Albert Hawkins, Executive Commissioner

Office of Inspector General Semi-Annual Report

May 2006

Brian Flood, Inspector General

OIG Mission Statement

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

OIG Vision Statement

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

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

The Office of Inspector General (OIG) is pleased to issue our report for the first six months of State Fiscal Year (SFY) 2006, which ended February 28, 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. For the first time OIG activities are now also reported in aggregate form by county beginning on page 53.

For the first six months of SFY 2006, OIG recovered $220,100,296 and cost avoided $177,312,439. Total recoveries for this period in SFY 2005 decreased by 2.7% primarily due to the assignment of OIG staff resources to Hurricanes Katrina and Rita relief efforts. OIG dedicated thousands of staff hours to eligibility offices and relief shelters assisting displaced residents and families from Louisiana, Mississippi, and Alabama to obtain Food Stamp and other benefit certifications.

However, other positive and significant issues are of note:

- The Medicaid Provider Integrity Section has had a 105% increase in opened cases over the same period in 2005.
- The Managed Care Special Investigations Units have increased their referrals to the OIG to investigate abuse and fraud in managed care by 108% over the same time in 2005.
- The Third Party Recovery Section has increased recoveries by 21% or $56 million over the same period in 2005.
- The Sanctions Section is now receiving "self-reported" Medicaid overpayments. These exceeded $1 million dollars in the first two quarters.
- Under section 531.102 (h)(4)(6) of the Government Code, the Office of OIG audits the use and effectiveness of state and federal funds including contract and grant funds administered by a person or state agency. It also recommends policies promoting economical and efficient administration of the funds. Policy initiatives under this provision have been directly responsible for the recovery of more than $4.4 million in the first two quarters. The calculated future cost savings generated by recent policy reviews and recommendations exceeds $3.7 million annually.

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. Criminal background checks are performed for any person or business entity who is a principal applying to become a Medicaid provider, or who is applying to obtain a new provider number or a performing provider number. As of February 28, 2006, over 3,900 checks have been conducted.

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 all audit activity is performed in accordance to 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 and operating with more than 560 staff, 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 the 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] through the second quarter of State Fiscal Year (SFY) 2006 were $220,089,427 (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.

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

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 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 for other insurance. These are actual claim denials in which the client was identified as having other insurance 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
- 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).

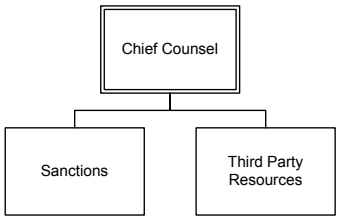
Audit

Expenses removed from cost reports because they are not considered reasonable and necessary to provide contracted client care and are not consistent with federal and state laws and regulations. The classification means only that the expense will not be included in the database for reimbursement rate determination purposes because the expense is not considered reasonable and/or necessary. The primary objective of the cost reporting process is to provide a basis for determining the appropriate rate of reimbursement to contracted providers.

Expenses removed from expenditure reports submitted by vendors and from supporting accounting records to resolve questioned or disallowed costs. Removal of the expenses restores the associated budget and allows the vendors to report allowable expenses instead. The legacy agency would make sure there is not a net overpayment for the contract in the close-out settle-up process.

Key Accomplishments and Recent Developments

Office of 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 program exclusions and civil monetary penalties on health care providers and litigates those actions. The Office of Chief Counsel includes two sections: Sanctions and Third-Party Resources (TPR).

CORF and ORF Initiative

The Office of Chief Counsel is 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 Physical Therapy and Speech Pathology Facilities (ORFs). CORFs and ORFs provide physical, speech, and occupational therapies to Medicaid recipients.

This initiative began in 2004 when OIG discovered that numerous CORFs and ORFs had not submitted yearly cost reports from which HHSC could calculate facility-specific cost-to-charge ratios and effect cost settlements.

During the first two quarters of this fiscal year, OIG Office of Chief Counsel has recovered $4,408,776 from CORFs/ORFs.

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.

On December 30, 2005, Sanctions worked collaboratively with other Office of Chief Counsel staff and Texas Medicaid & Healthcare Partnership (TMHP) to recover $4.5 million from a CORF in McAllen, Texas. The irregularities of this Medicaid provider, were brought to the attention of OIG as a result of TMHP review of the provider's cost reports irregularities, included unallowable amounts for owner salaries, unallowable related third party contracts, and other unsupported costs. In addition to recovering Medicaid overpayments, Sanc-

tions imposed and recovered a $525,000 administrative penalty.

Recently, Sanctions entered into a settlement agreement to recover an $875,000 overpayment paid to a large Medicaid dental provider. This overpayment was "self-identified" and reported to Sanctions by the provider. The Office of the Attorney General's Medicaid Fraud Control Unit (OAG-MFCU) initiated an investigation of possible criminal fraud against a dentist who was subcontracting services to this, and other Medicaid dental providers. Realizing the subcontractor error, the provider informed Sanctions of the overpayment and an agreement was reached to repay the overpaid Medicaid dollars.

To assist providers in the "self-reporting" of Medicaid overpayments, OIG is in the process of amending its administrative rules to include a "self-reporting" protocol. This protocol will emphasize the responsibility of providers to inform the OIG of overpayments detected by the provider and will provide information as to the proper procedures for doing so.

Sanctions' ability to pursue and recover overpayments and administrative penalties from providers has been enhanced by the addition of four full-time specialists and one full-time nurse. Sanctions is hiring two additional full-time nurses to further increase its ability to pursue Medicaid providers who are committing waste, abuse, or fraud.

Third Party Recovery

Third Party Resources continues to set records in cost avoidance and recovery operations. The first half of SFY 2006 shows a total increase of 21 percent over the same period last year. Total cost avoidance and recoveries totaled $323 million for the first half of SFY 2006, a $56 million increase over the same period in SFY 2005.

Under section 32.042 of the Human Resource Code as amended by Senate Bill 1188, 79th Legislature, effective September 1, 2005, TPR was able to expand its data matching activities. This legislation authorized OIG to complete an agreement to perform data matching, allowed by Centers for Medicare and Medicaid Services (CMS), with Express Scripts Incorporated (ESI). We are currently pursuing eight other agreements with Pharmacy Benefit Managers (PBMs) to perform data match work. This legislation was groundbreaking for the nation. TPR has shared the legislation, our draft contracts, and other documents relating to this effort with the CMS and other state Medicaid agencies. As we enhance our data match network with PBMs, we anticipate even greater recoveries.

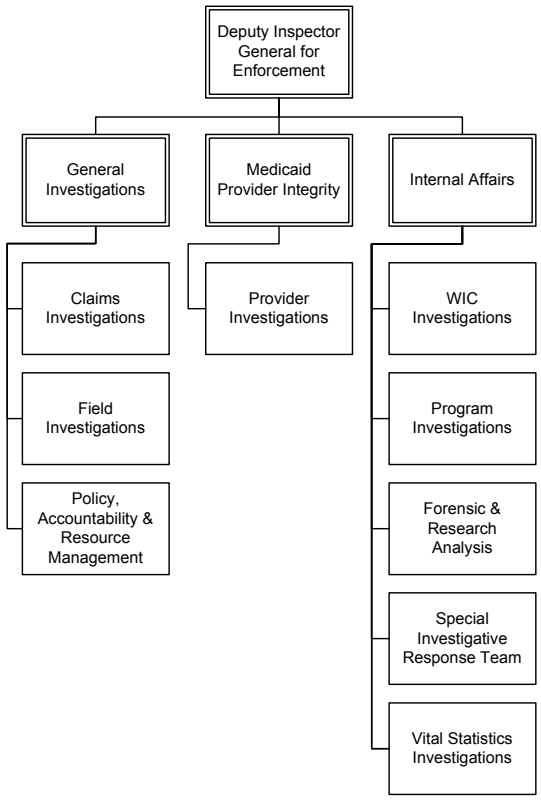
On a national scale, TPR is actively working with CMS and other state leaders to assist implementation of several projects. Most notably is the recently signed federal Deficit Reduction Act (DRA) of 2005. Section 6035, of the DRA, entitled "Enhancing Third Party Identification and Payment," expands state authority to perform data matches and introduces new requirements on third party

payers to reimburse states for Medicaid claims. We look forward to implementing and pursuing the requirements of the DRA, which requires stricter guidelines for payers. Ultimately, through legislation, Section 6035 will disable payers from denying claims based on time limit (up to three years), type or format of the claim, point-of-sale limitations, and other inappropriate denials, which insurers have used to deny Medicaid claims across the nation.

TPR collaborated with HHSC Information Technology (IT) to leverage existing abilities and eliminate manual processes. Working with them, TPR was able to eliminate a manual Medicaid identification look up process, which updated the existing Medicaid "other insurance" database. Now, an automated system performs the work and provides it directly to a vendor for input into the database. This improvement expedites the insurance update process and allows TPR staff to focus on more proactive measures.

TPR reduced administrative costs through two projects aimed at evaluating our mailing efficiency of tort and "1221" questionnaires. A tort questionnaire is generated when a trauma diagnosis code on a provider claim is identified, and a 1221 is generated when incomplete information on a potential third party resource is provided. OIG reviewed over 13,000 tort cases and found that only 550 of the nearly 3,000 diagnosis codes produced a tort lead. OIG provided the analysis to CMS and they have approved our proposal to stop sending questionnaires that are not cost-effective to produce. This internal efficiency review eliminates unnecessary production, postage, and pre-paid postage for the return questionnaire, envelope, and other administrative expenses associated with producing these questionnaires. Through a review of the 1221 mailing, TPR identified and corrected a duplication of effort that significantly reduced the mail out. These administrative savings efforts are the result of TPR staff ability to recognize and implement improvements within the existing infrastructure of the current operation.

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 (GI); Internal Affairs; and Medicaid Provider Integrity (MPI).

General Investigations

GI staff is primarily devoted to the investigation of recipient fraud in Food Stamp, Medicaid, and Temporary Assistance for Needy Families (TANF). For the first half of SFY 2006, collections for claims established totaled $8,213,454.

GI recoveries were negatively impacted by several events and factors occurring in the first half of SFY 2006. A majority of GI staff began the fiscal year by stepping out of their role in 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. The assistance provided was as varied as the staff involved and included handing out bottled water and sack lunches, assisting evacuees with filling out assistance applications, supporting the certification process, manning phones in the 2-1-1 call center, and issuing Lone Star cards. 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[2]. Also during this effort, many staff worked overtime, earning compensatory leave that will translate to

[2] 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.

additional loss of GI productivity as employees use their earned leave.

Soon after, GI was once again impacted by a hurricane when Rita followed closely on the heels of Katrina. Numerous GI offices were 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 were 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 two years and a reduction in collections.

During the second half of SFY 2006 GI anticipates an increase in the number of Food Stamp trafficking investigations conducted due to new initiatives. Eleven senior investigators were named as Food Stamp trafficking coordinators in each region to perform Food Stamp trafficking investigation activities. In addition, GI anticipates an increased number of fraud referrals in the Food Stamp and Medicaid programs due to the dramatic increase in the Food Stamp and Medicaid rolls following hurricanes Katrina and Rita. In an effort to detect this fraud, GI is conducting additional data matches to target waste, abuse, and fraud in the Texas eligibility certifications for the hurricane evacuees.

Internal Affairs

The Internal Affairs Section (IAS) conducts criminal and non-criminal investigations of waste, abuse, and fraud by HHS system employees, contractors and sub-contractors, and tracks and coordinates computer data matches to locate wanted felons and missing children. These investigations are conducted to ensure the integrity of HHS employees, programs, and operations are maintained through independent, impartial investigations of complaints.

Development has begun on a web based, centralized, security driven case management system for internal affairs investigations (CMSIA). CMSIA will replace the current stand-alone computer approach inherited from legacy agency operations. The system is being developed by Technology Analysis, Development and Support (TADS) section of OIG and is anticipated to begin operations this fiscal year. Once fully operational, the improvements offered by the new system will include:

- Complaints will be entered by any internal affairs 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 investigation on-line by management, eliminating the delay in initiating an investigation shipping documents folders;
- Investigation files are automated permitting real time review and comment 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 with whom the key is shared; 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 in IAS to handle the analysis of state owned and leased electronic devices and peripherals associated with allegations of internal waste, abuse, and fraud received by OIG. The decision to increase the size of the unit was based in part on 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. For the first and second quarters of SFY 2006, FRAU examined a total of 31 hard dives involving 22 cases.

As of January 31, 2006, the FRAU added two examiners, who completed a basic week of training, and are using the new forensics machines called Forensics Recovery of Evidence Device (FRED SR).

FRED SR is a more advanced forensic workstation with dual processors, integrated peripheral support, and increased memory and bandwidth. As opposed to its predecessor, which had a one-gigahertz processor, the more advanced FRED SR, with four-gigahertz processors, dramatically reduced the time needed for evidence acquisition and forensics software processes during examinations. We anticipate up to a 50

percent reduction in time spent on data acquisition and software processes.

Medicaid Provider Integrity

Medicaid Provider Integrity (MPI) staff is primarily devoted to the investigation of provider fraud in the Texas Medicaid Program. The 79th Legislature, Regular Session approved an exceptional item through a Legislative Appropriations Request (LAR) granting an increase in MPI staffing levels by 16 additional FTE's. This 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 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 TMHP. In addition, 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 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 February 2006 (2nd quarter, SFY 2006), MPI has conducted nearly 4,000 criminal history checks on Medicaid providers. Of those, 155 were either denied, or are pending receipt of return information.

For the first two quarters of SFY 2006, the number of provider complaints more than doubled from the same time frame in SFY 2005. During the first and second quarters of SFY 2005, MPI opened 213 cases. For the same time frame in SFY 2006, MPI has opened 438 cases. This reflects a 105 percent increase in complaints.

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 the first two quarters of SFY 2006, OIG saw a 108 percent increase in complaint referrals from MCO's based on their mandated Special Investigative Units (SIU's).

OIG and OAG Interagency Coordination

The United States Department of Health and Human Services, Office of Inspector General, approved a staged expansion and matching federal grant funds to increase the MPI unit to 208 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 commis-

sioned 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 HHSC-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. The HHSC-OIG established timelines and minimum standards 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, and both 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 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 MFCU by OIG.

Periodic planning sessions have occurred to coordinate case-methodology guidelines that apply to all case, regardless of type. Appendix B, Section III under MPI, contains three charts, which provide the number of waste, abuse and/or fraud referrals, which have been received and sent from MPI between September 2005 and February 2006.

External and Governmental Relations

The External & Governmental Relations section is structured according to 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) establish and maintain independence of organizational placement and funding; (5) maintain a flexible strategic planning system to meet the needs and priorities of federal and state legislative bodies, and other appropriate agencies; (6) foster balanced reporting of public management issues; and (7) coordinate communication and collaboration with appropriate governmental and public entities and make recommendations to improve preventative and cost-savings initiatives.

The Texas Senate Finance Committee hearing on January 18, 2006, addressed Medicaid Fraud in Texas. The Committee members requested information on performing criminal background checks on all current providers over the next year. Additionally, when asked how to close the loopholes within the system to prevent fraud, Inspector General Flood explained to the Committee Members that it is the policies that contribute to the waste, abuse, and fraud, and OIG's independence would enable enhanced addressing of the weaknesses or vulnerabilities within the system. At this hearing, Chairman Steve Ogden commended the Office of Inspector General regarding the article appearing in the New York Times, January 14, 2006, stating, "Texas, for example, has set up a state inspector general's office that is considered a model to fight health care fraud."

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.

During the month of February, Inspector General Brian Flood was requested to ap-

pear before the Senates of the States of New York and Missouri to explain his experiential knowledge gained from successfully creating the Office of Inspector General under the massive consolidation of health and human service agencies mandated by HB 2292, 78th Legislature, Regular Session, 2003. External and Governmental Relations activities have expanded to include detailed information sharing with other states inquiring about best practices for structuring an independent Office of Inspector General. Additionally, due to the recent enactment of the federal DRA in February 2006, this detailed information sharing has extended to include inquiries for subject matter expertise as well as state impact analysis of federal legislation from industry fraud and compliance associations, law enforcement entities, as well as national health care associations.

On February 2, 2006, New York Senate Joint Committee Chairman Skelos invited Inspector General Flood to testify as the national subject matter expert on fighting Medicaid fraud before New York State lawmakers. "For every dollar that Texas spent to operate my organization last year," Flood explained to the New York State Senate's Medicaid Reform Task Force, "my organization recovered $10 that was misspent and prevented an additional $13 in unwarranted spending." Last year, Texas recovered $441.5 million and saved another $362.5 million from waste or fraud.

As a result of the joint hearings and using the Texas OIG as the national model, on March 14, 2006, the New York Senate passed historic legislation to fight Medicaid fraud. 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) See also New York Senate website for press release: http://www.senate.state.ny.us/pressreleases.nsf/2e0e86fa9105ed5a85256ec30061c0be/a8dcae1f528a000885257131006df339?OpenDocument.

In a March 14, 2006, article on the same issue regarding the New York Medicaid legislation, 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."

As a comparison between the two states, Texas Medicaid has annual expenditures in excess of $16.9 billion, approximately one-third of the state's budget. According to the New York Times in an article dated January 14, 2006, entitled "NY Governor Plans Agency to Fight Medicaid Fraud", New York spends $44.5 billion annually on their Medicaid program—the most expensive in the country. It covers 45 percent less people than California, costs three times more than Texas pays, and spends twice the national average on each of its 4.2 million recipients equaling one in every five New Yorkers.

Texas Governor Rick Perry appointed Mr. Flood as Inspector General in 2003 when the state was consolidating twelve health and human services agencies into five. Mr. Flood told the New York State lawmakers that creating the Office of Inspector General, streamlining operations, and providing the office with new legal authority, resulted in an immediate 23 percent increase in the first year of dollars recovered. OIG's focus on protecting the integrity of HHS programs during the last two years has resulted in over $1.5 billion in recoveries and cost avoidance for the State of Texas.

The New York Times published two articles last July that revealed how billions of dollars were potentially being lost through waste, abuse, and fraud in their state's Medicaid program. The hearing held on February 2nd is just one in a continuing series of public hearings occurring throughout New York on the problem of Medicaid fraud.

Mr. Flood, who serves on the boards of the National White Collar Crime Center and the National Insurance Crime Bureau, also appeared before the Missouri Senate in a hearing on February 9, 2006, as a subject matter expert on Medicaid fraud to assist improving the efficiency of their system. 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.

Additionally, Florida, Georgia, Maryland, and Pennsylvania have contacted OIG to potentially assist with improving their organizational and operational processes of identifying and eliminating waste, abuse, and fraud in their Medicaid programs.

On February 27, 2006, Texas Governor Rick Perry reappointed Mr. Flood as Inspector General for Health and Human Services for a term to expire February 1, 2007. (See Governor Perry's Press Release in Appendix D.)

U.S. Senator Tom Coburn, has requested Inspector General Flood to appear as a fraud subject matter expert at the upcoming

March 28, 2006, hearing addressing the U.S. Senate Committee on Homeland Security and Government Affairs, Subcommittee on Federal Financial Management, Government, Information, and International Security. The purpose of the hearing, "Bolstering the Safety Net: Eliminating Medicaid Fraud," is 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 will be 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 CMS. Hearing details will be available in the upcoming semi-annual report for March 1, 2006 to August 31, 2006.

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 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.

Since September 2004, OIG and the UTD School of Social Sciences and Erik Jonsson School of Engineering and Computer Science have been working in partnership to create a groundbreaking data resource that will facilitate scientific measurements and studies of numerous social services phenomena. This data resource will enable social scientists to apply advanced research methodologies and theories to understand behaviors, procedures, and policies that result in excessive waste, abuse, or fraud of health and human services funds. The project is based on the idea that we can gauge how well and cost-effectively the Texas Medicaid program is using taxpayer dollars by collecting and analyzing data from many diverse sources to achieve the best possible "big picture" view.

TxHASIT also facilitates analyses of the geographic distribution of clients and their diseases. As a demonstration, the map shows the spatial distribution of diabetes claimants claims by Texas Legislature House. This type of model enables policy makers to spatially target scarce state resources toward prevention programs. (See Appendix F)

Since TxHASIT is designed to interact with a GIS, numerous other spatial operations will be available. Once the location of clients and providers is determined in the system, they can be analyzed in terms of any geographic boundary; e.g., school districts, hospital catchment areas, census tracts, and arbitrarily defined shapes.

The springboard for TxHASIT was a July 2004 executive order by the Governor's Office calling on state agencies to fight waste, abuse, and fraud. The system is the only

one in existence in the nation today and synthesizes state-of-the-art technology and massive amounts of data to answer some of the most complicated social and health issues facing Texas.

During the first six months of SFY 2006, the project has targeted specific disease analyses. One example, diabetes treatment analysis, allows program personnel to figure out how Texas Medicaid is treating diabetes, who is getting the best results, how well the dollars are being spent and, by inference, how treatments could be made more effective. Also, this analysis is a good tool for spotting inflated payment requests, ineffective treatment modes, and unethical providers' efforts to abuse the system. Health and human services agencies and the medical community can use this information to improve treatment of chronic health conditions. The system already has helped the Texas Diabetes Council address many of its goals for 2010 and has been used to answer a Texas Legislature required disease study of renal failure.

The project is much broader than just diabetes and can provide equivalent information relating to leukemia, asthma, childbirth, immunization rates, and more. Over the course of SFY 2006, the project will continue to explore these opportunities. TxHASIT incorporates a multifaceted team of Inspector General and Medicaid healthcare experts from HHSC with computer engineers, data analysts and social scientists.

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 the period of September 1, 2005, to February 28, 2006 are also listed in a chart by date in Appendix B, Section V-Other OIG Activities and includes:

- Inspector General Brian Flood --
  - Association of Certified Fraud Examiners, "Fraud Cases Referred to Health and Human Services," October 3, 2005;
  - Texas Medical Auditors Association Annual Conference, "The New 'Rules' for Waste, Abuse and Fraud," October 13, 2005;
  - Texas Government Accountability Conference, Panel Member, "Best Practices—The Governor's Fraud Initiative," November 1, 2005;
  - Blue Cross Blue Shield of Illinois Special Investigations, Health Care Panel, November 14, 2005;
  - Texas Senate Finance Committee, Medicaid Fraud in Texas, January 18, 2006;
  - New York Senate Public Hearing, testimony on waste abuse and fraud, February 2, 2006; and
  - Missouri Senate Special Committee on Medicaid Fraud, February 9, 2006.
- Deputy Inspector General of Enforcement Bart Bevers --
  - HHSC Regional Attorneys, "Administrative Investigations Processes of Internal Affairs," February 21, 2006.

- Director of Internal Affairs Wayne Sneed --
  - National Insurance Crime Bureau/State Farm Annual Training, "Overview of the Office of Inspector General," December 1, 2005.

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 United States General Accounting Office Government Auditing Standards.

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 has aided the implementation of the following policy changes in the last six months:

Enforcement of CORF and ORF Initiative In 2004 OIG discovered that numerous CORFs and ORFs had failed to submit yearly cost reports from which HHSC could calculate facility-specific cost-to-charge ratios and effect cost settlements.

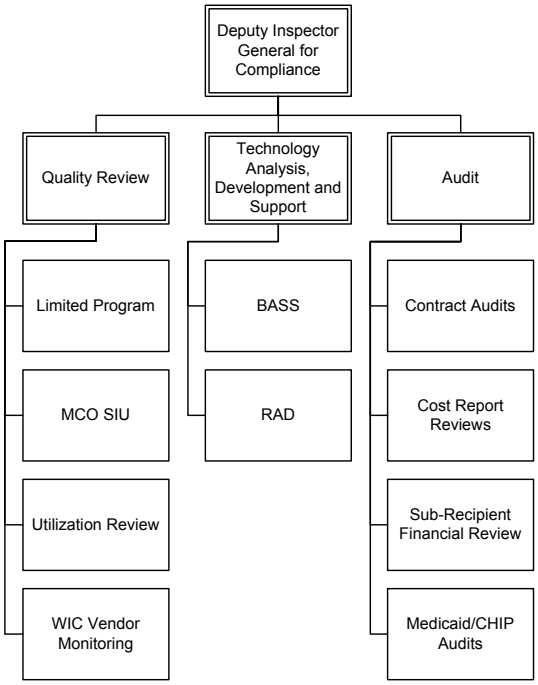
By aggressively enforcing state policy requiring the submission and review of CORF and ORF cost reports, OIG recovered $4,408,776 for the first two quarters of this fiscal year (please refer to Office of Chief Counsel for more details) due to this policy initiative.

Behavioral health twelve-hour limitation—this limitation was established in policy on October 31, 2005. System implementation of this policy is expected to occur in the near future. Based on SFY 2003 data, the Benefits Management Workgroup (BMW) estimates annual cost savings of approximately $3,785,738.

Under the new policy each individual practitioner is limited to a combined total of 12 hours of Medicaid reimbursement per day for behavioral health services. Each individual delegated to perform behavioral health services by a medical doctor (MD) or Doctor of Osteopathy (DO) is also limited to a combined total of 12 hours. Providers performing group therapy submit claims for each client attending group therapy. MDs and DOs delegating. Providers performing group therapy submit claims for each client attending group therapy. MDs and DOs delegating, and providers performing group therapy, may possibly submit claims in excess of 12 hours in a given day.

Retrospective review may occur for both the total hours of services performed per day and the total hours of services billed per day. If inappropriate payments are identified, the money will be recouped.

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, or fraud when appropriate. The Compliance division has three sections: Audit, Technology Analysis, Development & Support (TADS), and Quality Review.

Technology Analysis, Development and Support

The TADS section is responsible for directing and monitoring the development, implementation, and coordination of policies and procedures encompassing OIG information technology systems.

During this time period, the option to extend the Medicaid Fraud Abuse and Detection System (MFADS) contract with Electronic Data Systems (EDS) was exercised and the contract extended until August 31, 2007. Additional services purchased with this contract amendment include the development of monthly program metrics and monthly analysis of claims data utilizing the EDS analytical tool called Fast Cycle Retro. Both of these new services will enhance the ability to identify provider, program, policy, and system issues more timely.

TADS staff continues to work with HHSC-IT and OIG GI staff on the development of the Automated System for the Office of Inspector General (ASOIG). The ASOIG will replace the many systems GI currently uses and provide a one-stop application that will increase employee productivity. ASOIG related activities during this period includes:

- HHSC IT receipt and configuration of the required websphere servers;
- HHSC IT finalization of the Correspondences and Reports Software Requirement Specifications (SRS) addendums based on input from OIG;

- Screen design development and approval of the ASOIG prototype;
- HHSC IT is updating the ASOIG SRS based on the prototype review and comments; and
- Continued development of ASOIG interfaces with Texas Integrated Eligibility Redesign System (TIERS) and Accounts Receivable Tracking System (ARTS).

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 (WIC).

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 recipient received 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.

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 GI section.

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

The Limited Program staff works in conjunction with GI section and the Business Analysis Support Services (BASS) unit within the OIG to address system issues.

MCO-SIU

In accordance with Section 531.113 of the Government Code, a 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 SIU for the purpose of investigating fraudulent claims and other types of program abuse by recipients 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 to the start of the state fiscal year. As of July 2005, 14 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. As of September 1, 2005, all 14 plans were approved.

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

- Provide information about provider and member waste, abuse, and fraud;
- 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. The 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 (T.I.L.E.) 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 assessment 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 T.I.LE. assessment and billing. To address the issue, UR implemented new rules in August 2004. 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. 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 T.I.L.E. payment.

The nursing facility T.I.L.E. review process incorporates:

- Facility staff education;
- Opportunity for informal reconsideration of any T.I.L.E. 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 first half of SFY 2006 were $9,232,410. The details can be found in Appendix B, Section III.

Between September 1, 2005, and February 7, 2006, UR conducted 379 T.I.L.E. reviews at nursing facilities.

- 28 nursing facilities were placed on vendor payment hold;
- 24 nursing facilities were released from vendor payment hold; and
- 4 nursing facilities remained on vendor payment hold

Hospital Utilization Review: UR is also mandated to conduct 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 first half of SFY 2006 were $12,087,753. The details can be found in Appendix B, Section III. During this time period, UR conducted 145 on-site reviews and 429 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. Results of incorporating the new methodology will be provided in OIG's next Semi-Annual Report.

WIC Vendor Monitoring

The Women, Infants 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.

The WIC vendor monitors within the OIG tested the new Electronic Benefits Transfer (EBT) system, received training on the different equipment, and assisted in developing a process to determine if the vendors are in compliance with federal and state statutes. The WIC vendor monitors meet monthly with WIC program staff to report the results of the testing.

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 Services developed the 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 four counties. 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.

Audit

The Audit section consists of four units:

- Subrecipient Financial Review;
- Medicaid/CHIP Audit;
- Contract Audit; and
- Cost Report Review.

The Audit section focused on the following activities in SFY 2006:

- Hiring staff to fill 40 new positions and existing vacancies;
- Gaining an understanding of and planning for the Medicaid/CHIP and Contract Audits to be performed;
- Revising audit programs to improve audit processes including developing sampling methodologies to enhance efficient use of resources;
- Participating in the OIG strategic planning process; and
- Performing oversight activities of audit services contracted by the HHSC Medicaid/CHIP division.

Audits performed include the various types 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 Government 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

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 limited–scope audits of subrecipients. The quality control reviews conducted on CPA firms and limited-scope audits are based on a risk assessment process, while desk reviews are conducted on all single audit reports submitted by subrecipients of HHS agencies.

A subrecipient is subject to a single audit when receiving and expending 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 –in addition to routine desk reviews conducted on subrecipients, 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 going-concern. The information provided by these additional analyses are 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 current update provides a 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 allows SFRU to determine the timing for issuing reminder letters, delinquent letters, and/or follow-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. Collaborating with specific programs, such as the Special Nutrition Program to identify ways our services could assist them, (i.e. responding to specific inquiries on technical matters related to OMB Circular A-133, State of Texas Single Audit Circular, or interactions with their external auditors).
- Working with the KPMG auditors in their fieldwork of the SFY 2005 Statewide Audit (page 248) of contracts issued by HHSC to subrecipients for compliance with OMB Circular A-133 requirements. Currently, there are no findings against OIG on matters concerning our single audit reviews of the subrecipient reports. In addition, this unit was instrumental in resolving prior audit findings regarding insufficient monitoring efforts of subrecipients.

Quality Control Reviews –SFRU 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. In total, there are 67 quality control reviews that will be conducted in SFY 2006 on CPA firms located across the State of Texas. 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. To date, six quality control reviews of CPA firms are complete, and the remaining projects have been scheduled throughout the year using OIG geographical regions.

The objective of a quality control review is to determine whether the selected CPA

firms conducted the single audit of the subrecipients in accordance with the professional auditing standards and other requirements set forth in *Government Auditing Standards*, Generally Accepted Government Auditing Standards (GAGAS), Generally Accepted Auditing Standards (GAAS), and/or OMB Circular A-133. To implement this program, we have hired four new auditors, and are hiring two additional approved positions.

Limited Scope Audit –this function of the SFRU is still in discovery stage. The risk-assessment for this area begins in April/May 2006 with completion expected in July/August 2006. At completion, the Audit section 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 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 onsite audits of the subrecipients.

Medicaid/CHIP Audit

The Medicaid/CHIP Audit Unit is undergoing a period of rapid growth to meet the risks present in Medicaid and CHIP. Receiving initial staffing of 27 auditor positions for SFY 2006, the unit has filled 19 positions as of February 2006 and is on its way to becoming fully operational.

With a risk-based audit plan for the fiscal year already in place, the new auditors are initiating several planned projects, and are providing immediate contributions to the overall OIG mission. A major undertaking already in development is a methodology to audit Medicaid outpatient hospital costs reported in the Medicare Cost Report. This project, which will cover the past five years of program costs, is expected to result in a significant recovery of funds.

With State Auditor's Office approval, the unit has planned a final close-out audit of the National Heritage Insurance Company (NHIC) Medicaid claims administrator contract, as required by the Rider 16 of the HHSC bill pattern in the General Appropriations Act, 2005. Also, in coordination with HHSC Internal Audit, the unit is completing a required risk assessment of the entire Medicaid program.

The unit has organized an information systems audit team to meet the demands for assurance services related to the critical information systems relied upon to carry out program functions for Medicaid and CHIP. This team is undertaking projects already identified in the Audit Plan.

Finally, the unit is continuing its oversight of external audit contracts with Medicaid/CHIP programs to ensure the quality and effectiveness of these services. Through close collaboration with HHSC Contract Management staff, the unit assisted in the identifying additional questioned costs and ensured that prepared reports conform to

applicable professional standards and accurately reflect the nature of the work performed.

Contract Audit

In October 2005, a manager for this unit was hired and eight additional auditors were hired in January 2006. The Contract Audit Unit (CAU) provides audit coverage for all HHS contracts other than Texas Medicaid Administrative Services (TMAS) and subrecipient contracts.

To ensure needs and resources are balanced and the greatest impact and customer value is provided, an audit plan will be prepared after the completion of a risk assessment that identifies current and past contracts within a given time period. Risk criteria along with external and internal business risks and auditor judgment will be used to identify those contracts with the greatest risk.

Contracts to be included in the risk assessment 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 services contracts.

Audits are performed to reasonably assure 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 to date by the CAU includes:

- Completion of fieldwork for an examination of a long-term care provider that has an identified recoupment of $283,705 out of $405,421 in questioned costs. The final report will be released in April 2006.
- Completion of fieldwork for 21 audits of Intermediate Care Facilities for Mental Retardation (ICF/MR). The CAU conducts ICF/MR audits as mandated in the 40 TAC §§ 9.219 through 9.269 relating to provider reimbursement and client trust funds. Final reports will be released in April 2006.
- Completion of the planning phase for 23 ICF/MR audits.

CAU is currently updating ICF/MR policies, procedures, and work papers to conform to Yellow Book standards. Upon completion, all ICF/MR audits will be conducted using

TeamMate software. Additionally, new staff is being trained in the use of TeamMate.

CAU is also planning to move the Vendor Drug program to activation in the third quarter. At this time, CAU is planning the audits and will convert all policies, procedures, and work paper templates to conform to Yellow Book standards. The vendor drug audits will be conducted using TeamMate.

Cost Report Review

The Cost Report Review Unit (CRRU) completes onsite field audits and in-house desk reviews of provider cost reports[3]. Desk reviews of provider cost reports are conducted to ensure the financial and statistical information submitted in the cost report conforms to all applicable rules and instructions. Unallowable costs are removed from the cost report and ultimately from the HHSC database used to determine the 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 selection is currently based on a risk assessment analysis performed by the HHSC Rates Analysis division (RAD). Unallowable costs identified in the reviews and audits are removed from the cost reports. Cost avoidance savings are generated by the removal of these costs, resulting in lower reimbursement rates. This adjusted statistical and financial information is utilized by RAD 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 and desk reviews are being performed in accordance with GAGAS.

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 recovers overpayments based on these cost reports. CRRU performs desk reviews and field audits on these reports. Adjustments to these compensation reports can result in the recovery of additional overpayments made to these providers.

Both ICF/MR and Home and Community Based Service programs for mentally retarded individuals are required to spend at least 90 percent of the rate for direct care services to Medicaid clients. RAD recovers a portion of the rate component from a Medicaid provider failing to meet this requirement. CRRU performs desk reviews and field audits on the cost reports submitted by these providers. Adjustments to the re-

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

ported direct care cost often result in RAD recovering additional funds from the providers.

CRRU conducts investigative audits in conjunction with OIG MPI 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 participates 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 enterprise by those involved in any phase of the contracting cycle to conceptualize, and 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.[4]

Non-Audit Services

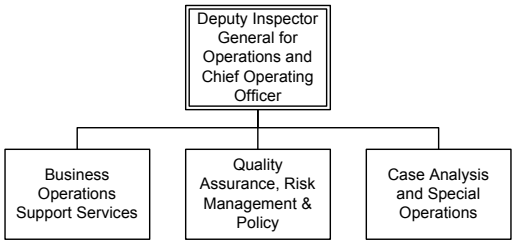
Non-audit services generally differ from audits in that auditors may perform tasks requested by management that directly support the entity's operations or provide information or data to a requesting party without providing verification, analysis, or evaluation of the information or data. These services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

As an 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 Medicaid claims operator 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 approximately $260,000 for excess costs charged to the contract for these years. We recommended, (1) denying

[4] 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.

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.

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 the first part of fiscal year 2006, Business Operations and Staff Services has contributed valuable assistance in various areas of responsibility. Some examples include:

- Processing over 500 personnel actions;
- 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 the United States Senate;
- Coordinating 411 operations (assigning space, coordinating security, scheduling of necessary staff) during the Katrina and Rita Hurricane disasters;
- Processing over 200 procurement requisitions;
- Managing of the OIG 1-800 Fraud Hotline;

- Facilitating the creation and implementation of the OIG Strategic Plan;
- Coordinating the OIG Internship Program;
- Maintaining the OIG 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
  - Governor's Center Training Expo.
- Sending staff to or bringing in subject matter experts to train in the following areas:
  - Understanding Hospital Cost Reports;
  - Fundamentals for the Health Care Fraud Investigator;
  - i2 Analyst Notebook and iBase Designer workshops; and
  - Specific computer skills.
- Providing opportunities for leadership and management development including:
  - Teambuilding, Problem Solving, Decision Making, & 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.

Quality Assurance, Risk Management, and Policy

The Quality Assurance, Risk Management, and Policy (QARP) 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.

Some significant contributions this section since its creation in December 2005 include:

- Beginning work on quality assurance Program protocols and procedures;
- Working with OIG staff in developing, testing, and deploying standardized

data analysis tools and analytical procedures;
- Initiating work on the statistical sampling of Provider Cost Reports;
- Developing and beginning to use interview protocols for the initial study of OIG structure, functions, interfaces, and culture;
- Exploring and suggesting possible methods for future pharmacy Audits;
- Helping clarify certain provisions of Article IX in the GAA; and
- 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, etc.)

Beyond these, QARP 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.

Case Analysis and Special Operations

OIG created the Case Analysis and Special Operations section in February 2006 to conduct specialized analyses 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. CASO employs full time research and link analysis specialists using the latest 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 G. 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.

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 Deputyship for Operations, through its MCO & Staff Development Training section, 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 seminars 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.

From December 2005 through February 2006 OIG Training conducted 3-hr waste, abuse, and fraud sessions. These sessions addressed the mission of OIG and the scope of it's investigations, specific beneficiary, provider, and MCO fraud issues, and developing organizational fraud controls. Over 200 individuals representing all contracted MCOs completed this mandatory training by February 15 2006.

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.

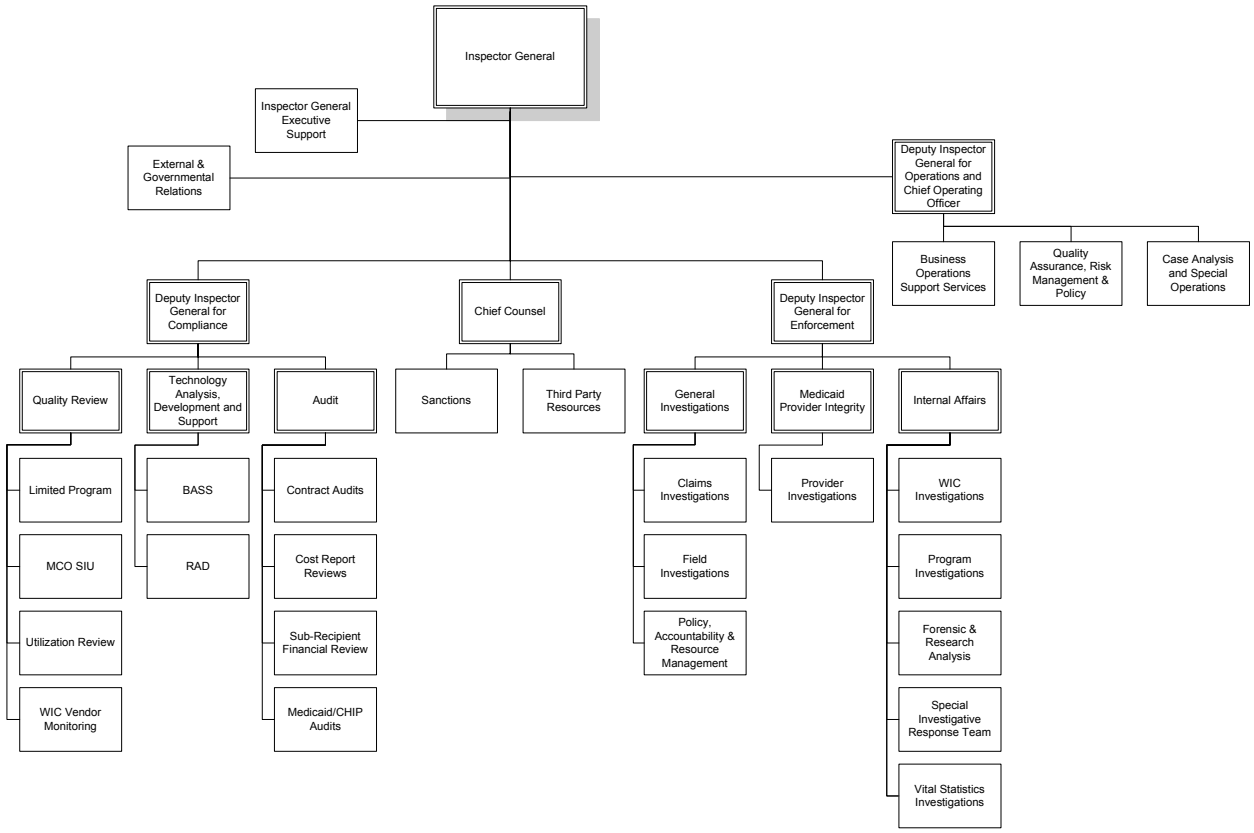
The objectives of HHSC/OIG training are to educate and inform about:

- 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 Texas State University (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[5]

Recovery Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Sanctions	$3,430,511	$5,262,123			**$8,692,634**
Civil Monetary Penalties (CMP)	$870,353	$782,316			**$1,652,669**
Utilization Review (Hospitals)	$5,423,360	$6,664,393			**$12,087,753**
*Utilization Review (Nursing Homes)	$4,740,410	$4,492,000			**$9,232,410**
Third Party Recoveries	$92,701,213	$85,603,992			**$178,305,205**
Technology Analysis, Development & Support (TADS)	$1,101,298	$726,319			**1,827,617**
General Investigations (Food Stamps, TANF, and Medicaid Recipients)	$2,878,108	$5,335,346			**$8,213,454**
WIC Investigation Recoveries	$12,427	$10,611			**$23,038**
WIC Vendor Monitoring	$883	$2,691			**$3,574**
Audit Activity	$61,940	$0			**$61,940**
Internal Affairs	$0	$0			**$0**
Total Recovery Activity	**$111,220,504**	**$108,879,792**	**$0**	**$0**	**$220,100,296**

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

Section II—OIG Cost Avoidance[6]

Cost Avoidance Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Sanctions	$264,104	$705,423			**$969,527**
TADS Provider Prepayment Review Process	$45,132	$50,856			**$95,988**
Third Party Resources	$76,366,334	$68,467,589			**$144,833,923**
Disqualifications (Food Stamps & TANF Recipients)	$587,988	$417,324			**$1,005,312**
Income Eligibility Verification System (IEVS) Data Matches (Food Stamps, TANF and Medicaid Recipients)	$172,466	$375,199			**$547,665**
Recipient Data Matches (Food Stamps, TANF and Medicaid Recipients)	$124,061	$111,001			**$235,062**
Audit Activities[7]	$4,164,405	$8,717,707			**$12,882,112**
WIC Vendor Monitoring	$626	$437			**$1,063**
CORF/ORF	$8,500,894	$8,500,894			**$17,001,787**
Total Cost Avoidance	**$89,966,010**	**$87,346,430**	**$0**	**$0**	**$177,312,439**

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

[7] Audit cost avoidance dollars are actually dollars identified through audit processes. Because other agencies are responsible for recovery of funds, rate adjustments, or other appropriate actions based on the audit work, OIG includes this as a cost avoidance figure.

Section III—OIG Summary Tables

Sanctions

Sanctions Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Cases Opened	61	162			**223**
Cases Closed	81	119			**200**
Cases Referred to Attorney General	0	0			**0**
Dollars Recovered	$3,430,511	$5,262,123			**$8,692,634**
Exclusions	54	77			**131**
Payment Holds	2	4			**6**
Civil Monetary Penalties Recovered	$870,354	$782,316			**$1,652,670**
Cost Avoidance	$264,104	$705,423			**$969,527**

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			**$144,833,923**
Other Insurance Credits	$68,074,513	$56,649,616			**$124,724,129**
Provider/Recipient Refunds	$1,736,658	$1,614,808			**$3,351,466**
Texas Automated Recovery System (TARS)	$7,211,447	$5,538,462			**$12,749,909**
Pharmacy	$5,075,033	$10,030,210			**$15,105,243**
PPRA	$682,114	$462,329			**$1,144,443**
Credit Balance Audit	$3,033,886	$3,096,421			**$6,130,307**
Tort	$4,275,232	$5,308,859			**$9,584,091**
Cash Medical Support	$2,612,330	$2,903,287			**$5,515,617**
Total Third Party Recovery Activity	**$169,067,547**	**$154,071,581**	**$0**	**$0**	**$323,139,128**

General Investigations

General Investigations Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Collections[8]	$2,878,108	$5,335,346			**$8,213,454**
Disqualification Cost Avoidance[9]	$587,988	$417,324			**$1,005,312**
Cost Avoidance Income Eligibility Verification System (IEVS) Data Matches**	$172,466	$375,199			**$547,665**
Cost Avoidance Recipient Data Matches	$124,061	$111,001			**$235,062**
Referrals/Complaints Received	12,880	16,007			**28,887**
Cases Completed	14,567	15,159			**29,726**
Percent of Cases Completed w/in 180 Days	90.50%	86%			**88.25%**
Cases Referred for Prosecution[10]	571	832			**1,403**
Admin. Disqualification Hearings (ADH) Cases Completed	1,220	1,397			**2,617**
Cases Adjudicated	493	359			**852**
Civil Disqualifications	1,266	925			**2,191**
Income Eligibility and Verification System (IEVS) Matches Cleared	33,522	36,331			**69,853**
Recipient Data Matches Cleared	4,275	3,825			**8,100**

[8] Collection activity is the responsibility of TDHS Fiscal Division and is based on Claims Established by General Investigations.
[9] Disqualification cost avoidance is based on an average monthly savings per client. IEVS and recipient data match cost avoidance is based on an average case savings.
[10] First Quarter number have been updated to include investigation in an additional category on the detail report, which was not previously reported.

GI-Food Stamp Investigations

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
Claims Established	$2,475,846	$2,985,865			**$5,461,711**
Collections	$2,406,192	$4,819,946			**$7,226,138**
Disqualification Cost Savings	$546,324	$379,692			**$926,016**
Cases Referred for Prosecution	385	580			**965**
ADH Cases Completed	1,064	1,229			**2,293**
Civil Disqualifications	1,061	760			**1,821**

GI-TANF Investigations

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
Claims Established	$571,490	$561,915			**$1,133,405**
Collections	$300,980	$357,633			**$658,613**
Disqualification Cost Savings	$41,664	$37,632			**$79,296**
Cases Referred for Prosecution	77	94			**171**
ADH Cases Completed	156	165			**321**
Civil Disqualifications	205	165			**370**

GI-Medicaid Investigations[11]

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
Claims Established	$204,675	$292,999			**$497,674**
Collections	$170,936	$157,767			**$328,703**
Cases Referred for Prosecution	103	152			**255**
ADH Cases Completed	0	3			**3**

[11] 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
IEVS Food Stamp Matches	27,852	30,599			**58,451**
IEVS TANF Matches	1,106	1,065			**2,171**
IEVS Medicaid Matches	4,564	4,667			**9,231**
TOTAL	**33,522**	**36,331**			**69,853**

GI-CHIP Investigations[12]

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
CHIP Investigations	0	0			**0**

GI-Other Investigations[13]

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
Other Investigations	6	6			**12**

GI-Other Matches

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	TOTAL
Other Data Matches Cleared	4,275	3,825			**8,100**

Internal Affairs

IA Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Complaints Received	91	84			**175**
Investigations Completed	60	26			**86**
Dollars Recovered	$0	0			**$0**
Cases Referred	2	4			**6**

[12] Currently do not have access to the CHIP eligibility database.

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

WIC Investigations

WIC Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Referrals/Complaints Received	45	65			**110**
Cases Opened	61	35			**96**
Cases Closed	48	43			**91**
Claims Established	36,317	25,643			**61,960**
Collections	$12,427	$10,611			**23,038**
Cases Adjudicated	2	1			**3**

Medicaid Provider Integrity (MPI)

MPI Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Cases Opened	235	203			**438**
Cases Closed	74	71			**145**
Cases Referred to Attorney General	20	69			**89**
Criminal History Checks Conducted	0[14]	3,923			**3,923**

[14] Criminal history check process was not initiated during the 1st quarter.

Waste, Abuse and Fraud Referrals Made By MPI
SFY 2006 (1st & 2nd Quarters)

Referral Source	Referred
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	89
Medicare Part A& B	7
Palmetto Government Benefits Administrators (GBA)	1
Department of Family and Protective Services (DPRS)	2
Texas Department of Aging & Disability Services (DADS)	5
Texas Department of State Health Services	1
Texas Department of Transportation (TXDOT)	2
Board of Dental Examiners	5
Board of Medical Examiners	4
Board of Nurse Examiners	2
Board of Pharmacy	1
Claims Administrator – Educational Contract	30
Claims Administrator – Claims/Record Review	1
HHSC – OIG Audit	1
Vendor Drug	1
Total Cases Sent	**152**

Waste, Abuse and Fraud Referrals Received By MPI
SFY 2006 (1st & 2nd Quarters)

Referral Source	Received
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	3
United States Department of Treasury	1
Medicare Matching Project	2
Assistant US Attorney's Office	1
Texas Department of Aging & Disability Services (DADS)	22
Texas Health Steps	31
Texas Department of State Health Services (DSHS)	9
Texas Medicaid Healthcare Partnership (TMHP)	5
Texas Department of Family and Protective Services (DFPS)	1
Law Enforcement Agency	1
Managed Care Organizations /Special Investigative Unit (SIU's)	19
2005 PAM III Study (Comptroller's Office)	1
2005 Year Four Perm Study (Comptroller's Office)	4
TX Health Care Claims Study 2005 (Comptroller's Office)	4
Parent/Guardian	19
Provider	20
Public	66
Recipient	147
Anonymous	44
HHSC – Internal Affairs	3
HHSC – Medicaid/Chip Division	2
HHSC – MPI-OIG Self-initiated (MPI)	16
HHSC – Utilization Review	14
Vendor Drug	3
Total Cases Received:	**438**

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			**1,727**
Cases Closed	672	1,138			**1,810**
Cases Referred to Attorney General	0	1			**1**
Dollars Recovered	$1,101,299	$726,319			**$1,827,618**
Cost Avoidance Due to Provider Prepayment Review Process (all OIG)	$45,132	$50,856			**$95,988**

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						
STAR (Rx Only)	226	228	220	224	228	209						
STAR+PLUS (Rx Only)	51	53	49	52	50	51						
Total Limited Program Activity	**501**	**498**	**485**	**494**	**494**	**489**	**0**	**0**	**0**	**0**	**0**	**0**

Utilization Review (UR)[15]

UR Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Hospitals - Recoveries	$5,423,360	$6,664,393			**$12,087,753**
Hospitals – Underpayments	$16,450	$11,660			**$28,110**
Nursing Homes – Recoveries	$4,740,410	$4,492,000			**$9,232,410**
Nursing Homes – Under-payments	$201,899	$178,039			**$379,938**
Nursing Homes– Facilities Visited	245	197			**442**
Nursing Homes - # of Forms Reviewed	9,309	8,082			**17,391**
Nursing Homes - # of Facili-ties Placed on Vendor Hold	17	11			**28**
Hospitals – Mail-ins	216	213			**429**
Hospitals – Facilities Visited	83	62			**145**
Hospitals - # of Claims Re-viewed	7,116	6,324			**13,440**

WIC Vendor Monitoring

WIC Vendor Monitoring Cate-gory	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Compliance Buys Conducted	79	86			**165**
Number of In-Store Evaluations	12	23			**35**
Number of Audits Closed	22	14			**36**
Vendor/Grocer Overcharges	$626	$437			**$1,063**
Dollars Recouped	$69	$0			**$69**
Civil Monetary Penalties	$814	$1,371			**$2,185**

[15] Underpayments are payments identified during utilization review that providers were entitled to but did not receive due to provider coding errors. During the exit conference, providers are educated as to correct coding guidelines. Underpayments identified are returned to the providers through the claims adjustment process.

Audit [16]

Subrecipient Financial Review

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Desk Reviews	216	139			**355**
Rejected Single Audits	30	4			**34**

Medicaid/CHIP Audit[17]

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

Contract Audit[17]

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Audits	1	1			**2**
Recoupments & Recovery	$61,940	$0			**$61,940**
Cost Avoidance	$0	$0			**$0**
Recipient Refunds	$0	$566			**$566**

Cost Report Review

Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2006
Number of Audits	72	45			**117**
Number of Desk Reviews	379	280			**659**
Cost Avoidance	$3,904,405	$8,717,707			**$12,622,112**

[16] A single audit is a financial statement audit performed by an Independent Certified Public Accountant in accordance with the Office of Management and Budget Circular A-133 and/or the State of Texas Single Audit Circular. These Circulars require that grant recipients and subrecipients submit a single audit to funding agencies. Desk reviews of the single audits submitted to HHSC are performed to determine compliance with these Circulars, acceptability of the single audits and disallowance of costs.

[17] Medicaid/CHIP Audit and Contract Audit Units are in the development phase/

Section IV

County Data [18]

Code	County	Cases Open	Cases Closed	Recovery
1	Anderson	2	4	$2,734
2	Andrews	3	1	$114
3	Angelina	6	6	$2,504
4	Aransas	2	0	$0
5	Archer	0	0	$0
6	Armstrong	0	0	$0
7	Atascosa	7	4	$1,947
8	Austin	4	2	$495
9	Bailey	0	0	$0
10	Bandera	2	1	$109
11	Bastrop	4	2	$17,940
12	Baylor	1	1	$114
13	Bee	3	2	$1,239
14	Bell	16	9	$1,999
15	Bexar	161	126	$60,800
16	Blanco	1	0	$0
17	Borden	0	0	$0
18	Bosque	0	0	$0
19	Bowie	5	13	$730
20	Brazoria	14	14	$3,723
21	Brazos	13	8	$5,750
22	Brewster	2	1	$308
23	Briscoe	0	0	$0
24	Brooks	0	1	$0
25	Brown	10	9	$2,354
26	Burleson	2	1	$0
27	Burnet	3	0	$0
28	Caldwell	1	2	$0
29	Calhoun	1	1	$335
30	Callahan	1	1	$110
31	Cameron	70	59	$72,274
32	Camp	0	1	$128
33	Carson	0	0	$0

[18] County data report is based on aggregated cases from the following sections in OIG: Audit, MPI, Sanctions, TADS, WIC 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
34	Cass	4	4	$1,052
35	Castro	0	0	$0
36	Chambers	4	2	$1,203
37	Cherokee	6	8	$1,214
38	Childress	2	1	$156
39	Clay	1	1	$464
40	Cochran	0	0	$0
41	Coke	0	0	$0
42	Coleman	0	1	$94
43	Collin	12	13	$1,313
44	Collingsworth	1	0	$0
45	Colorado	2	2	$105
46	Comal	4	3	$1,259
47	Comanche	1	3	$785
48	Concho	0	2	$0
49	Cooke	4	3	$216
50	Coryell	1	0	$100
51	Cottle	0	0	$0
52	Crane	0	0	$0
53	Crockett	0	0	$0
54	Crosby	2	2	$2,689
55	Culberson	0	0	$0
56	Dallam	2	1	$967
57	Dallas	325	204	$74,880
58	Dawson	1	1	$264
59	Deaf Smith	2	2	$2,117
60	Delta	0	0	$0
61	Denton	6	11	$745
62	Dewitt	1	1	$0
63	Dickens	0	0	$0
64	Dimmit	2	2	$168
65	Donley	0	0	$0
66	Duval	1	1	$383
67	Eastland	2	3	$593
68	Ector	13	15	$9,714
69	Edwards	0	0	$0
70	Ellis	6	3	$1,362
71	El Paso	62	47	$25,378
72	Erath	4	4	$533
73	Falls	1	1	$118

Code	County	Cases Open	Cases Closed	Recovery
74	Fannin	0	0	$0
75	Fayette	0	0	$0
76	Fisher	0	0	$0
77	Floyd	0	0	$0
78	Foard	0	0	$0
79	Fort Bend	12	10	$23,023
80	Franklin	1	1	$0
81	Freestone	1	1	$109
82	Frio	2	2	$420
83	Gaines	2	0	$0
84	Galveston	14	11	$6,026
85	Garza	0	0	$0
86	Gillespie	3	3	$265
87	Glasscock	0	0	$0
88	Goliad	0	0	$0
89	Gonzales	0	0	$0
90	Gray	2	2	$206
91	Grayson	13	14	$5,571
92	Gregg	17	14	$6,268
93	Grimes	1	2	$398
94	Guadalupe	1	0	$0
95	Hale	2	4	$1,041
96	Hall	0	0	$0
97	Hamilton	1	0	$0
98	Hansford	2	3	$323
99	Hardeman	2	2	$266
100	Hardin	0	0	$0
101	Harris	345	279	$804,132
102	Harrison	3	1	$397
103	Hartley	0	0	$0
104	Haskell	0	1	$0
105	Hays	5	4	$2,168
106	Hemphill	0	0	$0
107	Henderson	4	6	$3,459
108	Hidalgo	118	121	$5,135,292
109	Hill	3	0	$0
110	Hockley	1	0	$0
111	Hood	1	1	$311
112	Hopkins	5	2	$484
113	Houston	2	2	$1,796

Code	County	Cases Open	Cases Closed	Recovery
114	Howard	5	3	$714
115	Hudspeth	0	0	$0
116	Hunt	5	2	$258
117	Hutchinson	1	3	$426
118	Irion	0	0	$0
119	Jack	1	0	$0
120	Jackson	0	0	$0
121	Jasper	2	3	$715
122	Jeff Davis	1	0	$0
123	Jefferson	37	42	$30,938
124	Jim Hogg	0	0	$0
125	Jim Wells	6	4	$1,252
126	Johnson	1	3	$1,513
127	Jones	2	1	$0
128	Karnes	0	0	$0
129	Kaufman	7	5	$2,810
130	Kendall	0	2	$195
131	Kenedy	0	0	$0
132	Kent	0	0	$0
133	Kerr	1	2	$0
134	Kimble	1	1	$2,360
135	King	0	0	$0
136	Kinney	0	0	$0
137	Kleberg	9	7	$3,847
138	Knox	0	0	$0
139	Lamar	3	2	$1,292
140	Lamb	0	0	$0
141	Lampasas	1	1	$0
142	La Salle	3	2	$512
143	Lavaca	2	1	$251
144	Lee	1	0	$0
145	Leon	0	0	$0
146	Liberty	14	10	$5,885
147	Limestone	3	2	$788
148	Lipscomb	0	0	$0
149	Live Oak	0	0	$0
150	Llano	0	0	$0
151	Loving	0	0	$0
152	Lubbock	15	20	$9,102
153	Lynn	0	0	$0

Code	County	Cases Open	Cases Closed	Recovery
154	Madison	1	1	$198
155	Marion	0	0	$0
156	Martin	1	2	$285
157	Mason	0	0	$0
158	Matagorda	5	6	$1,998
159	Maverick	12	7	$1,938
160	McCullough	1	1	$167
161	McLennan	34	45	$6,992
162	McMullen	0	0	$0
163	Medina	5	1	$104
164	Menard	0	0	$0
165	Midland	14	9	$4,764
166	Milam	3	1	$541
167	Mills	0	0	$0
168	Mitchell	1	0	$0
169	Montague	1	1	$125
170	Montgomery	10	6	$11,277
171	Moore	1	0	$0
172	Morris	0	0	$0
173	Motley	0	0	$0
174	Nacogdoches	11	8	$4,372
175	Navarro	2	5	$0
176	Newton	1	0	$0
177	Nolan	3	4	$171
178	Nueces	47	60	$53,121
179	Ochiltree	2	2	$659
180	Oldham	0	0	$0
181	Orange	6	5	$476
182	Palo Pinto	3	2	$593
183	Panola	3	3	$1,008
184	Parker	4	5	$672
185	Parmer	0	0	$0
186	Pecos	4	2	$282
187	Polk	2	2	$178
188	Potter	32	18	$5,229
189	Presidio	0	0	$0
190	Rains	0	0	$0
191	Randall	0	0	$0
192	Reagan	1	0	$0
193	Real	0	0	$0

Code	County	Cases Open	Cases Closed	Recovery
194	Red River	1	2	$111
195	Reeves	4	3	$843
196	Refugio	2	1	$679
197	Roberts	0	0	$0
198	Robertson	1	0	$0
199	Rockwall	0	0	$0
200	Runnels	0	0	$0
201	Rusk	2	3	$111
202	Sabine	0	0	$0
203	San Augustine	0	1	$0
204	San Jacinto	0	1	$0
205	San Patricio	6	2	$126
206	San Saba	0	1	$0
207	Schleicher	0	0	$0
208	Scurry	2	2	$112
209	Shackelford	0	0	$0
210	Shelby	4	3	$873
211	Sherman	0	0	$0
212	Smith	17	14	$39,053
213	Somervell	0	0	$0
214	Starr	6	5	$536
215	Stephens	0	0	$0
216	Sterling	0	0	$0
217	Stonewall	0	0	$0
218	Sutton	1	1	$114
219	Swisher	1	1	$413
220	Tarrant	98	83	$30,598
221	Taylor	27	21	$63,094
222	Terrell	0	0	$0
223	Terry	0	0	$0
224	Throckmorton	0	0	$0
225	Titus	4	5	$73,181
226	Tom Green	10	7	$4,219
227	Travis	166	61	$70,042
228	Trinity	1	1	$301
229	Tyler	6	1	$215
230	Upshur	3	5	$689
231	Upton	1	0	$0
232	Uvalde	3	2	$257
233	Val Verde	2	4	$518

Code	County	Cases Open	Cases Closed	Recovery
234	Van Zandt	4	2	$629
235	Victoria	15	12	$7,757
236	Walker	1	1	$489
237	Waller	0	0	$1,951
238	Ward	0	0	$0
239	Washington	2	2	$1,016
240	Webb	53	31	$15,067
241	Wharton	7	2	$644
242	Wheeler	0	0	$0
243	Wichita	9	11	$2,076
244	Wilbarger	0	1	$0
245	Willacy	0	2	$0
246	Williamson	12	10	$2,818
247	Wilson	1	0	$0
248	Winkler	0	0	$0
249	Wise	1	1	$147
250	Wood	2	3	$0
251	Yoakum	0	0	$0
252	Young	4	4	$2,771
253	Zapata	1	1	$0
254	Zavala	13	1	$122
	Unknown Co.	23	16	$804
	Multiple Co.	0	0	$0
	Out of State	12	16	$10,195
	Total	**2,228**	**1,754**	**$6,786,112**

Utilization Review County Data

		Hospital Reviews[19]			Nursing Facility Reviews[20]		
Code	County	Cases Open	Cases Closed	Recovery	Cases Open	Cases Closed	Recovery
1	Anderson	1	1	$14,600	4	2	$0
2	Andrews	0	1	$10,949	0	0	$0
3	Angelina	2	2	$3,317	2	0	$29,258
4	Aransas	1	1	$4,617	0	0	$0
5	Archer	0	0	$0	1	0	$1,342
6	Armstrong	0	0	$0	0	0	$0
7	Atascosa	1	1	$0	2	0	$16,933
8	Austin	1	1	$0	0	0	-$2,513
9	Bailey	1	1	$1,886	0	0	$0
10	Bandera	0	0	$0	0	0	$0
11	Bastrop	1	1	$0	1	0	$0
12	Baylor	0	0	$0	0	0	$53,764
13	Bee	1	1	$15,050	2	0	$8,232
14	Bell	1	2	$59,607	4	1	$51,785
15	Bexar	9	10	$165,617	8	0	$515,829
16	Blanco	0	0	$0	0	0	$0
17	Borden	0	0	$0	0	0	$0
18	Bosque	1	1	$3,286	0	0	$48,635
19	Bowie	1	2	$80,117	1	0	$0
20	Brazoria	3	3	$1,996	0	0	$3,666
21	Brazos	2	3	$23,596	3	1	$13,077
22	Brewster	1	1	$31,004	0	0	$0
23	Briscoe	0	0	$0	0	0	$0
24	Brooks	0	0	$0	1	0	$1,088
25	Brown	1	1	$0	1	0	$13,877
26	Burleson	0	1	$0	0	0	$0
27	Burnet	1	1	$0	0	0	$275
28	Caldwell	0	1	$2,724	2	0	$689
29	Calhoun	1	1	$0	0	0	$16,585
30	Callahan	0	0	$0	0	0	$0
31	Cameron	5	5	$146,724	0	0	$0
32	Camp	1	1	$7,101	0	0	$0

[19] Cases Opened are based on UR Nurse Reviewer review date between 12/1/2005 and 2/28/2006. Cases Closed are based on claim closed (status) date or account receivable recovered date.

[20] Cases Opened are based on UR Nurse Reviewer date between 12/1/2005 and 2/28/2006. Cases Closed represents reviews that were completed between 12/1/2005 and 2/28/2006 and no TILE changes were made.

		Hospital Reviews[19]			Nursing Facility Reviews[20]		
Code	County	Cases Open	Cases Closed	Recovery	Cases Open	Cases Closed	Recovery
33	Carson	0	0	$0	0	0	$0
34	Cass	1	2	$3,098	0	0	$86,712
35	Castro	0	0	$0	0	0	$0
36	Chambers	1	2	-$105	0	0	$12,231
37	Cherokee	1	1	$3,708	2	1	$0
38	Childress	1	0	$0	0	0	$0
39	Clay	0	1	$0	1	0	$30,777
40	Cochran	0	0	$0	0	0	$0
41	Coke	0	0	$0	1	0	$0
42	Coleman	1	1	$0	0	0	$0
43	Collin	4	4	$109,980	4	0	$255,756
44	Collingsworth	0	0	$0	0	0	$2,666
45	Colorado	2	2	$4,866	0	0	$0
46	Comal	1	1	$13,729	2	0	$74,268
47	Comanche	0	2	$0	1	0	$0
48	Concho	0	0	$0	0	0	$0
49	Cooke	1	1	$26,181	0	0	$6,467
50	Coryell	0	0	$0	2	0	$0
51	Cottle	0	0	$0	0	0	$26,421
52	Crane	1	0	$0	0	0	$0
53	Crockett	0	0	$0	0	0	$0
54	Crosby	1	1	$0	1	0	$265
55	Culberson	0	1	$0	0	0	$0
56	Dallam	1	1	$8,363	1	0	$501
57	Dallas	19	22	$2,335,437	14	0	$332,330
58	Dawson	0	1	$0	2	0	$12,046
59	Deaf Smith	0	1	$2,696	0	0	$41,077
60	Delta	0	0	$0	0	0	$0
61	Denton	3	3	$81,249	2	0	$15,956
62	Dewitt	1	1	$12,620	1	0	$51,628
63	Dickens	0	0	$0	0	0	$0
64	Dimmit	1	1	$0	0	0	$0
65	Donley	0	0	$0	0	0	$0
66	Duval	0	0	$0	0	0	$0
67	Eastland	1	1	$0	1	0	$12,318
68	Ector	2	3	$44,143	2	0	$39,222
69	Edwards	0	0	$0	0	0	$0
70	Ellis	2	2	$12,247	4	0	$87,187
71	El Paso	4	3	$0	2	0	$67,389

		Hospital Reviews[19]			Nursing Facility Reviews[20]		
Code	County	Cases Open	Cases Closed	Recovery	Cases Open	Cases Closed	Recovery
72	Erath	1	1	$0	1	0	$5,010
73	Falls	0	0	$0	1	0	$399
74	Fannin	1	1	$5,381	2	0	-$6
75	Fayette	1	1	-$2,038	1	0	$178
76	Fisher	0	1	$4,202	0	0	$0
77	Floyd	1	0	$0	1	1	$5,638
78	Foard	0	0	$0	0	0	$1,373
79	Fort Bend	3	3	$29,221	0	0	$0
80	Franklin	0	1	$0	0	0	$0
81	Freestone	1	1	$2,777	1	0	$195
82	Frio	2	2	$27,097	0	0	$0
83	Gaines	1	1	$0	1	0	$882
84	Galveston	2	3	$158,322	1	0	$0
85	Garza	0	0	$0	1	0	$5,573
86	Gillespie	1	1	$13,252	1	0	$27,644
87	Glasscock	0	0	$0	0	0	$0
88	Goliad	0	0	$0	0	0	$0
89	Gonzales	1	1	$6,658	2	0	$28,031
90	Gray	1	0	$0	0	0	$31,682
91	Grayson	2	2	$217,735	1	0	$83,445
92	Gregg	3	3	$0	1	0	$14,444
93	Grimes	1	1	$0	1	0	$3,132
94	Guadalupe	1	1	$0	2	0	$13,528
95	Hale	1	1	$0	1	0	$61,375
96	Hall	0	0	$0	0	0	$0
97	Hamilton	0	0	$0	1	1	-$4,941
98	Hansford	0	1	$5,503	1	0	$592
99	Hardeman	0	0	$0	0	0	$0
100	Hardin	0	0	$0	2	1	$0
101	Harris	30	31	$765,485	3	$0	$25,473
102	Harrison	1	1	$19,459	0	0	$0
103	Hartley	0	0	$0	0	0	$0
104	Haskell	0	0	$0	0	0	$0
105	Hays	0	1	$0	1	0	$0
106	Hemphill	0	0	$0	0	0	$0
107	Henderson	1	1	$37,919	0	0	$71,429
108	Hidalgo	7	7	$338,254	3	0	$14,765
109	Hill	1	2	$2,459	2	0	$10,710
110	Hockley	0	0	$0	0	0	$38,840

		Hospital Reviews[19]			Nursing Facility Reviews[20]		
Code	County	Cases Open	Cases Closed	Recovery	Cases Open	Cases Closed	Recovery
111	Hood	1	1	$3,120	1	0	$3,149
112	Hopkins	1	1	$9,415	0	0	$0
113	Houston	1	1	$0	0	1	$0
114	Howard	1	0	$0	0	0	$0
115	Hudspeth	0	0	$0	0	0	$0
116	Hunt	2	3	$57,560	0	0	$0
117	Hutchinson	1	1	$7,508	0	0	$0
118	Irion	0	0	$0	0	0	$0
119	Jack	0	0	$0	0	0	$0
120	Jackson	0	0	$0	1	0	$32,352
121	Jasper	2	1	$4,516	2	0	$37,072
122	Jeff Davis	0	0	$0	0	0	$0
123	Jefferson	4	5	$47,400	1	1	$11,559
124	Jim Hogg	0	0	$0	0	0	$0
125	Jim Wells	1	2	$68,939	0	0	$0
126	Johnson	1	1	$26,006	3	0	$13,928
127	Jones	2	2	$33,429	1	1	$0
128	Karnes	0	0	$0	0	0	$0
129	Kaufman	2	2	$0	0	0	$12,145
130	Kendall	0	0	$0	1	0	$15,835
131	Kenedy	0	0	$0	0	0	$0
132	Kent	0	0	$0	1	0	$12,884
133	Kerr	1	1	$0	1	0	$4,889
134	Kimble	0	0	$0	0	0	$0
135	King	0	0	$0	0	0	$0
136	Kinney	0	0	$0	0	0	$0
137	Kleberg	1	1	$13,678	0	0	$0
138	Knox	0	0	$0	0	0	$0
139	Lamar	0	1	$23,192	0	0	$28
140	Lamb	1	0	$0	3	0	$0
141	Lampasas	0	1	$0	0	0	$0
142	La Salle	0	0	$0	0	0	$0
143	Lavaca	0	1	$12,383	2	0	$0
144	Lee	0	0	$0	0	0	$0
145	Leon	0	0	$0	0	0	$4,462
146	Liberty	1	1	$46,963	0	0	$0
147	Limestone	1	1	$0	0	0	$3,206
148	Lipscomb	0	0	$0	0	1	$0
149	Live Oak	0	0	$0	0	0	$6,927

		Hospital Reviews[19]			Nursing Facility Reviews[20]		
Code	County	Cases Open	Cases Closed	Recovery	Cases Open	Cases Closed	Recovery
150	Llano	0	1	$0	0	0	$13,561
151	Loving	0	0	$0	0	0	$0
152	Lubbock	4	2	$8,038	2	0	$45,857
153	Lynn	1	0	$0	0	0	$0
154	Madison	0	1	$0	0	0	$0
155	Marion	0	0	$0	0	0	$0
156	Martin	0	0	$0	0	0	$23,813
157	Mason	0	0	$0	0	0	$0
158	Matagorda	1	1	$13,425	3	0	$17,711
159	Maverick	1	1	$28,378	0	0	$0
160	McCullough	1	0	$0	2	1	$0
161	McLennan	2	3	$28,913	2	0	$53,952
162	McMullen	0	0	$0	0	0	$0
163	Medina	1	1	$1,681	1	0	$199,059
164	Menard	0	0	$0	0	0	$0
165	Midland	1	1	$0	1	0	$27,350
166	Milam	1	2	$3,488	2	1	-$1,780
167	Mills	0	0	$0	2	0	$6,003
168	Mitchell	1	0	$0	0	0	$1,882
169	Montague	1	0	$0	0	0	$117
170	Montgomery	3	3	$91,595	0	0	$3,853
171	Moore	1	1	$0	1	1	$42,865
172	Morris	0	0	$0	0	0	$0
173	Motley	0	0	$0	0	0	$0
174	Nacogdoches	2	2	$54,806	0	0	$14,599
175	Navarro	1	1	$3,338	0	0	$0
176	Newton	0	0	$0	0	0	$1,412
177	Nolan	0	1	$0	0	0	$0
178	Nueces	2	3	$113,794	2	0	$127,621
179	Ochiltree	1	1	$2,056	1	1	$0
180	Oldham	0	0	$0	0	0	$0
181	Orange	1	1	$4,639	0	0	$0
182	Palo Pinto	0	0	$0	1	0	$14,144
183	Panola	1	1	$21,807	1	0	$9,262
184	Parker	2	2	$32,412	2	0	$60,181
185	Parmer	0	0	$0	0	0	$0
186	Pecos	0	0	$0	0	0	$0
187	Polk	1	1	$533	0	0	$0
188	Potter	0	0	$0	3	0	$39,671

		Hospital Reviews[19]			Nursing Facility Reviews[20]		
Code	County	Cases Open	Cases Closed	Recovery	Cases Open	Cases Closed	Recovery
189	Presidio	0	0	$0	0	0	$0
190	Rains	0	0	$0	1	0	$0
191	Randall	1	1	$0	1	0	$41,210
192	Reagan	0	0	$0	0	0	$0
193	Real	0	0	$0	0	0	$0
194	Red River	1	1	$16,010	0	0	$2,732
195	Reeves	1	0	$0	0	0	$0
196	Refugio	1	1	$4,896	1	0	$2,052
197	Roberts	0	0	$0	0	0	$0
198	Robertson	0	0	$0	0	0	$0
199	Rockwall	1	1	$12,260	0	0	$0
200	Runnels	0	1	$2,845	0	0	$0
201	Rusk	0	1	$16,234	0	0	$0
202	Sabine	1	1	$0	1	0	$562
203	San Augustine	1	1	$0	1	0	$10,388
204	San Jacinto	0	0	$0	0	0	$0
205	San Patricio	0	0	$0	1	0	$13,255
206	San Saba	0	0	$0	2	0	$5,692
207	Schleicher	0	0	$0	0	0	$0
208	Scurry	1	1	$4,044	0	0	$21,569
209	Shackelford	0	0	$0	0	0	$1,417
210	Shelby	1	1	$13,861	1	0	$9,578
211	Sherman	0	0	$0	0	0	$384
212	Smith	3	4	$134,566	3	1	$10,905
213	Somervell	1	1	$0	1	0	$0
214	Starr	1	1	$41,425	0	0	$0
215	Stephens	1	1	$0	1	0	$9,103
216	Sterling	0	0	$0	0	0	$0
217	Stonewall	0	0	$0	0	0	$0
218	Sutton	0	0	$0	0	0	$0
219	Swisher	1	0	$0	0	0	$0
220	Tarrant	10	11	$300,332	7	0	$541,500
221	Taylor	0	0	$0	3	0	$21,909
222	Terrell	0	0	$0	0	0	$0
223	Terry	0	0	$0	1	0	$14,941
224	Throckmorton	0	0	$0	1	0	$7,607
225	Titus	1	1	$7,603	1	0	-$248
226	Tom Green	2	2	$47,225	0	0	$0
227	Travis	5	9	$60,808	2	0	$80,960

		Hospital Reviews[19]			Nursing Facility Reviews[20]		
Code	County	Cases Open	Cases Closed	Recovery	Cases Open	Cases Closed	Recovery
228	Trinity	1	1	$0	0	0	$0
229	Tyler	1	1	$0	0	0	$19,067
230	Upshur	0	0	$0	0	0	$0
231	Upton	0	1	$3,136	0	0	$7,401
232	Uvalde	1	1	$3,826	0	0	$59,652
233	Val Verde	1	1	$2,174	0	0	$93,429
234	Van Zandt	1	1	$0	1	0	$8,906
235	Victoria	2	2	$97,643	0	0	$0
236	Walker	1	1	$0	0	0	$0
237	Waller	0	0	$0	0	0	$0
238	Ward	1	1	$3,993	0	0	$0
239	Washington	0	1	$0	1	0	$32,626
240	Webb	1	3	$223,109	0	0	$2,682
241	Wharton	2	2	$10,936	2	0	$57,963
242	Wheeler	0	0	$0	0	0	$0
243	Wichita	1	1	$1,174	5	1	$10,925
244	Wilbarger	0	0	$0	1	1	$0
245	Willacy	0	0	$0	0	0	$0
246	Williamson	1	2	$6,165	4	0	$144,886
247	Wilson	0	0	$0	0	0	$0
248	Winkler	0	0	$0	1	0	$6,272
249	Wise	1	1	$11,139	1	0	$5,214
250	Wood	2	2	$5,770	0	0	$0
251	Yoakum	0	1	$8,116	1	0	$2,749
252	Young	1	2	$0	1	0	$18,721
253	Zapata	0	0	$0	1	0	-$711
254	Zavala	0	0	$0	0	0	$0
	Unknown Co.	0	0	$0	0	0	$0
	Multiple Co.	0	0	$0	0	0	$0
300	Out of State-Louisiana	1	1	$0	0	0	$0
	Total	**256**	**293**	**$6,664,392**	**198**	**19**	**$4,492,000**

Section V—Other OIG Activities

Education and Prevention

Type of Course	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total Enrolled
TILE Training - Nursing Facilities – Correspondence Course	*	83			
TILE Training - Nursing Home – On-Line Internet Course	*	58			
TILE Training – Community Based Alternatives – Correspondence Course	*	199			
TILE Training – Community Based Alternatives - On-Line Internet Course	*	138			
Total	***245**	**478**	**0**	**0**	**723**

* First quarters numbers were not tracked by the individual TILE training course.

Staff Presentations

Date	Audience	Subject	Presenter
September 14, 2005	Texas Healthcare Association	Overview of Utilization Review	Elidia Cancino
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 (Blue Cross Blue Shield 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
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
February 24, 2006	HHSC-General Counsel	Internal Affairs – Administrative Investigations Processes	Bart Bevers / Wayne Sneed

Appendix C—OIG Division Summary Excluding TPR

	2005		2006-Year to Date (Sept. 1st - Feb 28th)	
	Recoupments	Cost Avoidance	Recoupments	Cost Avoidance
Compliance				
Quality Review				
Utilization Review				
Hospitals (DRGs)	$22,867,551	g	$12,087,753	g
Nursing Homes (Case Mix Review)	$10,448,797	g	$9,232,410	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	$20,202	$6,076	$3,574	$1,063
Technology, Analysis, Development, and Support	$2,660,128	$333,812	$1,827,618	$95,988
RADS				
Surveillance and Utilization Review Sub-systems (SURS)	d	g	d	g
MFADS	d	g	d	g
Audit	$943,398	$98,679,947	$61,940	$12,622,112
Enforcement				
Medicaid Provider Integrity	e	e	e	e
General Investigations	$21,342,829	$3,858,575	$8,213,454	$1,788,039
Internal Affairs	$2,371	N/A	$0	N/A
WIC Investigation Recoveries	$46,251	$853	$23,038	$0
Chief Counsel				
Sanctions	$46,828,148	$3,881,784	$8,692,634	$969,527
Civil Monetary Penalties	$13,045,838	N/A	$1,652,669	N/A
Third Party Recoveries (TPR)	$323,345,679	$255,727,973	$178,305,205	$144,833,924
TOTAL Recoupments without TPR	**$118,205,513**		**$41,795,090**	
TOTAL Cost Avoidance without TPR		**$106,761,047**		**$15,476,729**

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.

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.

Gov. Perry Reappoints Flood as Inspector General

Office of the Governor of Texas
2/27/2006

AUSTIN – Gov. Rick Perry today announced the reappointment of Brian Glenn Flood of Austin as Inspector General for Health and Human Services for a term to expire Feb. 1, 2007. The inspector general works to prevent, detect and investigate fraud, abuse and waste in state health and human services programs.

Gov. Perry signed into law House Bill 2292 from the 78th session, which established the Office of Inspector General at the Health and Human Services Commission. He then issued executive order RP36, which directed the OIG to take additional and specific steps to eliminate fraud at the HHSC. Since then, the OIG recovered $441.5 million and saved Texas taxpayers another $362.5 million from waste or fraud in 2005.

Flood, who serves on the boards of the National White Collar Crime Center and the National Insurance Crime Bureau, recently appeared before both the New York State and the Missouri Senate as the national subject matter expert on fighting Medicaid fraud.

Flood formerly was chief of the specialized crime division of the Dallas County District Attorney's Office. A graduate of Texas A&M University, he received a law degree from Texas Wesleyan University School of Law.

This appointment is subject to senate confirmation.

Texas' Medicaid Watchdog Shares Tips for Success

Richard Perez-Pena
New York Times
February 3, 2006

 See Page 75.

A Lone Star Medicaid Fix?

Ridgley Ochs
NY Newsday
February 3, 2006

Texans may be showing New Yorkers a thing or two - at least when it comes to reducing Medicaid fraud.

A state Medicaid reform task force, led by state Sens. Kemp Hannon (R-Garden City) and Raymond Meier (R-Rome), held a public hearing yesterday at Hofstra University on ways to reduce fraud and abuse. New York's Medicaid program is the most expensive in the country, costing the state more than $44 billion last year, officials said. Although there are no firm figures, fraud and abuse cost the state an estimated $4.4 billion last year.

Brian Flood, inspector general for Texas' Health and Human Services Commission, testified before the task force that by consolidating Medicaid's investigative groups under his office and giving it more regulatory power, Texas last year recouped $441.5 million and saved another $362.5 million from waste or fraud - about 5 percent of its overall Medicaid budget. The office also turned over a record number of cases to the state's attorney general or to local district attorneys for investigation.

"We have become the 5,000-foot watchdog," Flood said.

His message resonated with the senators.

"We want to lay the foundation to what should be done to what is a convoluted system," Hannon said.

Meier listed all of the state agencies that handle Medicaid fraud - including the Department of Health, the Office of Mental Health, the Office of Mental Retardation and Developmental Disabilities, the Office of Alcohol and Substance Abuse Services, the Department of Aging, and the attorney general's office.

"And it only gets worse" when all of the county district attorneys are considered, he said.

Speaking of fraud and abuse, state Sen. Dean Skelos (R-Rockville Centre) said, "If we were able to recoup half of that, that would be billions of dollars."

Skelos last year introduced a bill that was passed in the Senate to establish an independent Office of Medicaid Inspector General. However, the bill found no sponsor in the Assembly. In August, Gov. George Pataki signed an executive order also calling for an inspector general, but critics say an executive order doesn't have the regulatory teeth needed to do the job.

Tom Dunham, a spokesman for Skelos, said the senator plans to introduce a new, more comprehensive bill in two weeks.

Other witnesses included general counsel Henry Zwack, whose Office of Alcoholism and Substance Abuse Services in July fined and shut Lake Grove Treatment Centers in Medford and its affiliated 42 sober homes for infractions including Medicaid fraud. The "data runs" pointed to the abuse, he said. "The numbers were obscene."

Referring to Texas' program, Zwack said the challenge is ensuring that a new program doesn't lose the expertise of professionals now monitoring agencies. But he acknowledged Texas' approach to pull together "makes great sense."

Legislators Focus on Medicaid Fraud

Jeremy Harrell
Long Island Business News
February 2, 2006

HEMPSTEAD - New York State could save as much as $5 billion per year by better policing Medicaid spending, state senators said at a Thursday meeting.

Sen. Kemp Hannon, R-Garden City, brought the Senate's Medicaid Reform Task Force to Hofstra University, and the assembled lawmakers sounded a theme that has become prevalent in recent weeks. The Senate's deputy majority leader, Dean Skelos, R-Rockville Centre, said the state spends $47 billion per year on Medicaid, although at least 10 percent of that sum is lost to fraud and abuse.

"If we were able to recover half of that, we're talking about billions of dollars," Skelos said.

Democrat Nassau County Executive Tom Suozzi, who is considering a run for governor, has made the same issue the centerpiece of his unofficial campaign. By his estimate, the state could retrieve at least $5 billion per year by rooting out Medicaid fraud and abuse. State government could then distribute the money to Long Island property taxpayers, New York City schools and sagging upstate communities.

Hannon and Skelos on Thursday touted a Skelos measure, signed by the governor last summer, creating an inspector general dedicated to tracking down Medicaid abuse. Brian Flood, who performs the same function in Texas, told the task force that each year his office recovers $130 million in Medicaid overspending.

His office co-ordinates with five state agencies, the attorney general and local law enforcement, returning an average of $23 in savings for every dollar spent to fund the inspector general's office.

"I'm the 5,000-foot watchdog - find problem, kill problem," Flood said.

Hannon, Skelos and the rest of the task force plan to roll out a package of Medicaid reform proposals later this month after completing this series of statewide meetings.

HEALTH AND HUMAN SERVICES COMMISSION

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 prepayment 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 fundamentally 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 appropriation 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.

Appendix E—Letters of Recognition

The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

Gary R. VanLandingham, Director

January 11, 2006

Mr. Tim Broadhurst
Manager, Third Party Resources
Texas HHSC Office of Inspector General
11101 Metric Blvd.
Austin, TX 78758

Dear Mr. Broadhurst:

Chapter 2004-344 *Laws of Florida* directs The Florida Legislature's Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct biennial reviews of Florida's Medicaid Program Integrity office.

As part of this review, we want to look at other states' efforts to identify ways in which Florida's program can improve. We are particularly interested in efforts to:

- detect and recover overpayments,
- efforts to deter abusive billing practices,
- calculate return on investment (ROI) for funds recovered by the program, and
- calculate ROI for prevention or cost-avoidance activities.

As background and context, it would also be helpful for us to understand your state's:

- total program integrity staffing,
- total program integrity recoveries for FY 2004-2005, and
- total Medicaid expenditures for 2004-2005.

We appreciate you speaking with us about how you calculate ROI and sending us *The Texas Health and Human Services Commission, Office of Inspector General's Semi-Annual Report, September 2005*, the breakdown of cost centers for each area of your agency, and for discussing the types of activities that are included in as cost avoidance.

If you or someone from your office could please contact me at 850-487-9278 with a time that would be convenient to speak with us about your most successful methods for detecting and recovering overpayments, deterrence efforts, I will schedule a 20 minute phone interview.

OPPAGA is a legislative research office that conducts independent evaluations and policy reviews of Florida's state agencies and programs.

Thank you,

Kim Shafer,
Senior Legislative Analyst

111 West Madison Street ■ Room 312 ■ Claude Pepper Building ■ Tallahassee, Florida 32399-1475
850/488-0021 SUNCOM 278-0021 FAX 850/487-3804
www.oppaga.state.fl.us

Office of the State Inspector General
2 Martin Luther King Jr. Drive, S.W.
Suite 1102 West Tower
Atlanta, Georgia 30334

January 17, 2006

James E. Sehorn

Mr. Brian G. Flood, Inspector General
Health and Human Services Commission
P.O. Box 13247 MC:C-5000
Austin, Texas 78711-3247

Brian,

I would like to take this opportunity to thank you personally for your assistance in our effort to establish a fraud prevention training program in the Executive Branch of Georgia government.

Your assistance has been very valuable and greatly appreciated. I look forward to sharing thoughts and ideas on how to more effectively protect the tax payers' resources in both Georgia and Texas.

Most sincerely,

Jim Sehorn
Georgia State Inspector General

HEALTH AND HUMAN SERVICES COMMISSION

Christopher A. Koster

February 14, 2006

Mr. Brian Flood
Inspector General
Health & Human Services Commission
11101 Metric Blvd., 78758
P.O. Box 85200
Austin, TX 78708

Dear Brian,

It is with great appreciation that I thank you for taking the time out of your busy schedule to appear before the Special Committee to Investigate Medicaid Fraud. Your testimony was exceptionally informative and helpful in providing information to the policy makers in the State of Missouri who are determined to bring solutions to this vast problem.

On behalf of the Missouri Senate, I thank you for your willingness to be inconvenienced and travel on short notice to provide us with your knowledge.

Again, my personal thank you for your testimony.

Sincerely,

CHRIS KOSTER
Missouri State Senator

PAID FOR BY MISSOURIANS FOR KOSTER, P.O. BOX 9, HARRISONVILLE, MISSOURI 64701

Appendix F—Geographic Distribution Demonstration

Figure 3.2
Dollar Value of Diabetes Claims by
House District

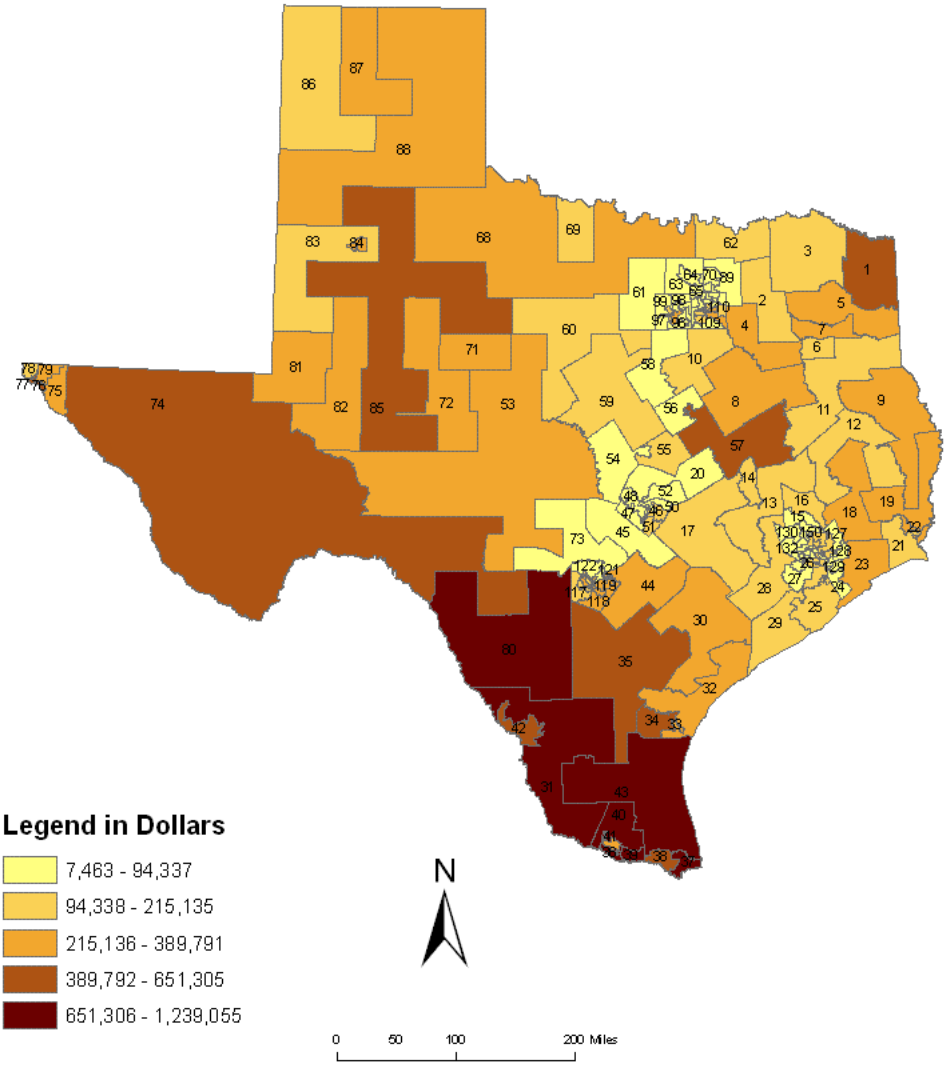
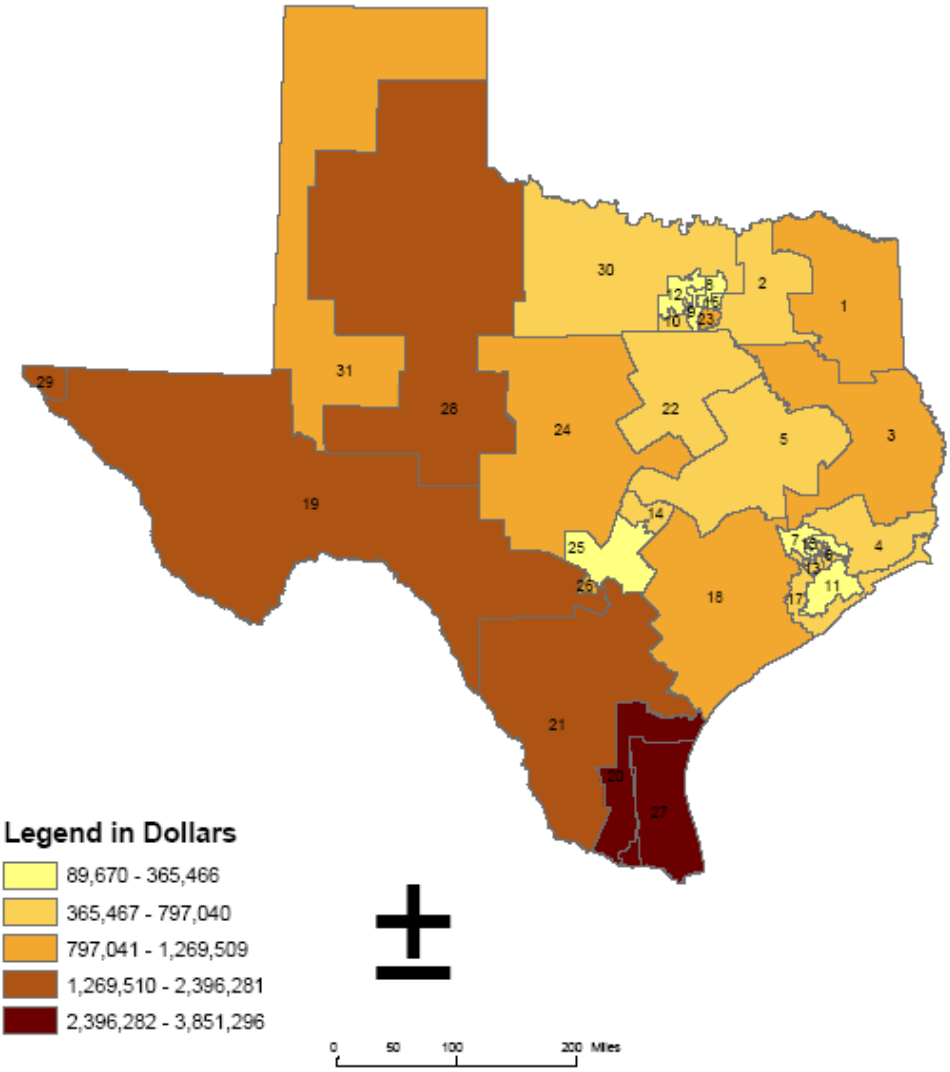
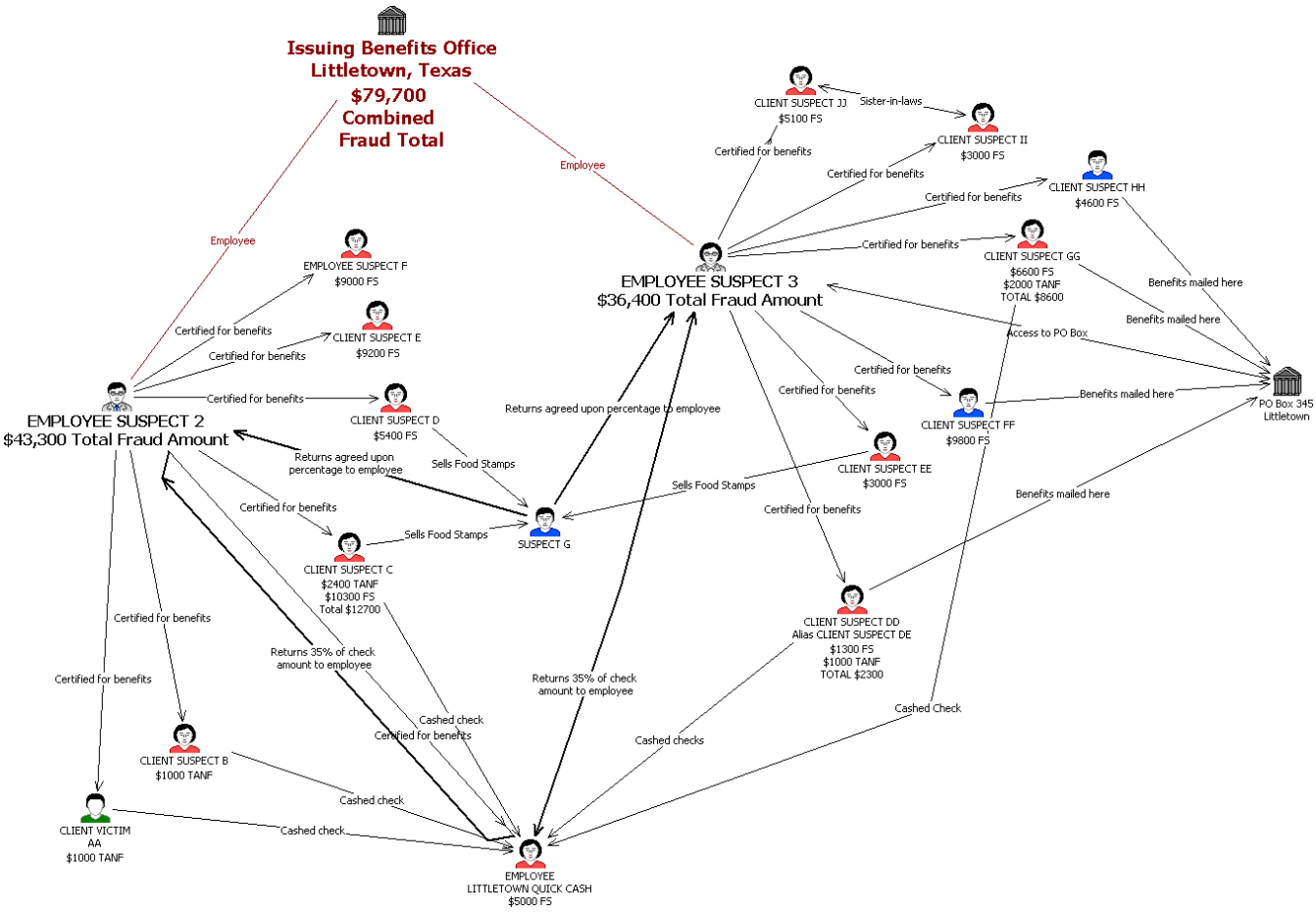


Figure 3.3
Dollar Value of Diabetes Claims by Senate District



Appendix G—Link Analysis Diagram Example



End of Report