care Facilities for Mental Retardation (ICF/MR). The CAU conducts ICF/MR audits as mandated in 40 TAC §§ 9.219 through 9.269 related to provider reimbursement and client trust funds; and
- Revisions to the ICF/MR audit process needed to conform to Yellow Book standards.

Cost Report Review Unit

The Cost Report Review Unit (CRRU) completes onsite field audits and in-house desk reviews of reports[6]. Desk reviews of provider cost reports are conducted to ensure that the financial and statistical information submitted in the cost reports conforms to all applicable rules and instructions. Unallowable costs are removed from the cost report and from the HHSC database used to determine the provider reimbursement rates.

The majority of CRRU work consists of technical desk reviews of provider cost reports to ensure the accuracy and integrity of statistical and financial information reported and costs are in accordance with program rules and regulations. The selec-

[6] TAC, Title 1, Part 15, Chapter 355, Subchapters D and F mandate Medicaid provider cost report and field audits.

tion is currently based on a risk assessment analysis performed by the HHSC Rate Analysis Division (RAD). Unallowable costs identified in the desk reviews and field audits are removed from the cost reports. Cost avoidance savings are generated by the removal of these costs, resulting in lower reimbursement rates. RAD uses adjusted statistical and financial information to recommend future reimbursement rates for program services to the Texas Legislature.

CRRU uses TeamMate software to perform and maintain audit working papers in an electronic format. Field audits are performed in accordance with Generally Accepted Governmental Auditing Standards.

A large percentage of community care providers and nursing facilities participate in the Direct Care Staff Rate program and receive enhanced funding for the provision of direct care services to Medicaid clients. The participating providers are required to complete and submit an Annual Staffing and Compensation Report. RAD may recover overpayments based on audit adjustments made to these cost reports.

Both ICF/MR and Home and Community Based Service programs for mentally retarded individuals are required to spend at least 90 percent of the reimbursement rate for direct care services to Medicaid clients. RAD may recover a portion of the rate component from a Medicaid provider failing to meet this spending requirement. CRRU performs desk reviews and field audits on the cost reports submitted by these providers. Adjustments to the reported direct care cost often result in RAD recovering additional funds from the providers. CRRU conducts investigative audits in conjunction with OIG's Medicaid Provider Integrity section to facilitate recoveries of funds or aid in the prosecution of providers who may have committed fraud.

Other Audit Section Activities

In addition to its regular functions, the Audit section continues to participate in the following HHSC Workgroups:

- *HHS Contract Administration and Tracking System (HCATS) Workgroup* – participation includes providing user information for system development and the single audit processes and database. The single audit database developed by OIG will be the primary source of subrecipient data for the single audit module in HCATS.
- *Contractor Risk Assessment Workgroup* – participation included providing technical knowledge and information to develop a recommended guide for use throughout the HHS enterprise by those involved in any phase of the contracting cycle to conceptualize, develop, and implement appropriate and useful contracting risk management methodologies. The guide addresses several categories of contract types and the nine contracting life-cycle phases included in the HHS Contracting Process and Procedures Manual.
- *Senate Bill 1188 Reporting Module* – in compliance with Senate Bill 1188, 79th Legislature, Regular Session, 2005, the

Audit section implemented a new reporting module governing all investigations and audits conducted within the scope of the bill including required reports.[7]

Non-Audit Services

Non-audit services generally differ from audits in that auditors may perform tasks requested by management that directly support the entity's operations or provide information or data to a requesting party without providing verification, analysis, or evaluation of the information or data. These services may or may not result in the issuance of a report.

For example, in September 2005 the Medicaid/CHIP Audit Unit assisted Medicaid/CHIP contract management to identify the appropriate disposition of contract costs arising from NHIC's restatement of its contract cost settlement statements for SFY 2003 and partial SFY 2004 years. These costs were not originally identified in connection with Davila Buschhorn's audit of these contracts; therefore, they were not subject to the prior settlement agreement between NHIC and HHSC. As a result, Medicaid/CHIP Audit and Contract Management staff found that, NHIC owed HHSC $260,000 for excess costs charged to the contract for these years. We recommended, (1) denying the request to offset these amounts against the settlement funds, and (2) demanding immediate repayment. Medicaid program management and HHSC legal counsel later concurred with OIG's position.

Beginning in March 2006, the Director of Audit served as the contact for the State Auditor's Office during its audit of OIG. The Director, along with the SFRU Manager, facilitated the audit process between the State Auditor's Office and all OIG units.

Quality Review

The Quality Review section consists of four units:

- Limited Program;
- Managed Care Organization Special Investigative Unit (MCO-SIU);
- Utilization Review (UR); 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 indicates abuse, misuse, or suspected fraudulent actions related to Medicaid benefits and services.

[7] SB 1188, passed by the 79th Legislature, Regular Session, 2005, directed HHSC to make a number of reforms to streamline the administration of, maximize funding for, improve recipient outcomes in, and increase the cost effectiveness of the Medicaid program.

Although recipients are limited to a primary care provider and/or pharmacy, the participation of the provider and/or pharmacy is voluntary.

The Limited Program also refers cases of alleged Medicaid and Children's Health Insurance Program (CHIP) recipient waste, abuse, and fraud to OIG's General Investigation's (GI) section.

The Limited Program has been and continues to be impacted by implementation of new automation systems, including the Texas Integrated Eligibility Redesign System (TIERS) and the Vendor Drug claims processing system. Issues related to system access, configuration, and data reporting continuously hamper staff's ability to conduct accurate research and analysis.

The Limited Program staff works in conjunction with GI and OIG's Business Analysis Support Services (BASS) to address system issues.

MCO-SIU

In accordance with Section 531.113 of the Government Code, a Managed Care Organization (MCO) contracting with the state of Texas for the provision of health care services to individuals under government-funded programs must establish and maintain a special investigative unit (SIU) for the purpose of investigating fraudulent claims and other types of program abuse by recipient and providers. Section 531.113 also requires each MCO to develop a plan to prevent and reduce waste, abuse, and fraud. The plan must be submitted annually to the OIG for approval as long as the MCO is contracted with the State of Texas. The plan must be submitted 60 days prior of the state fiscal year end. As of July 2006, 18 MCOs were contracted with the State of Texas. Each of the MCOs submitted their plan for preventing and reducing waste, abuse, and fraud to OIG. All 18 plans have been approved.

During the second half of SFY 2006, OIG has continued to conduct quarterly meetings with the contracted MCOs to:

- Provide information about provider and member waste, abuse, and fraud:
- Provide training on investigating and referring cases to OIG;
- Strengthen coordination efforts; and
- Enhance the quality of detection, investigation, and reporting of possible acts of waste, abuse, and fraud.

Utilization Review

The Utilization Review (UR) unit conducts reviews of nursing facility assessment forms and inpatient hospital claims to validate compliance with state and federal regulations. Reviews are conducted by registered nurses in 15 regional and satellite offices throughout the state.

Nursing Facility Utilization

Nursing facilities receive Medicaid payments based on the Texas Index of Level of Effort (TILE) classification system. The system is defined in terms of the recipient's condition, functional performance in activities of daily living, and level of staff intervention. Nursing facilities submit an as-

sessment form indicating the level of effort required by the nursing facility to care for the recipient.

UR nurses conduct reviews to validate the accuracy of the forms submitted by the nursing facilities by reviewing the clinical record and observing recipients in the facility. On-site reviews are unannounced and are conducted at a minimum of once every 16 months.

In 2003, UR identified continued non-compliance of inappropriate TILE assessment and billing. To address the issue, in August 2004, UR implemented new rules. Under the revised rules, if a facility's error rate at the initial visit is 25 percent or greater, a return visit is conducted in seven to nine months. If a facility's error rate at the return visit is 20 percent or greater, vendor payment hold may be initiated. OIG informs the Department of Aging and Disability Services of all potential vendor holds to ensure such action will not affect the care of the residents. The revised rules also direct nursing facility compliance with certification requirements attesting to the validity of the assessment form. Continued non-compliance results in a decreased TILE payment.

The nursing facility TILE review process incorporates:

- Facility staff education;
- Opportunity for informal reconsideration of any TILE change;
- Facility's right to an administrative hearing;
- Initiation of vendor payment hold for continued non-compliance;
- Timely release of the facility from Vendor Payment Hold once compliance is established; and
- Recommendation for contract termination for failure to achieve compliance.

Total recoveries from nursing facility reviews for the second half of SFY 2006 were $8,008,308. The details can be found in Appendix B, Section III.

Between March 1, 2006 and August 31, 2006, UR conducted 543 TILE reviews at nursing facilities:

- 39 nursing facilities were placed on Vendor Payment Hold;
- 40 nursing facilities were released from Vendor Payment Hold; and
- Zero nursing facilities remained on Vendor Payment Hold

Hospital Utilization Reviews

UR also conducts reviews of inpatient hospital claims for fee-for-service Medicaid recipients including medical necessity, Diagnosis Related Group (DRG) validation, and quality of care. The process involves a quarterly sample of inpatient hospital paid claims. Registered Nurses conduct both on-site and mail in reviews. Final determinations are made by HHSC contracted Physician consultants.

Total recoveries from Hospital reviews for the second half of SFY 2006 were $6,277,040. The details can be found in Appendix B, Section III. During this time period, UR

conducted 117 on site reviews and 375 mail-in reviews.

In 2005, UR contracted with Navigant Consulting, Inc., to perform analysis of DRG claim data to identify the most potentially error prone DRGs and associated claims. The reproducible methodology enhances the quarterly sampling process. UR staff identified an additional 434 claims in the second half of SFY06 for adjustment / recovery as a result of the new methodology. Due to delays in the claims processing requirements, only 22 of the 434 claims have been finalized for this time frame. The 22 adjusted claims resulted in $50,814 being returned to the Medicaid program. It is anticipated the additional 412 claims will increase the recovery dollars.

WIC Vendor Monitoring

The Women, Infant and Children (WIC) Program serves to safeguard the health of low-income women, infants, and children up to age five who are at nutritional risk by providing nutritious food to supplement diets, information on healthy eating, and referrals for health care.

To streamline and improve the delivery of benefits to Texas WIC recipients, the Food Issuance and Redemption Services Section of the WIC Program at the Department of State Health Service (DSHS) developed the Electronic Benefits Transfer (EBT) System in conjunction with authorized grocer-vendors, consumer advocates, local agency personnel, and WIC participants. The purpose of the system is to improve the processing of WIC information throughout the state.

The EBT system currently operates in 104 counties in Texas. The purpose of the EBT card is: 1) to provide WIC recipients with a portable health record, and 2) to facilitate sharing recipient demographic, clinical, and financial information among various health-care programs within the constraints of confidentiality.

OIG WIC Vendor Monitors are testing the new EBT System as it rolls out to various counties and are providing feedback to DSHS regarding the performance and accuracy of the system. The WIC Vendor Monitors continue to perform on-site evaluations and compliance buys to ensure that WIC vendors are in compliance with federal and state statutes regarding the WIC Program.

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 MFADS generated targeted queries and models. This section also provides oversight and direction on cases identified by the Medicaid claims administrator, ACS-TMHP, through the federally required Surveillance and Utilization Review Subsystem (SURS).

During this time period, TADS staff was involved in several technology developments. These include:

- Create a secure environment for OIG data and applications - OIG has made strides in adding network security and controls by:
  - Obtaining Hardware Firewalls and switches; and
  - Implementing a .NET architecture to create better, adaptable, and secure applications through an internal Web accessible portal.

With the addition of this type of architecture, OIG has been proactive in preventing intrusion and un-authorized access to sensitive OIG data and applications.

- Migration of OIG servers and applications from HHSC to OIG – (Still ongoing) OIG will be better able to consolidate data, application management, systems security, and disaster recovery processes and procedures locally that were previously outside of OIG's control. In addition, the planned migration of ASOIG to the Braker I computer room provides OIG with additional security and the consolidation of sensitive data and access controls.
- Development and deployment of the OIG portal homepage - This is the official homepage for the OIG employees.
  - This site provides a central access point to all future applications and allows developers to deploy a quicker, more secure application; and
  - TADS staff are currently working on a Report Manager, Security Manager, and File Manager to implement into this new, more powerful portal system.
- Development and deployment of an internal project request application that is accessed via the OIG portal - This application will be used by designated OIG staff to request TADS assistance with :
  - Building applications (Windows or web-based applications / forms / reports);
  - Purchasing hardware; and
  - Purchasing software.
- Development of the Case Assistance Request System (CARS) for OIG's Case Analysis and Special Operations (CASO) section - This application allows anyone in OIG to electronically submit a Case Assistance Request to the Case Analysis and Special Operations unit.
- Development and internal testing of Phase I of the State Investigations Unit case management system – It is a web-based, centralized, security-driven case management system to streamline the current State Investigations Unit paper-based operation.
- Development of the OIG Secured Issue Management System – This application gives OIG staff an extendable, flexible and scalable web application that:
  - Tracks various forms of communications, including:
    - External Inquiries
    - Legislation
    - Legislative Inquiries
    - Projects
    - Open Records Requests

  - Commissioner Requests
  - Agreements
- Ability to restrict viewing / editing / deleting individual communication threads; and
- Produce Management Reports.

TADS reported recoveries for this period show a negative amount for the third quarter. TADS previously reported during SFY 2005 a little over one million dollars in recoveries based on a targeted query run in the Medicaid Fraud and Abuse Detection System (MFADS) that identified dental providers that received Medicaid payments for services rendered during the time that their dental license was in a delinquent status due to non-payment of the renewal fee to the Texas State Board of Dental Examiners. However, it was subsequently determined that the Board's process for informing dentists that their license was in a delinquent status and that they were not allowed to perform dental services during this time was factually and legally insufficient. Based on these new findings, Brian Flood, HHSC Inspector General, decided that this licensure violation would not be pursued. He required TADS staff to stop action on all of the cases, identify monies that had already been recovered and repay those monies to the providers at state expense. During the third and fourth quarters of this year, $1,365,905 was repaid.

Communications and Governmental Affairs

The Communications and Governmental Affairs division is structured according to the Association of Inspectors General's Principles and Standards for Offices of Inspector General (Green Book standards). This function adheres to the following *Green Book* core competencies:

1. Keep appropriate officials, legislative bodies, and the public properly informed of OIG's activities, findings, recommendations, and accomplishments as consistent with OIG's legal authority and confidentiality requirements;
2. Respond to requests for information from legislative bodies, other agencies, and organizations;
3. Review and report on legislation and regulations impacting OIG activities to ensure that the public interest is protected without imposing unnecessary burdens;
4. Maintain a flexible strategic planning system to meet the needs and priorities of federal and state legislative bodies, and other appropriate agencies;
5. Foster balanced reporting of public management issues; and
6. Coordinate communication and collaboration with appropriate governmental and public entities and make recommendations to improve preventative and cost-savings initiatives.

Flood Testifies before United States Senate

U.S. Senator Tom Coburn requested Inspector General Brian Flood to appear as a fraud subject matter expert on March 28, 2006, before the U.S. Senate Subcommittee on Federal Financial Management, Government Information, and International Security of the Committee on Homeland Security and Government Affairs. The hearing, "Bolstering the Safety Net: Eliminating Medicaid Fraud," was held to examine the current infrastructure and challenges for the Medicaid program as well as to determine the efficacy of the tracking system for improper spending and fraud at the federal and state levels.

Also testifying were Leslie G. Aronovitz of the Government Accountability Office (GAO), Inspector General Daniel R. Levinson of the U.S. Department of Health and Human Services, and Dennis Smith of the Centers for Medicaid and Medicare Services (CMS).

Their testimony emphasized that the essential elements of a successful fraud and abuse program include partnerships with other government enforcement agencies, enhanced third- party recoupment efforts, deployment of technology, and recruitment of people.

Recent GAO and CMS reviews of states

found a wide variance in program sophistication and ability to address waste, abuse, and fraud. Texas is on the high end for performance, technology, and innovations to control spending and ensure proper payments. Mr. Flood attributed Texas' success to OIG's people and technology. Chairman Coburn complimented the Texas Office of Inspector General, describing it as the national example for success.

OIG Activities Featured in Five National Trade Publications

OIG has worked hard to develop an organization committed to fighting fraud, waste, and abuse in Texas's health and human services programs. We have demonstrated that balancing partnership and accountability is the key to achieving the greatest rate of return for effort spent. Several recent articles favorable to Texas and a sharp review of New York's Medicaid Integrity Program by the Centers for Medicare and Medicaid Services (CMS) support this approach.

Reporting on OIG's successful anti-fraud strategies are the June 2006 issues of the National White Collar Crime Center's (NW3C) *Informant*, the Health Care Compliance Association's (HCCA) *Compliance Today*, Atlantic Information Services' (AIS) *Report on Medicare Compliance*, CCH *Journal of Healthcare Compliance* July–August 2006, and KPMG's *Health Care Insider* (HCI). In these articles, Inspector General Brian Flood promotes front-end partnerships with health policy and information technology experts involved in the Texas Health Analytics Information Technology (TxHASIT) project; the provider community through training seminars on Medicaid policy and billing; the federal government; and state governmental bodies (see Appendix D for Compliance Today article).

The AIS article notes the pressure states are feeling from the federal government to reduce payment error rates under the Improper Payments Information Act of 2002and to enact state versions of the federal False Claims Act under the Deficit Reduction Act (DRA) of 2005. Among other things, the DRA establishes a CMS Medicaid Integrity Program to oversee the propriety of state Medicaid expenditures.

CMS recently criticized New York's Medicaid integrity in CMS' Review of Program Integrity Procedures Final Report – State of New York, issued in May 2006. Articles published by the *Associated Press* and the *New York Times* on June 6, 2006, highlight the report's harsh findings in four areas of enforcement and post-payment oversight, including "in adequate staffing, diminished audit collections, insufficient provider sanction activity, and insufficient referrals to the Medicaid Fraud Control Unit." Prior to recent hearings in the New York Senate, the state focused their resources on controls to prevent fraudulent claims on the front-end. "While it is important to have an effective front-end effort, it is equally important to maintain an aggressive recovery program," the CMS report states. "Employing the less

aggressive approach of education versus enforcement may explain why New York's audit program appears to be less effective than in the past."

By creating an independent oversight of Medicaid integrity, Texas anticipated and mitigated many of the shortfalls addressed in the CMS report on New York. OIG has improved the effectiveness of Texas's Medicaid integrity program, as evidenced by $428.5 million in cost recoveries and $362.5 million in improper claims avoided for SFY 2005.

Helping Other States

Governor Perry's vision for accountability in state government, which he presented in a speech to the Texas Association of Broadcasters on February 03, 2005 (see Appendix D), included the creation of Inspector General positions at large state agencies to ensure ethics and public integrity within a statewide, taxpayer-funded program. Since its creation in 2003, OIG has transformed into a modern investigative arm with extensive expertise and diverse resources capable of successfully targeting waste, abuse, and fraud, and reducing inappropriate or unjustified program expenditures. With this success, OIG is swiftly becoming the nationally recognized model for other states to emulate. OIG is soundly committed to assisting them with their Medicaid abuse and fraud reduction programs.

Communications and Governmental Affairs activities have expanded to include detailed information sharing with other states inquiring about best practices for structuring an independent Office of Inspector General. Based upon requests from other states regarding our methodologies for calculating statistics on recoveries, cost avoidances, and cost savings, OIG now includes this methodology in every semi-annual report.

Texas' standing as the national model for other states' Medicaid fraud prevention programs was reinforced by the New York Senate's March 14, 2006, press release announcing the passage of New York's Medicaid Fraud Prevention and Recovery Act of 2006. Senate Majority Leader Bruno's press release dated March 14, 2006, stated:

"The comprehensive Senate Medicaid fraud plan was developed after statewide public hearings held by the Senate Medicaid Reform Task Force. At the hearings, the task force received input and suggestions from people in the health care industry and the law enforcement community on what could be done to strengthen the state's efforts to detect and prevent Medicaid fraud."

"Among those who testified at the hearings was Texas Health and Human Services Commission Inspector General Brian Flood, who spoke about the remarkable results of Texas Medicaid fraud plan, *upon which the Senate plan is modeled*. Brian Flood will discuss New York's legislation as a model for state level efforts to fight Medicaid fraud when he testifies before the United States Senate." (See Appendix D).

In a March 14, 2006, article on the same issue regarding the New York Medicaid legis-

lation, the *North Country Gazette* stated, "Among those who testified at the hearings was Texas Health and Human Services Commission Inspector General Brian Flood, who spoke about the remarkable results of Texas Medicaid fraud plan, upon which the Senate plan is modeled. Brian Flood will discuss New York's legislation as a model for state level efforts to fight Medicaid fraud when he testifies before the United States Senate."

The *North Country Gazette* went on to describe the new law as "the toughest, most comprehensive plan to combat Medicaid fraud in the United States." Both publications described New York's legislation as "similar to reforms enacted in Texas, which provided immediate results," and that "[a]pplying the results in Texas to New York's $46 billion Medicaid program, would result in an annual savings of $2.3 billion for the program and provide relief for State and local taxpayers."

Mr. Flood, who serves on the boards of the National White Collar Crime Center, National Insurance Crime Bureau, and Association of Inspectors General, has been contacted as a subject matter expert on Medicaid fraud to assist improving system efficiencies by other states, including: Arkansas, New Jersey, Missouri, Kansas, Florida, Georgia, Maryland, and Pennsylvania. In Missouri, the same department that pays out more than $5 billion a year in medical bills is also responsible for monitoring those expenditures to detect fraud or unnecessary billings. Mr. Flood testified that enforcement improved when Texas separated those two functions and put all its enforcement activities into one office. The management culture of those who process payments conflicted with the need for aggressive enforcement, he told lawmakers.

Florida AHCA and AG-MFCU Visit

On May 15-17, 2006, OIG hosted a delegation from the Florida Agency for Health Care Administration (AHCA) and the Florida Attorney General (AG) Medicaid Fraud Control Unit (MFCU). Florida had heard positive feedback about Texas' efforts to monitor Medicaid fraud and abuse. Inspector General Flood and staff from OIG's MCO-SIU, TADS, General Investigations, Chief Counsel, and Case Analysis & Special Operations provided functional overviews, success stories, and lessons learned. Medicaid/CHIP staff also participated in a discussion relating to managed care, including contract requirements, collection and use of encounter data, and how managed care capitation rates are set.

Georgia Office of Inspector General Visit

On July 17, 2006, Georgia Department of Community Health Inspector General Doug Coburn visited OIG headquarters to gather best practices information on organizational structure, TxHASIT collaborative project with UTD, policy change procedures, fraud investigations, computer algorithms to identify aberrant patterns, and calculation methodologies for cost savings.

CMS Unveils Plan to Take Medicaid Enforcement to a New Level

As a result of the recent enactment of the Deficit Reduction Act of 2005 (DRA), Title VI, signed by the President on February 8, 2006, Public Law 109-171, OIG's extensive information sharing has expanded to include inquiries for DRA subject matter expertise as well as state impact analysis from industry fraud and compliance associations, law enforcement entities, as well as national health care associations.

On July 18, the Center for Medicare & Medicaid Services (CMS) unveiled a sweeping proposal for implementing the Medicaid Integrity Program (MIP) mandated by the Deficit Reduction Act of 2005 (DRA). MIP and its corresponding five-year Comprehensive Medicaid Integrity Plan (CMIP) is "CMS's first national strategy to combat fraud and abuse in the 41-year history of the Medicaid program."

In their initial CMIP, MIP very broadly describes its statutory requirements, philosophy, implementation, strategies, and organizational resources, including the use of contractors "to review the actions of those seeking payment from Medicaid, conduct audits, identify overpayments and educate providers and others on program integrity and quality of care." To fund the new initiative, Congress appropriated $55 million for federal fiscal years (FFY) 2006-2008 and $75 million for each subsequent FFY. In addition, 100 new staff will be assigned to the MIP.

Under the Center for Medicaid and State Operations (CMSO), MIP will oversee state program integrity activities and provide training and technical assistance to the states to combat Medicaid fraud and abuse. The CMIP focuses on the "four key principles of leadership, accountability, collaboration, and flexibility."

Concerns about the inherent conflicts that exist between MIP's duties of exercising oversight and providing technical assistance have been raised in consultations with interested parties. MIP's predecessor, the Medicaid Alliance for Program Safeguards (MAPS), balanced its roles by assigning staff from different geographic areas to state program integrity reviews. MIP plans to use a model similar to that of its predecessor to conduct state program integrity reviews.

According to CMS, MIP will serve as a "bully pulpit" to encourage states and Medicaid providers to enhance their program integrity activities and act as a regulator to enforce "reasonable requirements." The MIP, is expected to significantly impact many Medicaid providers and will result in an increase of four activities including:

1. Review actions of providers to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds in a manner which is not intended,

2. Audit claims for payment for services provided, including audits of cost reports, consulting contracts, and certain risk contracts,
3. Identify overpayments, and
4. Educate providers with respect to payment integrity and quality of care.

The initial CMIP states that MIP will utilize several strategies to ensure the program's success. These strategies consist of collaborating with various internal and external partners, including state program integrity units and federal and state law enforcement agencies, consulting with interested parties during plan development and employing evidence-based planning to identify vulnerabilities within the Medicaid program. CMS has already met with representatives from the:

- Department of Justice
- Federal Bureau of Investigation
- Government Accountability Office
- Office of Inspector General for the Department of Health & Human Services
- National Association of State Medicaid Directors
- National Association of Surveillance & Utilization Review Officials
- Medicaid Fraud & Abuse Technical Advisory Group
- National Association of Medicaid Fraud Control Units

Consultations were also conducted with staff from the U.S. Senate Finance Committee, a subcommittee of the Senate Committee on Homeland Security and Governmental Affairs, and the House Energy and Commerce Committee.

In identifying program vulnerabilities, MIP will initially focus on several areas identified as susceptible to fraud and abuse. These areas include nursing and personal care, prescription drugs to beneficiaries, durable medical equipment and improper claims for payment from hospitals and individual practitioners.

The CMIP also describes the relationship MIP will have with Medi-Medi, the Payment Error Rate Measurement (PERM) project, and providers.

CMS says suspending payments to suspect providers while simultaneously seeking to recover overpayments will be a fundamental part of MIP and that MIP will refer suspect practices and providers to federal and state law enforcement agencies.

Appendix B in the CMIP indicates the PERM findings will be "incorporated" in fiscal year 2009. What this means for the states is unknown. At this point, all that is known is that 20 MIP employees will work on PERM and Medi-Medi under the guidance of the federal Office of Financial Management and that the results of PERM and Medi-Medi will be used to guide future planning for MIP.

Ultimately, MIP plans to use the lessons it learns to develop guidance and directives aimed at fraud prevention. Audits conducted by Medicaid Integrity Contractors (MIC) will take into

consideration both the potential value of individual provider overpayments as well as the potential for prevention-oriented guidance to the states. Through a "carefully crafted audit program," MIP expects to identify "significant overpayments." After identifying vulnerabilities in state Medicaid programs, CMSO will make re-commendations and directives to the states to prevent future improper payments to providers.

As mandated by the DRA, MIP must submit an annual report to Congress detailing the use and effectiveness of the funds allotted to it. To evaluate the effectiveness of MIP, CMS will "describe MIP's return on investment (ROI) for its audit, oversight and technical assistance activities." CMS says it will be "fairly straightforward to report on the actual monies directly recovered through the labors of the Medicaid Integrity Contractors," but "calculating the cost savings or cost avoidance from MIP's other efforts will not be so simple."

In addition, the MIC's will evaluate the various cost savings methodologies used by the states. In the long run, MIP plans to develop "best practices guidance on reporting cost avoidance statistics for program integrity work."

Further, the ROI methodology will be a "conservative and reasonable measure of the value of CMS' anti-fraud and abuse duties." At the same time, MIP "expects a high ROI from its prevention efforts, whether it comes from amending CMSO practices or those of the States."

Historically, the responsibility of identifying and recovering improper Medicaid payments has rested solely on the states. With the enactment of the DRA, CMS has gained substantially more authority and resources to combat Medicaid fraud and abuse. Under the MIP, CMS will use contractors to audit all the way down to the provider level under the guise of supporting state program integrity efforts and improving the overall efficiency and effectiveness of the Medicaid integrity program. In doing this, CMS will effectively create an entirely new process, the effectiveness of which is unknown. HHSC-OIG is continuing to work with other states directly and through the CMS Technical Assistance Group (TAG) to resolve conflicts and gain an understanding of CMS' future intentions. We are also working with various provider, compliance and legal associations to get them the information they need to be in compliance beginning January 1, 2007.

False Claims Act and the Deficit Reduction Act of 2005

To protect the Medicaid system, Congress also added language under the DRA to encourage states to pass their own versions of the federal False Claims Act (FCA). This eliminates a loophole in which the FCA only applies to fraud against the Federal Government, not the states, and therefore does not cover the states' share of Medicaid spending. Specifically, a state that has in

effect a qualifying False Claims Act is now entitled to an increase of ten percentage points in the share of any amounts recovered from an action brought under the Act. Texas is ahead of many other states since it currently has a False Claims Act in place.

Another section contained in this new law transforms the nature of compliance programs from voluntary to mandatory. "Entities" receiving $5 million or more of Medicaid payments are required to establish written policies and procedures for training all employees, contractors, and agents about the following: (1) details of the federal FCA and applicable state counterpart, (2) remedies provided by the FCA laws, (3) whistleblower protections, and (4) policies for preventing and detecting fraud and abuse through the entities compliance program.

Texas Health Analytics System Information Technology Project (TxHASIT)

The Texas Health Analytics System Information Technology (TxHASIT) project is a joint effort between OIG and the University of Texas at Dallas (UTD) to solve vital health and human services issues. In answer to Governor's Perry's call for innovative solutions to waste, abuse, and fraud from all state agencies, Inspector General Brian Flood partnered OIG with UTD to create a one-of-a-kind solution.

The TxHASIT project received recognition by the *Association of Inspectors General* in their *Quarterly Newsletter* and the Spring 2006 issue of *Government Technology*. Both publications exemplified TxHASIT as an example of state agencies working in partnership to come up with innovative solutions to combat waste, abuse, and fraud in the Medicaid program.

Developed by a multifaceted team of HHSC Inspector General Medicaid health care staff experts and UTD computer engineers, data analysts, and social scientists, this project is the first in the United States to implement a program synthesizing technology and Medicaid data. The system works by cross-referencing the massive collection of Texas Medicaid data, including paid and adjusted claims, provider information, and disease incidences with demographic statistics and the state map to discover possible causal links and associations.

Using TxHASIT, patterns will be detected, mapped, and studied for variations from the expected. Not only does this allow program personnel to determine how Texas Medicaid treats a health condition, such as diabetes, but how these treatments can be made more effective and cost-efficient. This analysis can also be used to spot inflated payment requests and unethical providers' efforts to defraud the system.

Staff Presentations

OIG continuously strives to maintain an open dialogue with healthcare associations, collaborative partnerships, and provider groups on issues impacting the healthcare

industry. Speaking engagements during SFY 2006, are listed in a chart by date in Appendix B, Section V-Other OIG Activities

OIG Strategic Planning Development

OIG remains focused on improving internal strategies and aligning business processes to intensify efforts preventing waste, abuse, and fraud and reducing inappropriate program expenditures. For the first six months of SFY 2006, OIG continued strategic planning in order to provide opportunities for strengthening accountability and integrity in the health and human services delivered to Texans. Included in the initial planning framework are a refined vision and mission statement, as well as detailed goals, objectives, and strategies to ensure the most effective and efficient distribution of program functions.

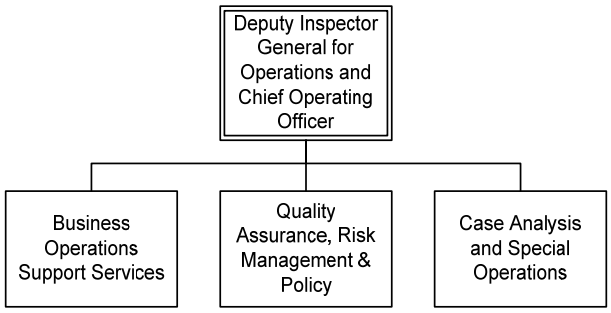
To improve the operational process of identifying and eliminating waste, abuse, and fraud, OIG has increased training, technology, and staff awareness of its role in supporting the overall health and human services purpose and mission. Each employee contributes to the common objective of getting quality services to citizens.

Throughout SFY 2006, OIG will continue to assess and improve the quality of its audits, investigations, reviews, and monitoring through standardization of practices, policies, and ethics; encouragement of professional development by providing educational opportunities; and the establishment of a quality assurance function. OIG is seizing the unprecedented opportunity to draw upon the principles and standards of the National Association of Inspectors General. Audit activity continues to be performed in accordance to the Yellow Book.

Summit 2006

The annual OIG Summit will be held on October 4-7, 2006, in Austin, Texas. Keynote speakers will include leaders from the major national nonprofit anti-fraud associations including: James F. Mathews, President, Association of Inspectors General; National Health Care Anti-Fraud Association Executive Director Lou Saccoccio; and Jim Ratley, President, Association of Certified Fraud Examiners. Summit details will be available in the upcoming semi-annual report covering September 1, 2006, to February 28, 2007.

Operations Division



The Operations division brings together the diverse functions that contribute to the overall organizational effectiveness of OIG. The three sections of Operations – Business Operations and Support Services; Quality Assurance, Risk Management, and Policy; and Case Analysis and Special Operations – create consistency of purpose, uniform action, 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.

Business Operations and Staff Services

The Business Operations and Staff Services section incorporates various business functions to effectively provide support to the organization. Included among these services are:

- Human Resource policy assistance;
- Business operations;
- Building and material management;
- Special project coordination;
- Executive administrative support;
- Contract monitoring;
- Procurement coordination;
- MCO & staff development training; and
- Fleet Management.

This section of OIG manages the formulation and administration of human resources policy and procedures; establishing policies, procedures, and guidelines associated with consistent facility and business support operations; maintaining those standards in all administrative activities for the division and its program sections; establishing and maintaining policies and procedures on all inventories; and establishing and maintaining an accurate accounting of property.

During SFY 2006, Business Operations and Staff Services has contributed valuable assistance in various areas of responsibility. Some examples include:

- Processing approximately 900 personnel actions that include job postings, selections, job audits, and merit requests;
- Coordinating special projects such as the OIG Semi-Annual Report, executive-level investigation summaries, publication of the monthly OIG Newsletter, and compiling testimony summaries presented to Legislatures;
- Attended the consolidation meetings for all nine regions and worked with the regional staff on consolidating OIG staff into one contiguous area in each region;
- Processing approximately 500 procurement requisitions;

- Managing of the OIG 1-800 Fraud Hotline;
- Coordinating the OIG Internship Program;
- Maintaining the OIG Operations Web Site; and
- Monitoring the OIG email fraud referral system.

In addition, Business Operations and Staff Services section was instrumental in furthering the professional development of knowledge and skills among OIG staff. This is accomplished through assessing specific staff training needs, researching the best methodology and sources to meet the needs, then bringing the sources and staff together, to include:

- Increasing OIG staff participation in professional organizations and conferences such as:
  - Association of Inspectors General;
  - Health Care Compliance Association;
  - Association of Certified Fraud Examiners;
  - Association of Certified Fraud Specialists; and
  - National Health Care Anti-Fraud Association.
- Sending staff to or bringing in subject matter experts to train in the following areas:
  - Suing & Defending Government Entities;
  - Advanced Administrative Law;
  - Certified Public Accountant examination review;
  - Hospital Cost Report review;
  - Yellow Book Standards;
  - Advanced Fraud Examination Techniques;
  - Governor's Executive Development; and
  - i2 Analyst Notebook.
- Providing opportunities for leadership and management development including:
  - Teambuilding, Problem Solving, Decision Making, and Project Management through the Governor's Center for Management Development; and
  - Communications, conflict management, teambuilding, and group facilitation through in-house developed and presented workshops.

Case Analysis and Special Operations

Background

OIG created the Case Analysis and Special Operations Section in February 2006, to conduct specialized analysis using advanced software applications to minimize the cost of investigations and maximize the recovery of funds paid due to waste, abuse, and fraud. CASO builds on current data mining techniques using advanced research capabilities and link analysis software to identify all participants and losses in individual cases.

In June 2006, CASO became fully staffed with full time research and link analysis specialists trained to utilize the latest analytical and link analysis software. The link analysis software has the ability to process

large amounts of data to develop and visually display links that are otherwise virtually impossible to detect. The same software provides a case visualization tool that assists in organizing and clarifying relationships and events in complex cases. An example of a link analysis diagram for a case is included in Appendix F. This specialized research and analysis across functional areas will minimize duplication of effort while achieving more effective investigations. CASO is also the core unit for coordinating large specialized investigations and operations, drawing necessary assets from all functional areas.

Case Analysis

Research and Analysis

CASO is now fully operational and is currently providing research, analysis, and link charting in ongoing investigations. CASO has identified and acquired access to over forty databases and information sources to meet this objective. Staff members have completed information analysis and medical data mining training. While the section is in its infancy, the research and analysis completed by the Section has already identified additional participants and links in schemes to defraud the state and developed litigation support materials for the District Attorney's Office to support prosecution of an organized crime case investigated by General Investigations.

Matches

CASO is also responsible for conducting multiple data matches against outside data sources to help identify individuals that are receiving benefits inappropriately. Once these potential frauds and overpayments are identified the information is forwarded to General Investigations for a complete investigation. Currently files are matched with Border States on a monthly and quarterly basis to ensure that recipients are not receiving dual benefits. Matches are run monthly against the federal Prison Verification System and the inmate roles for the Texas Department of Criminal Justice to ensure recipients are not receiving benefits while incarcerated. CASO also matches records against the Bureau of Vital Statistics and Social Security death records to ensure that individuals are not committing identity theft by using the social security numbers of deceased individuals to obtain benefits.

Law Enforcement Assistance

On a case-by-case basis CASO provided assistance to the Texas Department of Public Safety, Police Departments, and Sheriffs' Offices in locating wanted felons. CASO processed over twenty urgent requests from the law enforcement community relating to the tracking of missing persons and fugitives in felony cases.

Missing Children

CASO assists Child Protective Services with the Depart of Family and Protective Services in locating missing children by checking client roles quarterly for missing children. Subsequent to Hurricane Katrina, CASO assisted the National Center for Missing and Exploited Children (NCMEC) in locating approximately 530 displaced individuals living in Texas following the disaster. According to the NCMEC, following the Katrina disaster 6,635 parents and

14,665 children were declared missing. CASO received NCMEC data over a period of five months and ran missing persons data against agency databases to assist in locating missing individuals and reunite them with their families. NCMEC acknowledged and thanked OIG for its efforts.

Policy Development
CASO conducted an in-depth analysis regarding ultrasound utilization for review by experts in the field of obstetrics. The analysis provided the experts adequate data to make policy decisions and develop new rules addressing the appropriate level of care required. Depending on the policy decisions and the rulemaking process the potential savings could range from $1 to $3 million annually.

Special Operations
Department of Information Resources (DIR)
CASO was instrumental in negotiating an exemption with DIR for OIG computer data and hardware. The exemption was necessary to comply with federal statutory requirements. Implementation of this exemption is an ongoing project requiring significant computer data and hardware migration to OIG headquarters. CASO has coordinated this effort with OIG Business Analysis and Support Services, HHSC Commission Information Technology, HHS Enterprise Applications, and DIR. This project will continue until August of 2007 when the DIR vendor will assume full responsibility for all in-scope HHSC servers, except OIGs.

Integrated Eligibility and Enrollment (IEE) and Texas Integrated Enrollment Redesign System (TIERS)
CASO coordinated with OIG General Investigations, OIG Limited Program, OIG Third Party Resources, HHS Enterprise Applications, HHSC Office of Eligibility Services, and the IEE vendor to identify and address issues with IEE and TIERS that would negatively impact OIG's ability to recover recipient overpayments. OIG has worked with all of the participants to implement changes that will permit OIG to continue to recover the approximately 15.8 million dollars recovered annually by General Investigations. Until the changes are implemented, the federally mandated recovery of recipient overpayments by General Investigations is at risk. HHS Enterprise Application delivery dates on known changes and interfaces required for OIG to continue overpayment recovery operations currently reflect completion by August 2007.

Quality Assurance, Risk Management, and Policy

The Quality Assurance, Risk Management, and Policy section upholds OIG conformance to professional standards established by the Association of Inspectors General in the *Principles and Standards for Offices of Inspector General* (Green Book). This section exists to: (1) provide reasonable assurance that OIG processes and work performed adhere to Green Book 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.

Significant contributions of the QA section include:

- Working on Quality Assurance Program protocols and procedures;
- Testing and deploying standardized scoping, sampling, data analysis, and reporting policies, procedures, and tools
- Initiating procedures for and work on the statistical sampling of Provider Cost Reports and OIG Quality Control Reviews of State-contracted A-133 Audits;
- Executing protocols for initial analysis and reporting on OIG structure, functions, interfaces, and culture;
- Developing and deploying Business Process Risk Assessments;
- Coordinating OIG's Annual Internal Audit Risk Assessment;
- Designing and deploying methodologies, tools, and techniques for the conduct of Pharmacy Audits;
- Reviewing, commenting on, and clarifying the policy and resource impact of recent and proposed Federal legislation;
- Assisting OIG staff with responses to external requests for information and various projects and initiatives (e.g., Business Impact Analysis, administrative rules, conflict of interest statement, MCO-SIU sampling protocols, legislation, policies, special reports, and various contract provisions and amendments);
- Developing automated means for the collection, analysis, norming, trending, and reporting of OIG division and unit performance information;
- Initiating work on the integration and automation of processes for gathering and reporting OIG performance data and the Semi-Annual Report;
- Advising, and providing technical support to MCO-SIU's in sampling, data analysis, and reporting pertinent to fraud, waste, and abuse;
- Advising and providing technical support to HHSC agencies in their evaluation of vendor responses to Requests for Proposals;
- Training

Beyond these, QA staff will continue to study OIG's functions and operations, feed this information back to management and staff, and produce an office-wide quality assurance protocol.

Policy Initiatives

OIG understands that policy improvement recommendations play a vital role in furthering progress towards preventing waste, abuse, and fraud in health and human services and reducing inappropriate program expenditures. OIG continually assesses and recommends policies to strengthen fraud prevention and elimination efforts, as mandated in Government Code § 531.102(h)(6) directing the office to "recommend policies promoting economical and efficient administration of the funds described by Subdivision (4) and the prevention and detection of fraud and abuse in administration of those funds." Working collaboratively with HHSC Medicaid/CHIP and other divisions, OIG is aiding in the planning and imple-

mentation of several medical policy changes that will result in a cost savings by reducing, waste, abuse and fraud.

On March 10, 2006, the Office of Inspector General (OIG) notified the Health and Human Services Commission (HHSC) Medicaid/CHIP Division regarding problems in the provider enrollment process administered by Texas Medicaid and Healthcare Partnership (TMHP). Three areas of concern were noted including TMHP's (1) failure to verify required licensure information, (2) failure to check OIG's open investigations list, and (3) the erroneous enrollment of out-of-state providers. TMHP provided a response to OIG which included several lists of providers who were issued additional billing numbers while the providers were on OIG's open investigations list. To date, these "potential inappropriate payments" total in excess of $32 million. Currently, the OIG Audit Section is conducting an audit of TMHP's provider enrollment process with an expected date of completion in December 2006.

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 & 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 or 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 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
- How to report potential Medicaid fraud, abuse, or waste.

MCO-SIU Training

In November 2005, HHSC Medicaid/CHIP executed new joint procurement contracts with Medicaid/CHIP managed care organizations (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 Distance Learning Program

OIG renewed its contract with Texas State University (TSU) for the purposes of providing Medicaid fraud and abuse training. Under the provisions of section 531.105 of the Government Code, HHSC provides Medicaid fraud and abuse training to Medicaid contractors, providers, their employees, and to state agencies that are involved in the administration of health and human services programs on the identification and referral of abuse, or waste in the Medicaid Program.

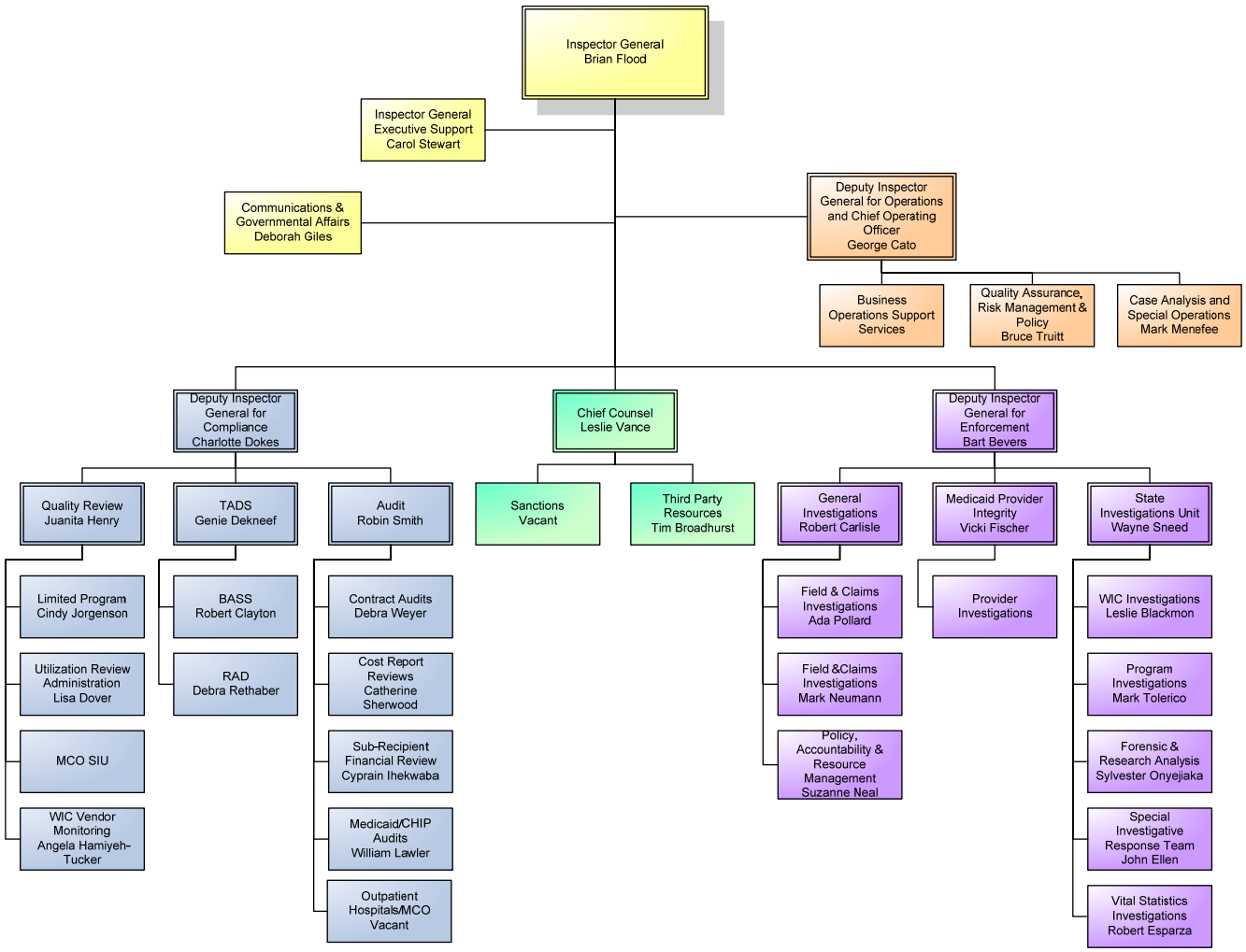
The objectives of HHSC/OIG training are to educate and inform about:

- 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.

Individuals who are required to take the Texas Index of Level of Effort (T.I.L.E.) training course may take the fraud-training component as part of the T.I.L.E. training course. The Fraud/T.I.L.E. 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 Waiver Program (CBA).

HHSC-OIG, in cooperation with TSU has made the Fraud/ T.I.L.E. 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/

Appendix A—OIG Organizational Chart



Appendix B—OIG Detailed Statistics

Section I—OIG Recovery Activity[8]

Recovery Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Sanctions-Overpayments[9]	$3,430,511	$5,262,123	$4,984,828	$2,123,778	**$15,801,240**
Sanctions-Civil Monetary Penalties (CMP)	$870,353	$782,316	$1,246,639	$296,034	**$3,195,342**
Utilization Review (Hospitals)	$5,423,360	$6,664,393	$3,865,640	$2,411,400	**$18,364,793**
Utilization Review (Nursing Homes)	$4,740,410	$4,492,000	$4,063,792	$3,944,516	**$17,240,718**
Third Party Recoveries[10]	$92,701,213	$85,603,992	$98,005,469	$98,148,972	**$374,459,646**
Technology Analysis, Development & Support (TADS)	$1,101,299	$726,319	-$164,073[11]	-$66,571[11]	**$1,596,974**
General Investigations (Food Stamps, TANF, and Medicaid Recipients)	$2,878,108	$5,335,346	$5,424,780	$2,186,706	**$15,824,940**
WIC Investigation Recoveries	$12,427	$10,611	$5,936	$2,731	**$31,705**
WIC Vendor Monitoring	$1,013[12]	$1,371[13]	$443	$69,924	**$72,751**
Audit Activity	$61,940	$0	$0	$0	**$61,940**
Internal Affairs	$0	$0	$0	$0	**$0**
Total Recovery Activity	**$111,220,634**	**$108,878,471**	**$117,433,454**	**$109,117,490**	**$446,650,049**

[8] Total recoveries reflect all dollars collected during the quarter. Other insurance credits are included in Third Party Recoveries.

[9] Due to a reduction in the recovery of overpayments and CMPs from Global Settlements, there was a significant percentage change in the Sanctions Unit's recovery of these dollars in FY 2006. Global Settlements are initiated and driven by other enforcement agencies such as the Office of the Attorney General and the U.S. Department of Justice. A percentage change comparison of these recoveries, inclusive and exclusive of Global Settlements, as well as other Sanctions Unit activities for FY 2006 and FY 2005, is provided in Section III – Sanctions Unit FY 2006/2005 Percentage Comparison.

[10] Consistent with HHSC reports to CMS, other insurance credits are reported as a recovery. These are recoveries made by the provider resulting from insurance information provided to providers by the Claims Administrator.

[11] Recoveries for these quarters are showing as negative due to a payout of $1,365,905 to reimburse providers for overpayments previously recovered and reported. This payout is the result of an Inspector General decision to not pursue the recoveries related to delinquent dental licensure status.

[12] The amount previously reported for this quarter did not include Farmer's Markets' activities and all recoveries.

[13] The amount previously reported for this quarter was incorrect due to calculation errors.

Section II—OIG Cost Avoidance[14]

Cost Avoidance Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Sanctions	$264,104	$705,423	$13,973,476	$32,072,438	**$47,015,441**
TADS Provider Prepayment Review Process	$45,132	$50,856	$96,950	$64,957	**$257,895**
Third Party Resources	$76,366,334	$68,467,589	$67,467,570	$62,299,482	**$274,600,975**
Disqualifications (Food Stamps & TANF Recipients)	$587,988	$417,324	$732,636	$664,008	**$2,401,956**
Income Eligibility Verification System (IEVS) Data Matches (Food Stamps, TANF and Medicaid Recipients)	$172,466	$375,199	$363,062	$210,300	**$1,121,027**
Recipient Data Matches (Food Stamps, TANF and Medicaid Recipients)	$124,061	$111,001	$110,392	$156,534	**$501,988**
Audit Activities	$4,164,405	$8,717,707	$131	$8,041,881	**$20,924,124**
WIC Vendor Monitoring	$798	$688	$2,182	$904	**$4,572**
CORF/ORF	$8,500,894	$8,500,893	$8,500,894	$8,500,893	**$34,003,574**
Potential Identified Inappropriate Payments	$0	$0	$0	$32,000,000	**$32,000,000**
Total Cost Avoidance	**$90,226,182**	**$87,346,680**	**$91,247,293**	**$142,285,612**	**$411,105,767**

[14] Cost avoidance represents a reduction to a State expenditure that would have occurred or was anticipated to occur without OIG intervention.

Section III—Sanctions Unit SFY 2006/2005 Percentage Comparison

Sanctions Unit Overpayment/CMP Recovery Activities

Recovery Category	Total SFY 2005	Total SFY 2006	Percentage Changes
Sanctions (Overpayments)[15]	$33,782,310	$15,801,240	**-53%**
Sanctions (Civil Monetary Penalties (CMPs))	$13,045,838	$3,195,342	**-76%**
Totals	**$46,828,148**	**$18,996,582**	**-59%**
Recovered Overpayments from Global Settlements	$26,281,112	$3,658,310	**-86%**
Recovered CMPs from Global Settlements	$12,768,763	$1,427,648	**-89%**
Total Recovered Overpayments and CMPs from Global Settlements	$39,049,875	$5,085,958	**-87%**
Recovered Overpayments *Minus* Global Settlement Amounts	$7,778,273	$13,910,624	**79%**
Recovered CMPs *Minus* Global Settlement Amounts	$277,075	$1,767,694	**538%**
Total Recovered Overpayments and CMPs *Minus* Global Settlement Amounts	$8,055,348	$15,678,318	**95%**

Cost Avoidance

Cost Avoidance Category	Total SFY 2005	Total SFY 2006	Percentage Change
Sanctions Unit	$3,881,784	$47,015,441	**1111%**

Sanctions Unit Other Activities

Sanctions Summary Category	Total SFY 2005	Total SFY 2006	Percentage Changes
Cases Opened	440	628	**43%**
Cases Closed	593	659	**11%**
Cases Referred to OAG	3	5	**67%**
Exclusions	308	498	**62%**
Payment Holds	5	30	**500%**

[15] The overpayment amount reported in the OIG Recovery Activity table in the March and September 2005 Semi-Annual Reports was incorrect. The total reported for the year in the September 2005 Semi-Annual Report was $46,828,148. This amount was overstated by $13,045,838 because it inadvertently included the recovery of Civil Monetary Penalties reported on the next line item in the table. This overstatement represents only 3% of OIG's total recoveries for SFY 2005. The correct SFY 2005 recovered overpayment of $33,782,310 is being used in this comparison.

Section IV—OIG Summary Tables

Sanctions

Sanctions Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Cases Opened	61	162	397	8	**628**
Cases Closed	81	119	310	149	**659**
Cases Referred to Attorney General	0	0	2	3	**5**
Overpayments Recovered	$3,430,511	$5,262,123	$4,984,828	$2,123,778	**$15,801,240**
Exclusions	54	77	252	115	**498**
Payment Holds	2	4	23	1	**30**
Civil Monetary Penalties Recovered	$870,354	$782,316	$1,246,639	$296,033	**$3,195,342**
Cost Avoidance	$264,104	$705,423	$13,973,476	$36,678,492	**$51,621,495**

Third Party Resources (TPR)

TPR Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Cost Avoidance	$76,366,334	$68,467,589	$67,467,570	$62,299,482	**$274,600,975**
Other Insurance Credits	$68,074,513	$56,649,616	$68,366,711	$69,376,172	**$262,467,012**
Provider/Recipient Refunds	$1,736,658	$1,614,808	$1,274,032	$1,356,845	**$5,982,343**
Texas Automated Recovery System (TARS)	$7,211,447	$5,538,462	$7,516,112	$6,556,344	**$26,822,365**
Pharmacy	$5,075,033	$10,030,210	$6,592,165	$5,991,784	**$27,689,192**
PPRA	$682,114	$462,329	$271,764	$1,280,937	**$2,697,144**
Credit Balance Audit	$3,033,886	$3,096,421	$3,501,134	$3,359,865	**$12,991,306**
Tort	$4,275,232	$5,308,859	$4,674,894	$6,573,353	**$20,832,338**
Cash Medical Support	$2,612,330	$2,903,287	$5,808,657	$3,653,672	**$14,977,946**
Total Third Party Recovery Activity	**$169,067,547**	**$154,071,581**	**$165,473,039**	**$160,448,454**	**$649,060,621**

General Investigations

General Investigations Summary Activity	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Collections[16]	$2,878,108	$5,335,346	$5,424,780	$2,186,704	**$15,824,938**
Disqualification Cost Avoidance[17]	$587,988	$417,324	$732,636	$664,008	**$2,401,956**
Cost Avoidance Income Eligibility Verification System (IEVS) Data Matches[18]	$172,466	$375,199	$363,062	$210,300	**$1,121,027**
Cost Avoidance Recipient Data Matches[18]	$124,061	$111,001	$110,392	$156,534	**$501,988**
Referrals/Complaints Received	12,880	16,007	18,872	17,053	**64,812**
Cases Completed	14,567	15,159	12,646	16,963	**59,335**
Percent of Cases Completed w/in 180 Days	90.50%	86%	87%	79%	**85.63%**
Cases Referred for Prosecution[19]	571	832	1,595	1722	**4,720**
Admin. Disqualification Hearings (ADH) Cases Completed	1,220	1,397	1,782	2,369	**6,768**
Cases Adjudicated	493	359	457	503	**1,812**
Civil Disqualifications	1,266	925	1753	1,708	**5,652**
Income Eligibility and Verification System (IEVS) Matches Cleared	33,522	36,331	54,957	44,336	**169,146**
Recipient Data Matches Cleared	4,275	3,825	3,804	5,394	**17,298**

[16] Collection activity is the responsibility of HHSC Fiscal Division and is based on Claims Established by General Investigations.

[17] Disqualification cost avoidance is based on an average monthly savings per client.

[18] IEVS and recipient data match cost avoidance is based on an average case savings.

[19] First quarter numbers have been updated to include investigations in an additional category on the detail report, which were not previously reported.

GI-Food Stamp Investigations

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Claims Established[20]	$2,587,148	$3,122,866	$4,376,507	$6,728,728	**$16,815,249**
Collections	$2,406,192	$4,819,946	$4,765,558	$1,770,805	**$13,762,501**
Disqualification Cost Savings	$546,324	$379,692	$697,692	$639,816	**$2,263,524**
Cases Referred for Prosecution	385	580	1,118	1,251	**3,334**
ADH Cases Completed	1,064	1,229	1,602	2,143	**6,038**
Civil Disqualifications	1,061	760	1,523	1,516	**4,860**

GI-TANF Investigations

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Claims Established[20]	$591,049	$598,284	$626,972	$673,675	**$2,489,980**
Collections	$300,980	$357,633	$402,489	$234,309	**$1,295,411**
Disqualification Cost Savings	$41,664	$37,632	$34,944	$24,192	**$138,432**
Cases Referred for Prosecution	77	94	174	167	**512**
ADH Cases Completed	156	165	180	226	**727**
Civil Disqualifications	205	165	230	192	**792**

GI-Medicaid Investigations[21]

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Claims Established[20]	$212,252	$319,986	$629,853	$609,084	**$1,771,175**
Collections	$170,936	$157,767	$256,734	$181,591	**$767,028**
Cases Referred for Prosecution	103	152	287	303	**845**
ADH Cases Completed	0	3	0	0	**3**

[20] Due to an error within the Accounts Receivable System reporting system 1st and 2nd Quarter numbers have been corrected.

[21] Two Medicaid descriptive categories (1) "Disqualification Cost Savings" and (2) "Civil Disqualifications" have been deleted because there is no statutory authority for those actions.

GI-IEVS

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
IEVS Food Stamp Matches	27,852	30,599	48,357	38,167	**144,975**
IEVS TANF Matches	1,106	1,065	1,220	1,201	**4,592**
IEVS Medicaid Matches	4,564	4,667	5,380	4,967	**19,578**
TOTAL	**33,522**	**36,331**	**54,957**	**44,335**	**169,145**

GI-CHIP Investigations[22]

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
CHIP Investigations	0	0	0	0	0

GI-Other Investigations[23]

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Other Investigations	6	6	16	1	29

GI-Other Matches

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Other Data Matches Cleared	4,275	3,825	3,804	5394	**17,298**

[22] During the fourth quarter a limited number of General Investigations staff received access to the Maxie CHIP database and are pending training on use of the technology.

[23] This category has been created to capture other recipient fraud investigations which do not include Food Stamps, TANF, and Medicaid.

Medicaid Provider Integrity (MPI)

MPI Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Cases Opened	235	203	210	152	**800**
Cases Closed	74	71	80	79	**304**
Cases Referred to Attorney General	20	70[24]	110	56	**256**
Criminal History Checks Conducted	0	4,090	3,534	2,542	**10,166**

MPI and Sanctions Waste, Abuse, and Fraud Referrals Received (March 1 – August 31, 2006)

Referral Source	Received
Health & Human Service, Office of Inspector General	1
US Department of Justice	1
Anonymous	27
Attorney	1
OIG Hotline	69
Managed Care Organization/Special Investigative Unit[25]	17
Parent/Guardian	29
Provider	16
Provider Self Reported	6
Public	28
Recipient	58
Texas Medicaid Healthcare Partnership	9
Attorney General's Medicaid Fraud Control Unit	3
Department of Aging & Disability Services	28
Dept of Assistive & Rehabilitative Services	1
Dept of Family & Protective Services	1
MP Self-initiated	52
OIG Internal Affairs	1
HHSC Office of the Ombudsman	1
Texas Department of Health	1
Texas Health STEPS	5
Utilization Review Division	3
Vendor Drug	2
Total:	**360**

[24] One referral was inadvertently omitted from previous report submitted May 2006.

[25] Includes seven additional cases inadvertently omitted during the 1st and 2nd quarter reporting for SFY 2006, issued in May 2006.

MPI and Sanctions Waste, Abuse, and Fraud Referrals Sent (March 1 – August 31, 2006)

Referral Source	Referred
AG Medicaid Fraud Control Unit	167
Board of Dental Examiners	15
Board of Licensed Vocational Nurse Examiners	1
Board of Medical Examiners	5
Board of Nurse Examiners	1
Board of Optometry	1
Board of Pharmacy	2
Claims Admin-Educational Contact	35
Dept of Aging & Disability (DADS)	18
DPRS	1
Health & Human Service, Office of Inspector General	1
HHSC OIG Audit	1
HHSC OIG Internal Affairs	1
Medicare Part A & B	26
Office of Inspector General (Recipient Fraud)	1
Palmetto GBA	2
Research, Analysis & Detection (RAD)	1
Texas Dept of State Health Services (DSHS)	1
TX DOT	5
US Dept of Labor	1
Vendor Drug	3
Total:	**289**

State Investigations Unit (SIU)

SIU Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Complaints Received	91	84	103	118	**396**
Investigations Completed	60	26	106	67	**259**
Dollars Recovered	$0	$0	$0	$0	**$0**
Cases Referred	2	4	16	0	**22**

WIC Investigations

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Referrals/Complaints Received	45	65	47	28	**185**
Cases Opened	61	35	47	20	**163**
Cases Closed	48	43	36	3	**130**
Claims Established	$36,317	$25,643	$13,841	$4,817	**$80,618**
Collections	$12,427	$10,611	$5,936	$2,731	**$31,705**
Cases Adjudicated	2	1	0	2	**5**

Audit

Sub-Recipient Financial Review

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Desk Audits	216	139	239	211	**805**
Rejected Single Audits	30	4	12	6	**52**
Quality Control Reviews[26]	0	0	2	14	**16**

Medicaid/CHIP Audit

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Audits	0	0	0	1	**1**
Recoupments & Recovery	$0	$0	$0	$0	**$0**
Cost Avoidance	$260,000	$0	$0	$0	**$260,000**
Recipient Refunds	$0	$0	$0	$0	**$0**

[26] A Quality Control Review (QCR) is a review of selected CPA Firms located across the state of Texas to determine whether the CPA Firm conducted the Single Audit of subrecipients in accordance with standards and other requirements set forth in the Yellow Book and/or OMB Circular A-133 reporting requirements. Reports for 16 quality control reviews were related in the second half of SFY 2006, in which these reviews were originally combined with the Number of Desk Audits performed.

Contract Audit

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Audits	1	1	23	18	**43**
Recoupments & Recovery	$61,940	$0	$0	$0	**$61,940**
Identified for Recovery[27]	$0	$0	$283,705	$0	**$283,705**
Cost Avoidance	$0	$0	$0	$0	**$0**
Recipient Refunds	$0	$566	$9,785	$9,388	**$19,739**

Cost Report Review

Summary	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Audits	72	45	0	26	**143**
Number of Desk Reviews	379	280	2	347	**1008**
Cost Avoidance	$3,904,405	$8,717,707	$131	$8,041,881	**$20,664,124**

[27] Overpayments of Personal Needs Allowance made to Intermediate Care Facility residents. The program agency is responsible for the recovery of these funds.

Utilization Review (UR)

UR Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Hospitals - Recoveries	$5,423,360	$6,664,393	$3,865,640	$2,411,400	**$18,364,793**
Hospitals – Underpayments	$16,450	$11,660	$19,391	$3,313	**$50,814**
Nursing Homes – Recoveries	$4,740,410	$4,492,000	$4,063,792	$3,944,516	**$17,240,718**
Nursing Homes – Underpayments	$201,899	$178,039	$228,123	$113,285	**$721,346**
Nursing Homes– Facilities Visited	245	197	278	266	**986**
Nursing Homes - # of Forms Reviewed	9,309	8,082	12,032	10,660	**40,083**
Nursing Homes - # of Facilities Placed on Vendor Hold	17	11	16	23	**67**
Hospitals – Mail-ins	216	213	176	199	**804**
Hospitals – Facilities Visited	83	62	46	71	**262**
Hospitals - # of Claims Reviewed	7,116	6,324	4,142	9,289	**26,871**

WIC Vendor Monitoring

WIC Vendor Monitoring Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Compliance Buys Conducted	80[28]	106[28]	144	114	**444**
Number of In-Store Evaluations	17[28]	23	15	176[29]	**231**
Number of Audits Closed	21[30]	14	24	18	**77**
Vendor/Grocer Overcharges	$798[28]	$688[28]	$2,182	$904	**$4,572**
Dollars Recouped	$199[28]	$0	$27	$208	**$434**
Civil Monetary Penalties	$814	$1,371	$417	$69,716[31]	**$72,318**

[28] The amounts previously reported did not include Farmer's Markets' activities and all recoveries.
[29] The increase in in-store evaluations during the 4th quarter was due to (1) monitors were primarily conducting compliance buys during the earlier quarters; (2) some evaluations had to be delayed due to EBT rollout; and, (3) the Farmer's Markets' Evaluations are conducted during the 4th quarter due to seasonal participation
[30] The amount previously reported for this quarter was incorrect due to calculation errors.
[31] CMP recoveries increased during the 4th quarter due to the settlement of three unusually large cases.

Limited Program

Lock-In Summary Category	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.
Fee-for-Service (FFS)	224	217	216	218	216	229	228	232	236	239	249	253
STAR (Rx Only)	226	228	220	224	228	209	209	214	218	214	207	208
STAR+PLUS (Rx Only)	51	53	49	52	50	51	52	50	52	50	53	55
Total Limited Program Activity	**501**	**498**	**485**	**494**	**494**	**489**	**489**	**496**	**506**	**503**	**509**	**516**

Technology Analysis, Development and Support (TADS)

TADS Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Cases Opened	425	1,302	494	1,141	**3,362**
Cases Closed	672	1,138	669	743	**3,222**
Cases Referred to Attorney General	0	1	1	0	**2**
Dollars Recovered	$1,101,299	$726,319	($164,073)[32]	($66,571)[32]	**$1,596,974**
Cost Avoidance Due to Provider Prepayment Review Process (all OIG)	$45,132	$50,856	$96,650	$64,957	**$257,595**

[32] Recoveries for these quarters are showing as negative due to a payout of $1,365,905 to reimburse providers for overpayments previously recovered and reported. This payout is the result of an Inspector General decision to not pursue the recoveries related to delinquent dental licensure status.

Section V—County Data

County Data[33]

Code	County	Cases Open	Cases Closed	Recovery
1	Anderson	11	6	$297
2	Andrews	3	4	$686
3	Angelina	16	10	$21,154
4	Aransas	2	2	$0
5	Archer	2	1	$0
6	Armstrong	0	0	$0
7	Atascosa	5	3	$32
8	Austin	1	3	$236
9	Bailey	0	0	$0
10	Bandera	4	1	$0
11	Bastrop	9	8	$450
12	Baylor	2	1	$359
13	Bee	5	5	$0
14	Bell	44	34	$9,887
15	Bexar	287	232	$13,318
16	Blanco	0	1	$0
17	Borden	0	0	$0
18	Bosque	2	1	$0
19	Bowie	19	18	$2,245
20	Brazoria	28	19	($10,091)
21	Brazos	25	24	$10,017
22	Brewster	3	2	$217
23	Briscoe	0	0	$0
24	Brooks	4	0	$0
25	Brown	15	14	$3,096
26	Burleson	4	3	$0
27	Burnet	6	3	$493
28	Caldwell	8	1	$105
29	Calhoun	3	2	$550
30	Callahan	0	0	$0
31	Cameron	124	96	$464,768

[33] County data is based on aggregated cases from the following sections in OIG: Audit, MPI, Sanctions, TADS, WIC Vendor Monitoring, and WIC Investigations. County data reports were available December 1, 2005 and will be included in subsequent quarters.

Code	County	Cases Open	Cases Closed	Recovery
32	Camp	0	0	$0
33	Carson	2	0	$0
34	Cass	5	3	$458
35	Castro	1	1	$0
36	Chambers	2	1	$20,000
37	Cherokee	14	8	$2,414
38	Childress	1	2	$121
39	Clay	2	1	$203
40	Cochran	1	1	$104
41	Coke	0	0	$0
42	Coleman	0	1	$0
43	Collin	63	30	($2,532)
44	Collingsworth	0	1	$103
45	Colorado	4	2	$350
46	Comal	13	10	$1,925
47	Comanche	1	1	$0
48	Concho	0	0	$0
49	Cooke	3	3	$415
50	Coryell	4	5	$192
51	Cottle	0	0	$0
52	Crane	0	0	$0
53	Crockett	1	0	$0
54	Crosby	2	2	$948
55	Culberson	0	0	$0
56	Dallam	1	1	$575
57	Dallas	329	264	$246,595
58	Dawson	0	1	$0
59	Deaf Smith	3	2	$1,182
60	Delta	1	0	$0
61	Denton	42	22	($2,586)
62	Dewitt	5	4	$185
63	Dickens	0	0	$0
64	Dimmit	1	0	$0
65	Donley	1	0	$0
66	Duval	0	0	$0
67	Eastland	2	0	$0
68	Ector	30	18	$4,632

Code	County	Cases Open	Cases Closed	Recovery
69	Edwards	0	0	$0
70	Ellis	14	11	$1,984
71	El Paso	113	93	$281,637
72	Erath	20	13	$462
73	Falls	3	1	$0
74	Fannin	3	3	$0
75	Fayette	3	2	$0
76	Fisher	1	0	$0
77	Floyd	1	0	$0
78	Foard	2	2	$0
79	Fort Bend	42	24	$5,493
80	Franklin	0	1	($173)
81	Freestone	1	1	$0
82	Frio	5	2	$192
83	Gaines	1	2	$728
84	Galveston	25	32	$9,963
85	Garza	0	0	$0
86	Gillespie	3	3	($790)
87	Glasscock	0	0	$0
88	Goliad	1	1	$0
89	Gonzales	2	2	$28
90	Gray	6	4	$853
91	Grayson	20	16	$2,491
92	Gregg	41	35	$12,531
93	Grimes	2	0	$0
94	Guadalupe	17	4	$375
95	Hale	15	6	$647
96	Hall	0	0	$0
97	Hamilton	0	0	$0
98	Hansford	0	3	$415
99	Hardeman	1	2	$0
100	Hardin	5	2	$0
101	Harris	643	486	$979,158
102	Harrison	9	7	$716
103	Hartley	3	0	$0
104	Haskell	2	1	$0
105	Hays	11	7	$265

Code	County	Cases Open	Cases Closed	Recovery
106	Hemphill	0	0	$0
107	Henderson	14	10	$2,728
108	Hidalgo	220	143	$1,826,213
109	Hill	4	5	$550
110	Hockley	7	8	$1,520
111	Hood	5	3	$156
112	Hopkins	6	5	$466
113	Houston	12	9	$556
114	Howard	13	5	$466
115	Hudspeth	0	0	$0
116	Hunt	6	12	$1,601
117	Hutchinson	5	1	$202
118	Irion	0	0	$0
119	Jack	1	2	$205
120	Jackson	0	0	$0
121	Jasper	12	9	$2,356
122	Jeff Davis	3	1	$248
123	Jefferson	93	53	$265,781
124	Jim Hogg	2	0	$0
125	Jim Wells	11	11	$1,715
126	Johnson	36	4	$0
127	Jones	9	2	$361
128	Karnes	0	1	($3,054)
129	Kaufman	11	10	$238
130	Kendall	6	4	$133
131	Kenedy	0	0	$0
132	Kent	0	0	$0
133	Kerr	13	12	($603)
134	Kimble	2	0	$0
135	King	0	0	$0
136	Kinney	0	0	$0
137	Kleberg	7	4	($29,814)
138	Knox	0	0	$0
139	Lamar	15	8	$2,248
140	Lamb	1	2	$0
141	Lampasas	2	3	$0
142	La Salle	4	5	$254

Code	County	Cases Open	Cases Closed	Recovery
143	Lavaca	0	0	$0
144	Lee	0	2	$0
145	Leon	0	0	$0
146	Liberty	18	10	$4,536
147	Limestone	7	4	$734
148	Lipscomb	0	0	$0
149	Live Oak	1	1	$0
150	Llano	3	2	$192
151	Loving	0	0	$0
152	Lubbock	73	36	$4,766
153	Lynn	2	0	$0
154	Madison	3	0	$0
155	Marion	2	2	$0
156	Martin	0	0	$0
157	Mason	0	0	$0
158	Matagorda	8	5	$1,823
159	Maverick	17	16	$307,184
160	McCullough	1	2	$286
161	McLennan	35	31	($102,229)
162	McMullen	0	0	$0
163	Medina	14	8	$773
164	Menard	0	0	$0
165	Midland	18	20	$786,623
166	Milam	4	4	$3,810
167	Mills	3	1	$0
168	Mitchell	1	2	$1,630
169	Montague	0	2	$278
170	Montgomery	27	21	$3,397
171	Moore	3	2	$126
172	Morris	0	1	$0
173	Motley	0	0	$0
174	Nacogdoches	23	18	$5,407
175	Navarro	11	8	$3,312
176	Newton	0	2	$122
177	Nolan	4	5	$944
178	Nueces	97	63	$54,032
179	Ochiltree	5	2	$235

Code	County	Cases Open	Cases Closed	Recovery
180	Oldham	0	0	$0
181	Orange	12	7	($2,030)
182	Palo Pinto	4	3	$389
183	Panola	2	3	$921
184	Parker	6	2	($13,245)
185	Parmer	3	2	$707
186	Pecos	2	5	$2,847
187	Polk	6	5	$1,673
188	Potter	57	50	$73,687
189	Presidio	1	0	$0
190	Rains	0	0	$0
191	Randall	4	1	$0
192	Reagan	0	0	$0
193	Real	2	4	$3,544
194	Red River	1	2	$0
195	Reeves	3	2	$172
196	Refugio	3	4	($3,512)
197	Roberts	0	0	$0
198	Robertson	1	0	$0
199	Rockwall	5	2	$0
200	Runnels	0	0	$0
201	Rusk	9	4	$129
202	Sabine	0	0	$0
203	San Augustine	2	2	$117
204	San Jacinto	3	1	$129
205	San Patricio	19	14	$3,092
206	San Saba	0	0	$0
207	Schleicher	0	0	$0
208	Scurry	2	3	$259
209	Shackelford	0	0	$0
210	Shelby	9	11	$0
211	Sherman	1	1	$0
212	Smith	52	26	$16,849
213	Somervell	0	1	$0
214	Starr	11	10	$63,443
215	Stephens	0	1	$0
216	Sterling	0	0	$0

Code	County	Cases Open	Cases Closed	Recovery
217	Stonewall	0	0	$0
218	Sutton	1	1	$136
219	Swisher	1	1	$0
220	Tarrant	193	142	$7,363
221	Taylor	55	35	$5,322
222	Terrell	1	0	$0
223	Terry	2	0	$0
224	Throckmorton	0	0	$0
225	Titus	6	4	$75,664
226	Tom Green	70	24	$12,659
227	Travis	148	121	($200,096)
228	Trinity	1	1	$352
229	Tyler	4	9	$0
230	Upshur	2	0	$0
231	Upton	1	1	$186
232	Uvalde	10	5	$3,544
233	Val Verde	13	5	$587,971
234	Van Zandt	2	4	$276
235	Victoria	30	19	$5,586
236	Walker	7	5	$267
237	Waller	5	1	$0
238	Ward	2	1	$0
239	Washington	4	3	$726
240	Webb	57	39	$54,044
241	Wharton	5	6	$314
242	Wheeler	1	0	$0
243	Wichita	27	23	$1,805
244	Wilbarger	4	1	$0
245	Willacy	1	2	($7,842)
246	Williamson	31	22	$3,680
247	Wilson	8	3	$0
248	Winkler	1	1	$674
249	Wise	4	2	$279
250	Wood	5	7	($15,751)
251	Yoakum	0	1	$0
252	Young	14	3	$1,904
253	Zapata	0	1	$1,272

Code	County	Cases Open	Cases Closed	Recovery
254	Zavala	2	3	$397
	Unknown Co.	48	51	$2,557,590
	Multiple Co.	8	0	$0
	Out of State	46	23	$3,409
	Total	**4121**	**2982**	**$8,493,490**

Utilization Review County Data

		Hospital Reviews[34]			Nursing Facility Reviews[35]		
Code	County	Cases Opened	Cases Closed	Recovery	Cases Opened	Cases Closed	Recovery
1	Anderson	2	2	$19,889.85	1	1	$3,015.74
2	Andrews	1	1	$0.00	1	1	$128.25
3	Angelina	2	2	$38,366.58	4	4	$93,171.36
4	Aransas	1	1	$7,347.71	2	2	$99,365.11
5	Archer	0	0	$0.00	0	1	$3,213.24
6	Armstrong	0	0	$0.00	1	1	$5,295.60
7	Atascosa	1	1	$0.00	2	3	$55,044.23
8	Austin	1	1	$3,946.70	0	0	$0.00
9	Bailey	1	1	$6,322.65	0	0	$0.00
10	Bandera	0	0	$0.00	1	1	$4,056.55
11	Bastrop	1	1	$0.00	2	3	$81,774.44
12	Baylor	1	1	$0.00	0	0	$0.00
13	Bee	1	1	$4,361.56	1	1	$4,794.28
14	Bell	3	3	$10,634.07	7	6	$17,391.23
15	Bexar	11	10	$1,096,902.67	31	28	$732,878.90
16	Blanco	0	0	$0.00	1	2	$3,567.10
17	Borden	0	0	$0.00	0	0	
18	Bosque	1	1	$0.00	4	3	$20,476.62
19	Bowie	1	1	$0.00	6	6	$88,068.85
20	Brazoria	2	2	$30,247.44	5	4	$53,579.50
21	Brazos	2	2	$33,308.95	1	2	$8,291.60
22	Brewster	1	1	$17,391.33	1	1	$3,663.95
23	Briscoe	0	0	$0.00	0	0	$0.00
24	Brooks	0		$0.00	0	0	$0.00
25	Brown	1	1	$20,636.53	4	5	$71,988.01
26	Burleson	1	1	$0.00	1	1	
27	Burnet	1	1	$0.00	2	2	$5,321.85
28	Caldwell	1	1	$0.00	4	2	$3,867.52
29	Calhoun	2	2	$6,546.65	0	0	$0.00
30	Callahan	0	0	$0.00	0	0	$0.00
31	Cameron	5	6	$141,778.74	6	6	$32,587.65
32	Camp	1	1	$0.00	0	0	$0.00
33	Carson	0	0	$0.00	1	0	$0.00

[34] Hospital Reviews: Cases Opened are based on UR Nurse Reviewer review dates between March 1, 2006 and August 31, 2006. Cases Closed are based on claim closed (status) date or account receivable recovered date.

[35] Nursing Facility Reviews: Cases Opened are based on UR Nurse Reviewer dates between March 1, 2006 and August 31, 2006. Cases Closed represents nursing facilities where no TILE changes were made or recoupments have been processed and dollars recovered between March 1, 2006 and August 31, 2006.

		Hospital Reviews[34]			Nursing Facility Reviews[35]		
Code	County	Cases Opened	Cases Closed	Recovery	Cases Opened	Cases Closed	Recovery
34	Cass	2	3	$1,114.52	5	4	$22,086.06
35	Castro	1	1	$0.00	1	0	$0.00
36	Chambers	1	1	$0.00	1	1	$11,259.41
37	Cherokee	2	2	$0.00	6	6	$32,167.75
38	Childress	1	1	$3,580.55	1	1	$2,901.03
39	Clay	1	0	$0.00	1	0	$0.00
40	Cochran	0	0	$0.00	0	0	$0.00
41	Coke	0	0	$0.00	2	2	$44,304.65
42	Coleman	1	2	$10,788.05	0	0	$0.00
43	Collin	4	4	$42,353.24	9	7	$78,253.00
44	Collingsworth	0	0	$0.00	0	0	$0.00
45	Colorado	2	2	$6,157.15	3	1	$0.00
46	Comal	1	1	$0.00	1	2	$124,125.76
47	Comanche	0	0	$0.00	0	1	$4,728.99
48	Concho	0	0	$0.00	1	0	$0.00
49	Cooke	2	2	$23,442.02	4	3	$33,150.66
50	Coryell	0	0	$0.00	2	4	$14,430.64
51	Cottle	0	0	$0.00	0	0	$0.00
52	Crane	1	2	$13,237.15	0	0	$0.00
53	Crockett	0	0	$0.00	1	1	$1,787.10
54	Crosby	2	2	$4,515.73	1	2	$3,483.05
55	Culberson	0	0	$0.00	0	0	$0.00
56	Dallam	1	1	$4,280.34	0	0	$0.00
57	Dallas	21	21	$525,206.93	27	28	$524,005.66
58	Dawson	1	1	$0.00	1	1	$0.00
59	Deaf Smith	1	1	$2,472.53	1	2	$24,348.69
60	Delta	0	0	$0.00	0	0	$0.00
61	Denton	3	3	$16,388.05	12	4	$43,242.49
62	Dewitt	1	1	$0.00	4	3	$24,143.41
63	Dickens	0	0	$0.00	1	0	$0.00
64	Dimmit	1	1	$10,422.07	1	0	$0.00
65	Donley	0	0	$0.00	1	1	$1,595.64
66	Duval	0	0	$0.00	1	1	$51,295.64
67	Eastland	1	1	$18,664.70	2	2	$19,066.54
68	Ector	3	3	$205,520.07	3	4	$19,712.68
69	Edwards	0	0	$0.00	0	0	$0.00
70	Ellis	2	2	$3,944.32	1	2	$2,698.55
71	El Paso	7	8	$202,228.55	3	3	$117,060.36
72	Erath	1	1	$532.70	4	4	$28,269.86
73	Falls	1	1	$0.00	3	2	$7,978.55

		Hospital Reviews[34]			Nursing Facility Reviews[35]		
Code	County	Cases Opened	Cases Closed	Recovery	Cases Opened	Cases Closed	Recovery
74	Fannin	1	1	$0.00	2	3	$212,892.97
75	Fayette	1	1	$0.00	4	4	$106,167.85
76	Fisher	0	0	$0.00	0	0	$0.00
77	Floyd	1	1	$0.00	1	0	$0.00
78	Foard	0	0	$0.00	0	0	$0.00
79	Fort Bend	3	3	$41,596.06	4	3	$23,907.45
80	Franklin	1	1	$0.00	1	1	-$3,155.15
81	Freestone	1	1	$0.00	0	1	$3,564.12
82	Frio	2	2	$791.84	2	2	$73,536.14
83	Gaines	1	1	$12,491.10	0	0	$0.00
84	Galveston	2	2	$161,932.12	3	3	$140,139.95
85	Garza	0	0	$0.00	0	0	$0.00
86	Gillespie	1	1	$25,621.12	3	2	$63,684.02
87	Glasscock	0	0	$0.00	0	0	$0.00
88	Goliad	0	0	$0.00	0		$0.00
89	Gonzales	1	1	$21,301.97	0	1	$11,279.74
90	Gray	1	1	$0.00	2	1	$606.00
91	Grayson	2	2	$704.59	5	3	$100,587.14
92	Gregg	3	3	$48,369.74	6	6	$128,841.85
93	Grimes	1	1	$0.00	0	0	$0.00
94	Guadalupe	1	1	$7,743.88	3	3	$82,236.80
95	Hale	1	1	$11,371.35	3	3	$8,505.78
96	Hall	0	0	$0.00	0	0	$0.00
97	Hamilton	1	1	$0.00	1	0	$0.00
98	Hansford	1	1	$0.00	0	0	$0.00
99	Hardeman	0	0	$0.00	0	0	$0.00
100	Hardin	0	0	$0.00	3	2	$31,613.21
101	Harris	31	32	$1,199,881.32	27	25	$487,889.39
102	Harrison	1	1	$2,187.48	1	1	$4,005.51
103	Hartley	0	0	$0.00	0	0	$0.00
104	Haskell	0	0	$0.00	0	0	$0.00
105	Hays	1	1	$0.00	4	3	$60,470.91
106	Hemphill	0	0	$0.00	1	0	$0.00
107	Henderson	1	1	$0.00	5	3	$10,710.26
108	Hidalgo	7	7	$200,581.65	7	7	$153,888.07
109	Hill	2	2	$0.00	2	2	$2,353.90
110	Hockley	1	1	$7,920.73	2	2	$15,877.76
111	Hood	1	1	$19,664.39	2	2	$19,082.58
112	Hopkins	0	1	$1,102.46	2	1	$7,257.54
113	Houston	1	1	$0.00	0	0	$0.00

		Hospital Reviews[34]			Nursing Facility Reviews[35]		
Code	County	Cases Opened	Cases Closed	Recovery	Cases Opened	Cases Closed	Recovery
114	Howard	0	1	$34,247.66	2	2	$61,938.30
115	Hudspeth	0	0	$0.00	0	0	$0.00
116	Hunt	2	2	$0.00	5	5	$47,082.71
117	Hutchinson	1	1	$8,331.24	1	1	$36,858.68
118	Irion	0	0	$0.00	0	0	$0.00
119	Jack	0	0	$0.00	1	1	$11,254.30
120	Jackson	0	0	$0.00	2	2	$0.00
121	Jasper	2	2	$3,067.43	2	3	$9,695.70
122	Jeff Davis	0	0	$0.00	0	0	$0.00
123	Jefferson	6	7	$16,016.61	8	4	$120,200.92
124	Jim Hogg	0	0	$0.00	1	1	$1,097.80
125	Jim Wells	1	2	$76,982.36	2	2	$12,407.43
126	Johnson	1	1	$6,712.46	3	6	$129,194.14
127	Jones	4	4	$94,752.96	1	1	$38,342.47
128	Karnes	0	0	$0.00	3	1	$382.08
129	Kaufman	2	2	$9,062.79	6	5	$72,766.82
130	Kendall	0	0	$0.00	2	2	$52,047.53
131	Kenedy	0	0	$0.00	0	0	$0.00
132	Kent	0	0	$0.00	1	1	$0.00
133	Kerr	1	1	$28,328.13	0	1	$17,914.85
134	Kimble	0	0	$0.00	1	1	$4,285.08
135	King	0	0	$0.00	0	0	$0.00
136	Kinney	0	0	$0.00	0	0	$0.00
137	Kleberg	1	1	$16,824.58	1	1	$12,495.94
138	Knox	0	0	$0.00	0	0	$0.00
139	Lamar	2	2	$14,902.98	3	2	$38,268.46
140	Lamb	1	1	$4,212.07	1	3	$62,112.71
141	Lampasas	1	1	$0.00	3	3	$2,630.92
142	La Salle	0	0	$0.00	0	0	$0.00
143	Lavaca	2	3	$12,495.64	1	2	$14,314.25
144	Lee	0	0	$0.00	2	0	$0.00
145	Leon	0	0	$0.00	0	0	$0.00
146	Liberty	1	1	$6,876.81	2	2	$29,376.95
147	Limestone	2	2	$3,842.78	3	2	$6,691.38
148	Lipscomb	0	0	$0.00	0	1	$938.86
149	Live Oak	0	0	$0.00	1	1	$41,848.34
150	Llano	1	1	$0.00	3	2	$28,546.76
151	Loving	0	0	$0.00	0	0	$0.00
152	Lubbock	4	4	$109,542.04	6	6	$85,837.87
153	Lynn	0	0	$0.00	0	1	$897.26

		Hospital Reviews[34]			Nursing Facility Reviews[35]		
Code	County	Cases Opened	Cases Closed	Recovery	Cases Opened	Cases Closed	Recovery
154	Madison	1	1	$0.00	0	0	$0.00
155	Marion	0	0	$0.00	2	2	$13,450.51
156	Martin	1	1	$2,378.67	0	0	$0.00
157	Mason	0	0	$0.00	0	0	$0.00
158	Matagorda	2	2	$9,236.10	0	0	$0.00
159	Maverick	1	1	$13,789.43	1	1	$4,483.23
160	McCullough	1	2	$13,196.06		1	$4,495.08
161	McLennan	3	3	$20,639.26	13	14	$82,700.11
162	McMullen	0	0	$0.00	0	0	$0.00
163	Medina	1	1	$0.00	2	1	$33.66
164	Menard	0	0	$0.00	1	1	$1,589.52
165	Midland	2	2	$24,471.11	2	3	$31,302.88
166	Milam	1	2	$39,674.25	2	1	-$359.57
167	Mills	0	0	$0.00	0	0	$0.00
168	Mitchell	0	1	$1,437.33	0	0	$0.00
169	Montague	2	2	$10,220.02	1	1	$7,456.49
170	Montgomery	3	3	$24,310.45	0	0	$0.00
171	Moore	1	1	$17,876.90	1	1	$5,792.68
172	Morris	0	0	$0.00	1	1	$8,676.06
173	Motley	0	0	$0.00	0	0	$0.00
174	Nacogdoches	2	2	$10,030.27	5	4	$21,445.50
175	Navarro	1	1	$3,115.59	3	2	$19,450.51
176	Newton	0	0	$0.00	1	0	$0.00
177	Nolan	1	1	$1,153.75	1	1	$0.00
178	Nueces	3	4	$102,019.24	3	3	$182,575.94
179	Ochiltree	1	1	$0.00	0	0	$0.00
180	Oldham	0	0	$0.00	0	0	$0.00
181	Orange	1	1	$0.00	2	1	$9,719.33
182	Palo Pinto	1	1	$10,721.40	1	1	$66,426.49
183	Panola	1	1	$0.00	0	1	$42,543.38
184	Parker	2	2	$558.67	2	2	$8,169.21
185	Parmer	1	1	$4,558.06	1	2	$24,774.28
186	Pecos	1	1	$0.00	0	0	$0.00
187	Polk	1	1	$18,314.66	3	2	$12,274.25
188	Potter	0	0	$0.00	5	5	$71,311.45
189	Presidio	0	0	$0.00	0	0	$0.00
190	Rains	0	0	$0.00	1	1	$22,794.25
191	Randall	2	2	$208,770.91	1	2	$30,304.51
192	Reagan	0	0	$0.00	1	1	$1,542.60
193	Real	0	0	$0.00	1	1	$42,379.98

		Hospital Reviews[34]			Nursing Facility Reviews[35]		
Code	County	Cases Opened	Cases Closed	Recovery	Cases Opened	Cases Closed	Recovery
194	Red River	1	1	$0.00	0	0	$0.00
195	Reeves	1	1	$12,173.25	0	0	$0.00
196	Refugio	1	1	$0.00	0	0	$0.00
197	Roberts	0	0	$0.00	0	0	$0.00
198	Robertson	0	0	$0.00	4	3	$540.90
199	Rockwall	1	1	$23,170.05	0	0	$0.00
200	Runnels	0	0	$0.00	2	2	$11,651.45
201	Rusk	1	1	$0.00	4	3	$38,729.92
202	Sabine	0	1	$3,645.10	0	0	$0.00
203	San Augustine	1	1	$0.00	0	0	$0.00
204	San Jacinto	0	0	$0.00	0	0	$0.00
205	San Patricio	0	0	$0.00	2	3	$55,733.39
206	San Saba	0	0	$0.00	0	0	$0.00
207	Schleicher	1	1	$678.25	1	1	$16,619.05
208	Scurry	1	1	$9,368.14	2	2	$22,163.38
209	Shackelford	0	0	$0.00	0	0	$0.00
210	Shelby	1	1	$12,838.83	2	1	$6,135.60
211	Sherman	0	0	$0.00	0	0	$0.00
212	Smith	3	3	$54,528.17	4	5	$121,599.89
213	Somervell	1	1		1	1	$20,717.07
214	Starr	1	1	$1,713.52	1	1	$29,579.09
215	Stephens	1	1	$12,534.11	2	1	$1,576.45
216	Sterling	0	0	$0.00	0	0	$0.00
217	Stonewall	0	0	$0.00	1	1	$3,405.70
218	Sutton	1	1	$0.00	0	0	$0.00
219	Swisher	1	1	$0.00	1	1	$8,659.00
220	Tarrant	11	11	$208,605.98	31	26	$498,898.00
221	Taylor	0	0	$0.00	4	5	$108,614.76
222	Terrell	0	0	$0.00	0	0	$0.00
223	Terry	1	1	$2,729.08	2	2	$0.00
224	Throckmorton	0	0	$0.00	0	0	$0.00
225	Titus	1	1	$3,518.00	0	1	$11,669.89
226	Tom Green	3	3	$29,046.47	4	4	$100,754.73
227	Travis	9	9	$52,082.92	15	16	$304,353.08
228	Trinity	1	1	$0.00	1	1	$339.75
229	Tyler	1	1	$0.00	0	0	$0.00
230	Upshur	0	0	$0.00	0	0	$0.00
231	Upton	0	0	$0.00	1	1	$2,541.33
232	Uvalde	1	1	-$1.75	1	0	$0.00

		Hospital Reviews[34]			Nursing Facility Reviews[35]		
Code	County	Cases Opened	Cases Closed	Recovery	Cases Opened	Cases Closed	Recovery
233	Val Verde	1	0	$0.00	3	1	$907.73
234	Van Zandt	1	1	$0.00	4	4	$33,606.44
235	Victoria	2	2	$23,891.91	4	3	$78,474.64
236	Walker	1	1	$6,694.68	2	2	$29,586.52
237	Waller	0	0	$0.00	0	0	$0.00
238	Ward	0	1	$4,095.06	1	1	$14,480.19
239	Washington	1	1	$0.00	3	2	$12,457.55
240	Webb	3	3	$408,641.33	0	0	$0.00
241	Wharton	2	2	$18,997.05	0	0	$0.00
242	Wheeler	1	1	$0.00	1	1	$8,324.17
243	Wichita	2	3	$72,613.26	5	6	$150,275.23
244	Wilbarger	1	1	$7,475.71	1	1	$2,420.00
245	Willacy	0	0	$0.00	1	1	$66,712.96
246	Williamson	2	2	-$466.18	4	4	$76,408.33
247	Wilson	1	1	$0.00	3	2	$96,331.95
248	Winkler	1	1	$2,926.11	0	0	$0.00
249	Wise	1	1	$4,821.52	2	3	$21,192.46
250	Wood	2	2	$3,979.50	2	2	$10,708.70
251	Yoakum	1	1	$3,358.68	0	0	$0.00
252	Young	2	2	$14,918.13	1	1	$13,796.76
253	Zapata	0	0	$0.00	0	0	$0.00
254	Zavala	0	0	$0.00	0	0	$0.00
	Unknown Co.	0	0	$0.00	0	0	$0.00
	Multiple Co.	0	0	$0.00	0	0	$0.00
300	Out of State	2	2	$0.00	0	0	$0.00
	Total	**326**	**341**	**$6,277,039.45**	**536**	**498**	**$8,008,308.44**

Section VI—Other OIG Activities

Education and Prevention

Type of Course	1st Quarter[36]	2nd Quarter	3rd Quarter	4th Quarter	Total Enrolled
TILE Training - Nursing Facilities – Correspondence Course		83	124	132	207
TILE Training - Nursing Home – On-Line Internet Course		58	162	389	220
TILE Training – Community Based Alternatives – Correspon-dence Course		199	162	376	361
TILE Training – Community Based Alternatives - On-Line Internet Course		138	342	944	480
Total	**245**	**478**	**790**	**1841**	**3354**

[36] Texas State University-San Marcos did not track by the individual TILE training course. Therefore, total enrollment by TILE training course cannot be calculated for SFY 2006.

Staff Presentations

Date	Audience	Subject	Presenter
October 3, 2005	Association of Certified Fraud Examiners	Fraud Cases Referred to HHS	Brian Flood
October 13, 2005	Texas Medical Auditors Association Annual Conference	The New "Rules" for Waste, Abuse and Fraud	Brian Flood
November 1, 2005	Texas Government Accountability Conference	Best Practices-The Governor's Fraud Initiative (Panel) Culture of Honesty & Ethics	Brian Flood
November 14, 2005	Special Investigations Department of Health Care Service Corporation (BlueCross BlueShield of Illinois)	Panel discussion of current issues regarding the development, referral and prosecution of health care fraud cases.	Brian Flood
December 1, 2005	State Farm / NICB Annual Training	OIG Overview	Wayne Sneed
January 18, 2006	Senate Finance Committee	Medicaid Fraud In Texas	Brian Flood
January 31, 2006	City of San Antonio Internal Auditors	Sampling and data analysis in fraud, waste, and abuse cases	Bruce Truitt
February 2, 2006	New York Senate Public Hearing	Testify on Medicaid fraud, waste, and abuse	Brian Flood
February 9, 2006	Missouri Senate Special Committee on Medicaid Fraud	Testify on Texas methods of combating Medicaid fraud, waste and abuse	Brian Flood
March 12, 2006	North Texas Health Care Provider Association	OIG Overview	Charlotte Dokes
March 28, 2006	U.S. Senate Committee on Homeland Security and Government Affairs Subcommittee on Federal Financial Management, Government Information, and International Security	Witness for hearing on "Bolstering the Safety Net: Eliminating Medicaid Fraud"	Brian Flood
March 29, 2006	Health Care Compliance Association Teleconference	2005 Deficit Reduction Act	Brian Flood
April 6, 2006	American Association of Medical Audit Specialists	Anti-Fraud Initiatives in the State of Texas-Creation of the Office of Inspector General	Brian Flood
April 6, 2006	Department of Family and Protective Services Procurement and Contracting Staff	Electronic compilation and statistical analysis of information received in response to RFP's	Bruce Truitt
April 12, 2006	Association of Government Accounts-San Antonio Chapter	Contract Auditing	Debi Weyer

Date	Audience	Subject	Presenter
April 24, 2006	2006 Association of Certified Fraud Examiners (ACFE) Insurance Fraud Conference	The Finer Points of Prosecuting Insurance Cases	Brian Flood
April 25, 2006	Health Care Compliance Association (HCCA) 10th Anniversary Compliance Institute	The Wave of Change in Government Enforcement: The DRA and Beyond	Brian Flood
May 16, 2006	Florida Fraud & Abuse Representatives	MFADS Overview	Genie DeKneef
May 17, 2006	Florida Fraud & Abuse Representatives	Sanctions Overview	Leslie Vance, Ralph Longmire, Nancy Steele
May 23, 2006	Department of State Health Services Procurement and Contracting Staff	Electronic compilation and statistical analysis of information received in response to RFP's	Bruce Truitt
June 6, 2006	Private Provider's Association	OIG and Cost Report Auditing Overview	Robin Smith
June 8, 2006	National Fraud and Abuse Forum	Using stop-and-go sampling in detecting fraud, waste, and abuse	Bruce Truitt
June 16, 2006	American Association of Healthcare Administrative Management	OIG Overview	Charlotte Dokes
June 21, 2006	Managed Care Organizations Special Investigators	Sampling and data analysis in fraud, waste, and abuse cases	Bruce Truitt
June 28, 2006	Kansas, Missouri, Arkansas, Oklahoma, and Texas Medicaid Programs	Combined State Fraud Meeting	Brian Flood
August 10, 2006	Texas Association of Rural Health Clinics	Medicaid Fraud and Abuse in Texas	Brian Flood
August 31, 2006	HCPro Live Audio conference	The Deficit Reduction Act: Get ready for the Medicaid enforcement revolution.	Brian Flood

Appendix C—OIG Division Summary Excluding TPR

	2005		2006	
	Recoupments	Cost Avoidance	Recoupments	Cost Avoidance
Compliance				
Quality Review				
Utilization Review				
Hospitals (DRGs)	$22,867,551	g	$18,364,793	g
Nursing Homes (Case Mix Review)	$10,448,797	g	$17,240,718	g
TEFRA Claims	h	N/A	h	N/A
Children's Summary	h	N/A	h	N/A
Psychiatric Summary	h	N/A	h	N/A
Compliance Monitoring and Referral	b	b	b	b
WIC Vendor Monitoring	$20,351	$6,077	$72,751	$4,572
Technology, Analysis, Development, and Support	$2,660,128	$333,812	$1,596,974	$257,895
RADS				
Surveillance and Utilization Review Subsystems	d	g	d	g
Medicaid Fraud and Abuse Detection System	d	g	d	g
Audit	$943,398	$98,679,946	$61,940	$20,924,124
Enforcement				
Medicaid Provider Integrity	e	e	e	e
General Investigations	$21,342,829	$3,858,675	$15,824,940	$4,024,971
Internal Affairs	$2,371	N/A	$0	N/A
WIC Investigation Recoveries	$46,251	$853	$31,705	$0
Chief Counsel				
Sanctions	$33,782,310[15]	$3,881,784	$15,801,240	$47,015,441
Civil Monetary Penalties	$13,045,838	N/A	$3,195,342	N/A
Potential Identified Inappropriate Payments (i)	N/A	N/A	N/A	$32,000,000
Third Party Recoveries (TPR)	$323,345,679	$255,727,973	$374,459,646	$274,600,975
TOTAL Recoupments *without* TPR	**$105,159,824**		**$72,190,403**	
TOTAL Cost Avoidance *without* TPR		**$106,761,147**		**$104,227,003**

a= Data for recovery and/or cost avoidance not available from HHSC-OIE.
b= Function discontinued in 2003.
c= Data previously captured by or not reported by legacy agencies.
d= SURS and MFADS recoveries are reported within TADS and/or Sanctions.
e= MPI dollars are reported under Sanctions.
f= Sanctions recovery and cost avoidance were previously reported under MPI.
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.
h= TEFRA Claims and Children's and Psychiatric Summaries consolidated and reported under Utilization Review Hospitals.
i= Includes 32 million identified potential improper payments (see page 46).

Appendix D—News Articles

Speech - February 3, 2005
Text of Gov. Rick Perry's Remarks To Texas Association of Broadcasters

(NOTE: Gov. Perry frequently deviates from prepared text.)

Thank you, Bob. It is an honor to be with you today.
There is not a day that goes by that I am not reminded of the power and reach of television. I suppose that was especially true three years ago when my opponent spent about $50 million to put grainy black-and-white images of me in every Texan's living room.

Of course, the broadcast media can have a tremendously positive impact too, as it has on the lives of millions of Texans.

Not only do you empower our citizens with the knowledge they need to make informed decisions, your efforts have helped make Texas a more responsible and more compassionate state.

Few, if any, other industries can claim to do more for their local communities than broadcasters.

In the past year alone, Texas television and radio stations have raised $46 million for local charities, more than $3 million for scholarships and civic causes, and dedicated thousands of hours of airtime to raising awareness of important issues through public service announcements.

One event I have been proud to be a part of in years past is the West Texas Rehab Telethon, which raises funds to help Texans recover from injuries and adjust to disabilities.

That is just one example of how the broadcast media helps build a stronger social fabric.

Of course, it doesn't stop there. Emergency weather and hazard warnings save lives.

The Amber Alert system that you helped establish has helped law enforcement close the net around child abductors.

Many of us have even benefited from exposés on which restaurants have slime in the ice machine.

But of the many needs you meet for our citizens there is none greater than telling the people of Texas what happens each day.

Broadcasters are a critical link between the people and their government, and help Texans hold their elected leaders accountable.

This is a vital service that many of us in America take for granted but I guarantee you, in other parts of the world where the free press is anything but free, that is a foreign concept.

Accountability is essential to our democracy.

In my state of the state address, I laid out a vision that calls for greater accountability in government specifically in education, protective services and property tax collection.

The initiative that I believe is essential to government accountability is the creation of Inspector General positions at large state agencies.

I believe we need an independent voice at large state agencies that is accountable not to the bureaucracy but to independent boards or individual commissioners and ultimately, to the people.

The function performed by an independent inspector general is complimentary to but distinctly different from the service performed by the state auditor.

As envisioned by statute, the State Auditors Office is largely composed of audit staff that review accounting practices, policies and procedures, and performs audits on a rotating schedule.

This is an important function. At the same time, we need to do more to ensure ultimate accountability with taxpayer funds.

An inspector general will not only look to see if agency policies and procedures are followed but whether those policies and procedures ensure an efficient delivery of services.

An inspector general would lead a staff that includes program specialists, criminal investigators, lawyers and experts in specific subject areas.

Inspectors general would have additional authority to subpoena documents in criminal investigations and coordinate with law enforcement to make sure that scam artists and crooks are brought to justice.

And they would have the broad authority needed to launch thorough investigations, and make sweeping changes to the structure and culture of an agency.

As an example of the difference an Inspector General can make in bringing greater accountability to government, I point to Brian Flood at the Health and Human Services Commission.

His work has already resulted in a $5 million settlement from a dental clinic that engaged in fraudulent Medicaid billing practices as well as the conviction of two individuals for Medicaid fraud, who combined, were sentenced to a record 98 years in prison.

I also called upon Inspector General Flood to oversee the investigations I ordered last year into child and adult protective services.

The CPS investigation which included a comprehensive review of case files, interviews with many caseworkers and a detailed analysis of how much time investigators devote to administrative tasks, in addition to work with families, revealed just how broken our safety net is for vulnerable children.

But just as importantly, because of the level of detail involved, that investigation gave us tremendous insight into needed reforms that will change Texas for the better.

Today, we have a blueprint for reform that will drop investigator caseloads by 40 percent, increase the time investigators spend with children and families by 39 percent, and reduce time spent on paperwork by 58 percent.

This reform plan will also improve salaries for CPS workers, improve case management through better utilization of technology and dramatically change the structure of the agency so no investigator is distracted from the main mission: helping abused and neglected children.

A sweeping reform plan often requires a sweeping investigation.

And that's exactly what we get from an inspector general.

The same kind of investigatory authority in place at the Texas Education Agency could help us track down allegations of test tampering at Texas schools.

Hopefully, test tampering is more isolated than has been reported.

An inspector general could get to the bottom of it in an efficient, independent manner.

I think it is important to have strong, independent oversight at our agencies especially those charged with expending large sums of money such as the Texas Department of Transportation, the Texas Department of Insurance, the Texas Workforce Commission and several more.

We may find we have the best run agencies in the nation.

At the same time, we may find areas where we can get more for Texans' money.

But the point is we won't know for sure until we try.

Let me conclude my comments on the one issue foremost on legislators' minds, education reform.

In fact, education reform is the subject of the day as leaders in the House announce their plans for increasing achievement at Texas school.

I applaud Speaker Craddick, Chairman Grusendorf and the leadership of the House for not only focusing on improving funding for our schools but improving performance too.

Their plan is a strong starting point because it devotes new resources to schools, improves teacher compensation and focuses the debate on achievement.

How much we spend on education is important. How we spend the money is most important.

I see this legislative session as a once-in-a-generation opportunity to improve education and improve young lives.

Despite a decade of progress and gains by students of every background, we still have an achievement gap in Texas schools that will be an opportunity gap when today's students become tomorrow's workers.

Look at the statistics: Today we have 36,399 students trapped in failing schools. Last year 889,468 students failed at least one section of the TAKS. And two years ago 15,665 students dropped out.

I want to dedicate new money to education in a way that draws the very best from our teachers and students, and that focuses our attention where it is needed most in schools where we have large numbers of economically disadvantaged students, where graduation rates are low and where too few children graduate prepared for college and success in life.

I believe we should attract our best and brightest teachers to our hardest learning environments with salary stipends as high as $7,500 for teachers that help turn around schools with large numbers of economically disadvantaged students.

We must also provide meaningful progress incentives for schools that serve mostly disadvantaged student populations.

And if schools struggle educating children of limited means I believe this state has an obligation to provide expert help in the form of school turn-around teams that can mentor teachers and review management practices.

As lawmakers convene for this 79th legislative session, we face great challenges but not insurmountable ones.

In fact, throughout my twenty years in public service I have never been more optimistic about our future.

Part of my confidence stems from all the good news I keep seeing on the television about how far Texas has come in the past two years.

We've turned a record budget shortfall into a revenue surplus, in just two years we were named the number one business climate in America and on the biggest issues

facing this session of the legislature, there is a growing consensus on the direction we need to move.

When our work is done a few months from now, I look forward to watching and listening to your reports on how this legislature has changed Texas for the better.

Thank you. I would be happy to take your questions.

News from
The Senate
Republican Majority
Senator Joseph L. Bruno, Majority Leader

Date: 03/14/2006

Office: Bruno
Title: SENATE PASSES HISTORIC PLAN TO FIGHT MEDICAID FRAUD
FOR RELEASE: Immediate, Tuesday, March 14, 2006
www.senate.state.ny.us

SENATE PASSES HISTORIC PLAN TO FIGHT MEDICAID FRAUD
New Initiative Is The Most Comprehensive in the Nation;
Increased Accountability Could Save Taxpayers More Than $2 Billion

The New York State Senate today passed the toughest, most comprehensive plan to combat Medicaid fraud in the United States. The Medicaid Fraud Prevention and Recovery Reform Act of 2006 (S.6872-A, Senator Dean Skelos, R, Rockville Centre) is a 10-point plan that would fight fraud and abuse at every step of the process, from billing and pre-payment review to investigation, civil recovery and criminal prosecution of Medicaid thieves.

"Medicaid fraud hurts every single taxpayer in this state," Senator Bruno said. "It's costing State and local governments billions of dollars every year. Criminals who steal through Medicaid fraud are also hurting people who need health care, and they are hurting honest, dedicated professionals who provide health care. I congratulate Senator Skelos, as well as Senator Hannon and Senator Meier, for developing this tough, comprehensive plan that will take every possible step to root out fraud, bring integrity and accountability to the Medicaid system and ensure that taxpayer funds are being used properly."

"Medicaid fraud steals from everyone in New York State. It drives up property taxes, state taxes and federal taxes and deprives the neediest New Yorkers of the quality health care they deserve," said Senator Skelos. "The Senate first raised this issue over a year ago and this ten-point plan is the most comprehensive Medicaid fraud package ever proposed. By strengthening the way we prevent, detect, investigate and prosecute Medicaid fraud, this legislation will fundamen-

tally reform a broken system and achieve real results for hardworking taxpayers."

"The goal of the State Senate's Medicaid Fraud package is simple -- saving our taxpayers over $2 billion and continue to provide health care services for those in need," said Senator Dale M. Volker. "For those who continue to exploit our state's Medicaid system, their illegal behavior will be met with severe criminal penalties. We will not tolerate and accept fraud within our Medicaid system, and we are giving our law enforcement agencies the needed legal tools to prosecute those who take advantage of the public's trust."

The Medicaid Fraud Prevention and Recovery Reform Act of 2006 includes similar reforms enacted in Texas, which provided immediate results. In the first year after enacting Medicaid reform, Texas increased the amount of money recovered from Medicaid fraud by 30 percent, without incurring any additional expense. Texas, now, annually recoups five percent of its total Medicaid expenditures. Applying the results in Texas to New York's $46 billion Medicaid program, would result in an annual savings of $2.3 billion for the program and provide relief for State and local taxpayers.

The Senate anti-Medicaid fraud plan includes:
> Creating a new, independent, Office of Medicaid Inspector General by consolidating responsibilities and staff from eight agencies into one new office within the Department of Health;
> Referring fraud cases to local district attorneys if a case is refused by the Medicaid Fraud Control Unit in the Attorney General's office;
> Allowing local governments and district attorney offices to share in Medicaid fraud recoveries if they provide information or evidence of fraud;
> Increasing civil and criminal penalties for people who commit Medicaid fraud;
> Requiring all health care institutions to implement corporate compliance and internal controls programs;
> Requiring the State Insurance Department to submit an annual report of health insurance fraud cases submitted by health plans;
> A $500,000 appropriation for the New York Prosecutors Training Institute to conduct an educational program on Medicaid fraud for local district attorneys;
> Authorizing the Department of Health to upgrade information technology to detect Medicaid fraud;
> A demonstration project in Chemung County using the latest technology to detect Medicaid fraud; and

> Adopting a State False Claims Act that would allow the State to collect 10 percent of the federal share of any recoveries made under the Act.

"The Senate has led the way in identifying efficiencies to control the growth of Medicaid without sacrificing quality. Fraud undermines both of those goals by wasting tax dollars and also straining the system to the point where quality is compromised," said Senate Health Committee Chairman Kemp Hannon (R, Garden City), co-chair of the Senate Task Force on Medicaid Reform.

"A goal of the Senate's Medicaid Reform Task Force was restoring accountability to a program that has run out of control for too long. Eliminating waste, fraud and abuse are key steps toward achieving that goal," said Senator Raymond A. Meier (R-C, Western), co-chair of the Senate Medicaid Reform Task Force.

The federal General Accounting Office estimates that 10 percent of Medicaid expenses are diverted through fraud, an amount equal to billions of dollars spent by New York on the program.

The comprehensive Senate Medicaid fraud plan was developed after statewide public hearings held by the Senate Medicaid Reform Task Force. At the hearings, the task force received input and suggestions from people in the health care industry and the law enforcement community on what could be done to strengthen the state's efforts to detect and prevent Medicaid fraud.

Among those who testified at the hearings was Texas Health and Human Services Commission Inspector General Brian Flood, who spoke about the remarkable results of Texas Medicaid fraud plan, upon which the Senate plan is modeled. Brian Flood will discuss New York's legislation as a model for state level efforts to fight Medicaid fraud when he testifies before the United States Senate.

The Senate Medicaid Reform Task Force, created by Senator Bruno in 2003, recommended several important measures that have become law, including the State cap on local Medicaid expenses and the State takeover of the local share of the Family Health Plus program, that have saved local property taxpayers billions of dollars.

Medicaid Fraud Prevention and Recovery Reform Act of 2006

The Medicaid Fraud Prevention and Recovery Reform Act of 2006 is a 10-point plan, including comprehensive legislation (S.6872-A) and a budget appropria-

tion for the New York Prosecutors Training Institute (NYPTI). The plan includes the following:

1. Office of Medicaid Inspector General
The legislation consolidates the Administration's Medicaid program integrity responsibilities and staff from each of the eight involved state agencies into a new Office of Medicaid Inspector General within the Department of Health. While the Office must remain within the Department of Health to receive federal matching funds and maintain access to the necessary claims information, its operations will be completely independent. The Inspector General would function independently and report directly to the Governor.

The Office will focus on three main functions: compliance, investigation and recoupment/sanctions. To this end, it will review all Medicaid expenditures and investigate those identified as suspected fraud or abuse. It will have the power to withhold payment until the claim is determined to be appropriate (up to 30 days under federal law), impose administrative sanctions and pursue civil recoveries and third-party recoveries, i.e., coordination of benefits with health insurers.

For those fraudulent claims determined to be criminal, the Office will serve as the investigative entity for provider fraud prosecutions initiated by the Attorney General's Medicaid Fraud Control Unit (MFCU) or, should the MFCU not accept a referral, local district attorneys and recipient fraud prosecutions initiated by the Welfare Inspector General and district attorneys.

2. Access to Information for Local Prosecutions
The MFCU will have 30 days to accept a criminal fraud referral from the Office. If it fails to accept, the Office will be required to refer the case file to the local district attorney.

3. Restoration of the Local Share for Certain Medicaid Fraud Recoveries
If the Office or the Attorney General achieves any restitution or recovery from information or evidence developed by a local county (or its district attorney), the county will receive 15 percent of the non-federal share (general fund) and the district attorney will receive 15 percent of the non-federal share (for investigation/prosecution of Medicaid fraud or other crimes against revenue). If the local district attorney achieves restitution, the county and the district attorneys office will each receive 20 percent of the non-federal share.

4. False Claims Act

The federal Deficit Reduction Act encourages the states to adopt state False Claims Acts mirroring the federal False Claims Act by providing the state with 10 percent of the federal share of any recovery achieved under the Act.

5. Improved Technology

The Senate bill authorizes and directs the Department of Health to contract with vendors for upgraded information technology necessary to detect Medicaid fraud, conduct utilization review and coordinate third-party benefits (health plans). Improved technology would improve accountability in Medicaid expenditures throughout the process and coordinate benefits with health plans to ensure Medicaid is the payor of last resort.

6. New Medicaid Fraud Offenses and Penalties

The Senate bill incorporates the Executive Budget proposals for tougher civil and criminal penalties on people who commit Medicaid fraud, but limits the applicability to Medicaid.

7. Chemung County Demonstration Project

The Senate bill incorporates the Executive Budget's proposal for the establishment of a local Medicaid fraud demonstration project in Chemung County, which would develop a fraud detection system that uses the latest technology to review inappropriate utilization of services.

8. Health Insurance Fraud Report

The Senate bill requires the State Insurance Department to annually submit a report detailing its investigation of health insurance fraud cases submitted by health plans. Currently, SID is investigating 2.9 percent of all such cases—far below levels for other types of suspected insurance fraud.

9. Corporate Compliance Program

As a prerequisite for Medicaid eligibility, the Senate bill requires larger Medicaid providers to implement Sarbanes-Oxley style corporate compliance and internal controls programs designed to prevent improper and inaccurate billings and fraud.

10. NYPTI Appropriation

The Senate Majority's Medicaid fraud package includes a $500,000 budget appropriation for NYPTI to conduct an educational program relating to Medicaid fraud for local district attorneys and prepare form materials/basic research.

In addition, the grant will require NYPTI to report to the Legislature regarding the necessity of additional staff in certain district attorneys' offices to prosecute Medicaid fraud and judicial reforms, such as creating a Medicaid fraud or crimes against revenue division within the State Supreme Court.

The bill was sent to the Assembly.

NEW YORK POST

Stopping the Bleeding in New York Medicaid Program
May 2, 2006

By Steven Malanga

For nearly 40 years, New York counties have had the worst of all possible Medicaid worlds, because they've been forced to pay a big chunk of the state's cost for the gigantic health care program while they had little say over how it was designed or administered. Among other frustrations, county officials have watched as the state reduced its efforts at detecting fraud amid widespread reports of corruption and inefficiency.

But under intense pressure, state officials have finally given a handful of counties the right to begin scrutinizing their local Medicaid programs to search for fraud, abuse and waste - and the initial results are astonishing.

In Rockland County, a preliminary investigation into the prescribing practices of high-volume pharmacies found that nearly half of all their bills, constituting $13 million in payments, were questionable, and up to a quarter of the bills were so problematic that they could well involve fraud. "If even just half those questionable cases turn out to be fraudulent or incorrect billings, the savings will turn out to be enormous," says Rockland County Executive C. Scott Vanderhoef, who adds, "this is just the beginning of our efforts."

At $300 billion, Medicaid is one of our federal government's biggest programs - one it shares with the states, which administer it. Unfortunately, Medicaid often also seems like one of our most-abused programs, the subject of an estimated $30 billion in waste and fraud each year by recipients, health-care providers and outright scam artists who target the program.

But after decades of lax enforcement by states, the stories of mismanagement and abuse within Medicaid are pushing some states and counties to take action. They're showing that we needn't tolerate abuse of the program. New York state could take a page from what's happening elsewhere.

Leading the way is Texas. In 2003, its Legislature created an inspector general's office, responsible for all of the state's Medicaid enforcement functions. The state hired dozens of new oversight workers to reinforce its troops of

computer experts, nurses and pharmacists who scrutinize patient records, and prosecutors. Today, Texas's Medicaid program, which at $18 billion a year is about 60 percent smaller than New York's, has four times as many people working to uncover fraud and prevent billing errors. Last year, Texas recovered $441 million in erroneous or fraudulent billings.

Following Texas's lead, Ohio's Legislature has authorized its state auditor to start inspecting Medicaid providers (previously, only the state's health department could do so). Even New York is now contemplating an inspector general's office. "We need to have one agency and one person who has ownership of the Medicaid fraud problem," says Deputy Senate Majority Leader John DeFrancisco. "Right now, no one person is accountable."

Such officials will be mere window dressing unless legislators give them the tools to prosecute Medicaid fraud effectively - including tougher laws. Many states still don't criminalize Medicaid fraud, so officials must prosecute on insurance fraud, mail fraud or racketeering charges. That's not always easy, since some courts refuse to recognize Medicaid as an insurance program.

But under laws enacted in the 1990s, New Jersey now hands out up to 10-year prison sentences for Medicaid fraud, as well as fines of up to five times the amount involved. Other states, such as North Carolina, have made it easier for prosecutors to win judgments against sham Medicaid providers in civil court.

States are also making it harder for service vendors and health-care practitioners to become eligible to receive Medicaid funds. Illinois has amended its Medicaid law to require ambulette firms - "a hotbed for potential fraud and abuse," says the state inspector general - to undergo criminal background checks and fingerprinting before participating in the program.

Governments are also investing in sophisticated new technology, like that being used by Rockland County, which can monitor Medicaid's staggering number of transactions for suspicious billing patterns. Perhaps the most ambitious use of advanced technology is a Texas pilot program that relies on fingerprinting and biometric readers in doctors' offices and hospitals. Medicaid recipients get a "smart card," imprinted with their fingerprint. Electronic card readers then check the fingerprint to verify that the patient applying for care is indeed the cardholder, thereby reducing recipient fraud. Patients swipe the cards at the start and end of a visit, to record the time they spent at

the facility - a safeguard against overbilling or charging for more elaborate services than those actually provided.

Even with tougher enforcement, states must confront the troubling reality that Medicaid programs have grown too large and complex to manage easily. That's why the best idea for reducing fraud over the long term may be Florida's push to overhaul its entire Medicaid program.

Last fall, the federal government gave Florida permission to try a drastic revamping of the system. The state will stop acting as a giant health insurer and instead move recipients into private plans. Florida will pay the insurance companies a yearly fee to enroll the recipients, in the same way that a private employer now pays for its employees to receive health coverage. As in the private sector, each insurer will be responsible for auditing bills and sniffing out fraud by providers or recipients in its system, and lax efforts to eliminate waste, inefficiency and incorrect billings will eat away at companies' bottom lines.

Other states have pledged to watch Florida's effort carefully over the next five years. If it succeeds, it may well become the next Medicaid model. Until then, states still have plenty of room for improvement in their efforts to stem Medicaid fraud.

This article is adapted from the Spring 2006 issue of the Manhattan Institute's *City Journal*, where Steven Malanga is a contributing editor.

HCCA HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

A publication for health care compliance professionals

feature article

Meet Texas IG Brian Flood

Editor's note: This interview with Brian Flood, Texas Health and Human Services Inspector General, was conducted by Frank Sheeder, a member of the HCCA Board of Directors in April 2006. Texas Governor Rick Perry appointed Brian Flood as Inspector General for Health and Human Services in October 2003. Mr. Flood may be reached by telephone at 512/424-6500 and Frank Sheeder may be reached by telephone at 214/999-6191.

FS: What is your professional background?

BF: I was an insurance claims adjuster while attending night law school. After graduation I joined the Dallas County District Attorney's Office as a criminal prosecutor. I served as the Chief of the Specialized Crime Division, which prosecuted white-collar crimes, including health care fraud, until I came to this position. I have also served for many years on the Board of Directors for the National White Collar Crime Center, a multimillion-dollar nonprofit dedicated to serving local, state, federal and international regulatory, criminal justice and law enforcement agencies for white-collar crime training, technology, and enforcement. I currently serve as Vice-chairman of the Board. I have also been on the lecture staff for the University of Texas at Dallas. I recently obtained my CHC after attending the Health Care Compliance Association's (HCCA) Compliance Academy in March.

FS: I understand that your position is fairly new and unique. Can you tell us how it came into existence and how you were chosen for this role?

BF: The Texas Legislature created the position in 2002. It was part of a bill that completely reorganized the Health and Human Services System, combining 12 agencies into 5 and creating an Office of Inspector General for the System. After the passage of the bill, the Governor's office created a search committee that looked for candidates. My name came up during their

search. I was contacted, interviewed, and then selected by the Governor's office for the appointment. I was recently re-appointed by the Governor.

FS: What are some of your responsibilities as Inspector General?

BF: Oversimplified, the office oversees the entire health and human services enterprise and systems to find, control, reduce, or recover funds from events of waste, abuse or fraud. For example, we oversee all fee for service hospital DRG (Diagnosis Related Group) payments and nursing home payment rates TILE (Texas Index of Level of Effort). We audit all long-term care provider cost reports, review single audits, and conduct special audits. We investigate Medicaid; Children's Health Insurance Program (CHIP); Temporary Assistance for Needy Families (TANF); Food Stamp; and Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC) benefits. We investigate any alleged criminal acts involving abuse or fraud. You can review our reports for all of our activities at: http://www.hhs.state.tx.us/OIG/reports/Semi-Annual_Sept2005.pdf

FS: What kinds of resources do you have in your office for preventing and prosecuting Medicaid fraud, abuse, and waste?

BF: We consolidated most of the previously existing resources that were scattered among the 12 original legacy agencies. The office utilizes state-of-the-art technology and over 560 dedicated staff to perform its mandate. We use our technology to assign assets to anomalies we identify or to reports of fraud that are sent to us. We have a Web site and a 1-800 number to receive reports of waste, abuse, and fraud.

FS: Those are substantial resources. It seems like Texas is at the "top of the game" on these issues.

BS: For the moment, Texas is performing very well to make sure payments are made only to those who are entitled to them and only for the correct amount under program rules and policy.

FS: Can you please explain the philosophy that your office uses when dealing with providers on fraud, abuse, and waste issues?

BF: We do not believe the system can be properly operated or regulated in a vacuum. The office seeks to interact with the community we serve as often as practical. We host ongoing training to the provider community. Last year the OIG trained over 1,700 provider staff on Medicaid policy and billing. In the last two years we have also appeared at many provider and legal forums to explain how we operate. We feel that an informed relationship better serves the program, the providers, and the beneficiaries. That is why I recently participated in a presentation with you at the HCCA Annual Compliance Institute.

FS: The Deficit Reduction Act of 2005 (DRA) creates an incentive for states to have statutes that mirror the federal False Claims Act by January 1, 2007. What are some of factors that may have influenced Congress to feel the need to create such an incentive?

BF: All of the states, at the local, county, state and federal levels are feeling the pinch from the increased budget loads that the various benefits programs place on them. Ensuring benefits are only paid to the proper party actually makes more benefits available to the necessary beneficiary and vendor. Otherwise, funds are drained away by abuse and fraud and therefore unnecessarily increase the deficit. This provision creates another tool to ferret out and recover improper payments.

FS: What are the implications of that for the incentive for the states? How close are they to having the things in place that they will need to benefit from the financial incentive?

BF: Since 1999, the GAO [Government Accountability Office] and CMS [Centers for Medicare and Medicaid] have made several reviews of the states. They have found a wide variance in program sophistication and ability to address waste, abuse, and fraud. Texas is on the high end for performance, technology, and innovations to control spending and ensure proper payments. Only about one-third of the states currently have statutes that parallel the federal False Claims Act. With the DRA, that is going to change. State legislatures across the country are now endeavoring to enact the laws necessary to obtain the financial incentives provided by the DRA.

More federal involvement will mandate higher accountability throughout the system for enforcement initiatives. There is a big picture shift for overseeing how both federal and state dollars are spent. Consider the following four recent initiatives. First, the recent federal approval in the DRA of an aggregate yearly $100 million new dollars to enhance new HHS-OIG and CMS Medicaid enforcement initiatives over the state's benefits payment and health care systems. Second, the United States Senate hearings in March, "Bolstering the Safety Net: Eliminating Medicaid Fraud": http://hsgac.senate.gov/index.cfm?Fuseaction=Hearings.Detail&HearingID=334

Third, the GAO, in March and April, issued two reports of note: GAO-96-578T, MEDICAID INTEGRITY, Implementation of New Program Provides Opportunities for Federal Leadership to Combat Fraud and Abuse, *http://hsgac.senate.gov/_files/032806Aronovits.pdf,* and GAO-06-347, IMPROPER PAYMENTS, Federal and State Coordination Needed to Report National Improper Payment Estimates on

Federal Programs. They recommend to the OMB [Office of Management and Budget], who agreed, that federal and state agencies share responsibility for the prudent use of federal funds. The Improper Payment Information Act of 2002 requires the executive branch agencies to systematically address improper payment activity and the reporting of any overpayments in programs exceeding $10 million dollars and an error rate in excess of 2.5 percent. Finally, on April 26, 2006, at the Health Care Compliance Association's Compliance Institute, Ms. Kim Brandt, Director of Program Integrity, Centers for Medicare and Medicaid Services, told the audience that the Center would be implementing a national error rate program effective 2008 for the payment system and for all Medicaid programs in 2009. This is consistent with the GAO reports and the DRA funding. It clearly shows a commitment that will forever change the way the Medicaid world is measured and regulated

FS: I understand that you have been helping other states as they try to work on these issues and get their laws and programs in place. Can you please tell us about that?

BF: We were cited in the New York Times, along with some other states, as a positive comparison model for Medicaid fraud control. It seems that because of that we were subsequently asked to testify in the New York, Missouri, and the United States Senate on how we made the changes and what benefits we gained from them. To date, we have supplied similar information at the requests of Georgia, Florida, Pennsylvania, Maryland and New Jersey, and to the United States Congress and Senate.

FS: As you know, the DRA has some mandates for recipients of $5 million or more in Medicaid funding. They are prerequisites to payment. For example, including details of the Federal False Claims act and its state counterpart in employee manuals and policies. Providing that information to employees, contractors, and agents of the organization. What are the implications for providers?

BF: It will increase the providers' internal and associated parties' educational requirements. In my experience this will likely increase the potential for litigation of claims that are filed under the new act. It will also likely require an increase in the compliance and documentation requirements within the company.

FS: What will happen if providers do not comply with the Act? What kinds of things might you be looking for when auditing or investigating a provider?

BF: We try to include a broad look at the provider after a risk issue has been identified. We look to see if the provider appears to be trying, with due diligence, to comply with the required statutes, rules, and policies. We look more favorably on providers that are clearly demonstrating a material attempt to comply and apply proper due diligence to program oversight. We use these factors to determine whether a sanction should be applied or if only a simple repayment of the error should be made.

FS: You recently attended the HCCA Compliance Academy. Let me say first that we are honored that you participated. I am sure our members would be interested in knowing why you decided to participate. Can you share that with me?

BF: I think it is better if you can walk a mile in another's shoes. However, in this environment I can't literally obtain this goal but this course offered me a way to become familiar with the industry requirements and issues. I was pleased to receive the CHC[Certified in Healthcare Compliance] credential after taking the exam on the last day of the Academy.

FS: I agree with you that the best approach to compliance is one in which industry and government have an open, collaborative dialogue. I applaud your efforts in that regard and believe that there will be many benefits coming from your participation in the dialogue. Thanks for discussing these matters, which are so relevant to HCCA members. ■

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June 15, 2006

Contact: Michael J. Costello
Director of Investigation Support
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mcostello@nhcaa.org

FOR IMMEDIATE RELEASE

BRIAN G. FLOOD, TEXAS HEALTH & HUMAN SERVICES COMMISSION, JOINS THE ELITE RANKS OF "ACCREDITED HEALTH CARE FRAUD INVESTIGATORS"

WASHINGTON, DC—The National Health Care Anti-Fraud Association (NHCAA)—the nation's private-public organization dedicated to fighting health care fraud—announced today that Brian G. Flood, Texas Health & Human Services Commission, has been presented the NHCAA's unique professional credential—"Accredited Health Care Fraud Investigator," or "AHFI." Based in Austin, TX, Mr. Flood serves as Inspector General of the Commission.

Established in 2002, the AHFI program provides the first-ever formal accreditation of individuals who meet specific qualifications in professional experience, ongoing training, formal education and demonstrated knowledge in the detection and investigation and/or prosecution of fraud against private or government-funded health insurance plans. Individuals accredited under the program also must meet stringent requirements of continuing professional education in order to maintain their AHFI status.

Continued on next page.

"The AHFI program was created in part to reflect the considerable specialized skills, knowledge and experience that the detection and investigation of health insurance fraud demand," said NHCAA's Director of Investigation Support, Michael J. Costello. "Brian Flood epitomizes those qualities at the highest levels, and NHCAA is very proud to recognize his achievement."

Founded in 1985 and headquartered in Washington, DC, the non-profit National Health Care Anti-Fraud Association is comprised of the anti-fraud units of 100 private health payers, and the formal Law Enforcement Liaisons of federal and state agencies that have law enforcement or administrative jurisdiction over health care fraud.

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Appendix E—Letters of Recognition

United States Senate

COMMITTEE ON
HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS
WASHINGTON, DC 20510-6250

April 13, 2006

Mr. Brian Flood
Inspector General
Texas Health and Human Services Commission
Office of Inspector General
P.O. Box 85200
Austin, TX 78708-5200

Dear Mr. Flood:

Thank you for your March 28, 2006, testimony before the Senate Subcommittee on Federal Financial Management, Government Information, and International Security. We had a productive hearing, and your testimony helped elucidate a very important topic.

Enclosed with this letter is a copy of the hearing transcript. Please follow the attached directions, respond to the questions, and return the corrected transcript and responses to:

Liz Scranton, Chief Clerk
Subcommittee on Federal Financial Management, Government Information, and International Security
Committee on Homeland Security and Governmental Affairs
439 Hart Senate Office Building
Washington, DC 20510

The Subcommittee would appreciate receiving your corrected transcript and question responses by May 5, 2006. If you have any questions, please contact Liz Scranton at (202) 224-2254.

Thank you very much.

Sincerely,

Tom Coburn, MD
Chairman
Subcommittee on Federal Financial Management,
Government Information, and International Security

Brown McCarroll L.L.P.

2001 Ross Avenue, Suite 2000, Dallas, Texas 75201-2995
214-999-6100 fax 214-999-6170

KRISTALEE GUERRA
E-Mail: kguerra@mailbmc.com

Writer's Direct Number:
(214) 999-6122

March 29, 2006

VIA U.S. MAIL
Ms. Charlotte Dokes, M.S.A., B.S.N., CHC
Deputy Inspector General of Compliance
Office of Inspector General
Health and Human Services Commission
P.O. Box 85200
Austin, TX 78708-5200

Dear Charlotte:

On behalf of the North Texas Healthcare Compliance Professionals Association (NTHCPA), I would like to thank you for speaking to our organization in Dallas, Texas on March 14, 2006.

The NTHCPA members appreciated your speech regarding the Office of the Inspector General's latest trends and activities. NTHCPA, as you know, is a local group of compliance officers, attorneys, and consultants in the Dallas-Fort Worth area who meet monthly to discuss current health care compliance issues. Your presentation will help NTHCPA members plan and implement better compliance practices in each of their respective organizations for the upcoming year.

Again, thank you.

Sincerely yours,

Kristalee Guerra
Program Chair, NTHCPA

cc: Erma Lee, President, NTHCPA (via facsimile)
Lisa Taylor, Secretary, NTHCPA (via facsimile)

DAL:668626.1

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FOR LEGISLATIVE OPERATIONS

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July 7, 2006

Mr. Brian Flood
Inspector General
Texas Health and Human Services Commission
P.O. Box 85200
Austin, Texas 78708-5200

Dear Brian:

Thank you for your assistance during the New York State Senate's public hearings on Medicaid fraud. Through your involvement, the State Legislature successfully adopted comprehensive legislation prior to the conclusion of the 2006 legislative session.

As you know, my colleagues and I in the Senate Majority encountered tremendous resistance during our effort to restructure New York State's Medicaid program integrity, enforcement and recovery functions. Your testimony to the Senate's Medicaid Reform Task Force was instrumental to both the legislative process and the generation of support for this crucial reform.

As a recognized, national expert in this field, your shared expertise and experience were invaluable assets that validated our purpose and focused this effort. To this end, your insightful remarks were consistently cited by the Senate Majority and Minority, as well as members of the State Assembly, during debates, negotiations and public engagements.

Again, it was a great pleasure to meet you on Long Island and I am grateful for your help.

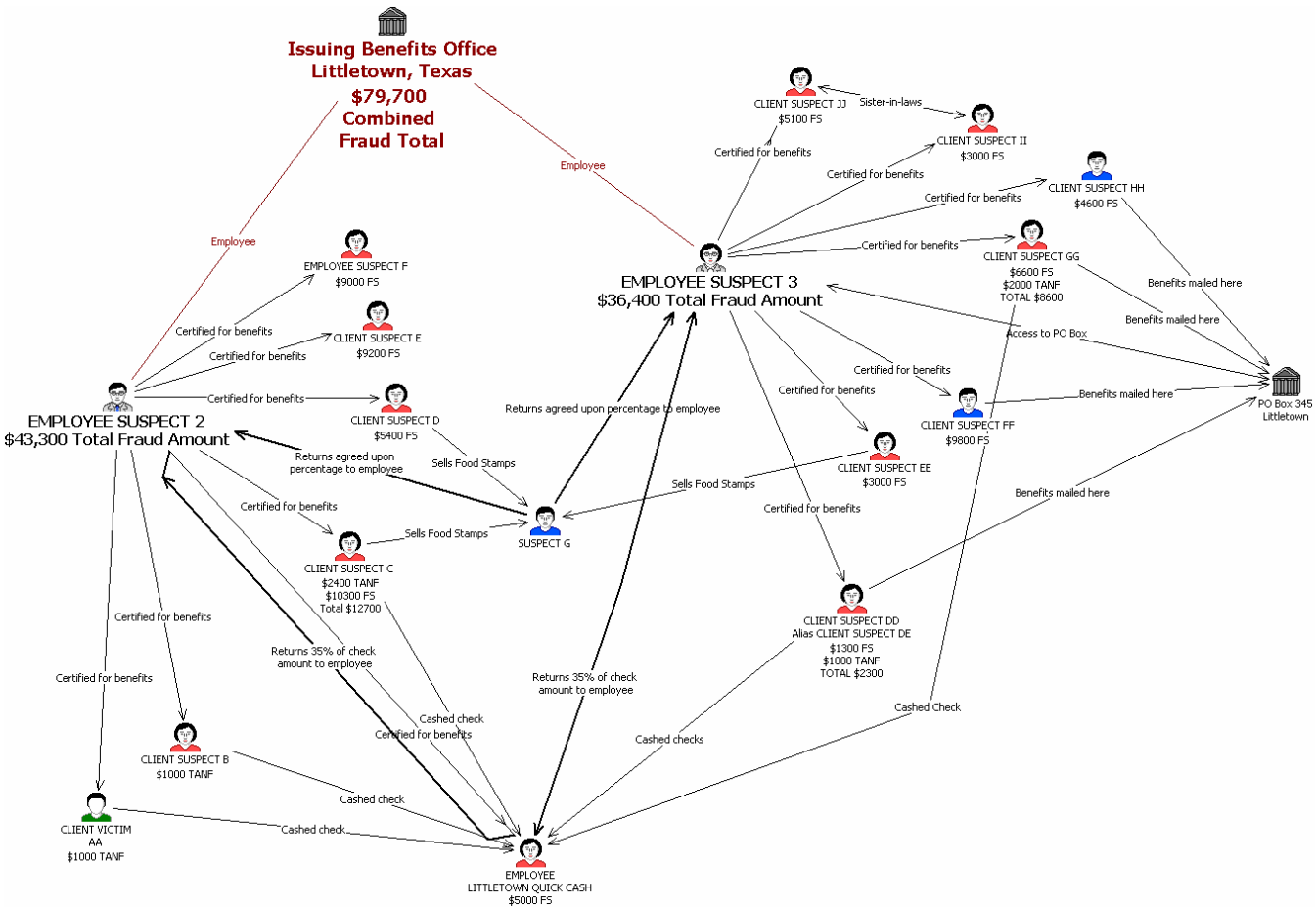
Best wishes and kind regards.

Thanks for everything. We couldn't have done it without you!

Sincerely,

Dean G. Skelos
Deputy Majority Leader

Appendix F- Link Analysis Diagram Example



End of Report