Albert Hawkins, Executive Commissioner

Office of Inspector General Semi-annual Report

March 2005

Brian Flood, Inspector General

OIG Mission Statement

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

OIG Vision Statement

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

HEALTH AND HUMAN SERVICES COMMISSION

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HEALTH AND HUMAN SERVICES COMMISSION

Executive Summary

APRIL 1, 2005

The Office of Inspector General (OIG) is pleased to issue the semi-annual report for the first half of state fiscal year (SFY) 2005, which ended February 28, 2005. This report contains a year to date synopsis of OIG recoveries and cost-avoidance, and provides an overview of our key accomplishments this fiscal year.

The OIG continues to manage the fraud and abuse prevention and detection functions for all legacy agencies. Several lines of business, with an over-riding focus on protecting the integrity of health and human services programs in Texas, as well as the health and welfare of the recipients of those programs, have been integrated into a streamlined organizational structure. This organizational structure promotes clarity of task ownership, facilitates information sharing, and provides flexibility to perform a variety of tasks quickly and efficiently.

OIG has recovered $226,203,428 and cost avoided $200,803,849. As these funds are directed back into the program, we know that the $427,007,277 has provided needed healthcare and other state-funded assistance to many Texans. Although we anticipate reaching a steady state in recovery activity, total recoveries for the period have increased by 20%.

Among a variety of tasks, we continue to focus efforts on the creation of our Medicaid/CHIP and Contract Audit Units. OIG has developed a strong working relationship with the Medicaid/CHIP division and continues to work closely with the Office of Attorney General Medicaid Fraud Control Unit. The development of these relationships has enabled the State to achieve cost savings in a variety of Medicaid related areas.

OIG continues to enhance our technical infrastructure with an overriding focus on building external systems enabling easier public access to OIG. In addition to the consolidation of toll free lines, now answered by live operators, a variety of web-portals have been deployed. A summary of these deployments can be found on pages 8 – 10 in our Technology Analysis, Development, and Support section.

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

Brian Flood
Inspector General

Background

In 1997, the 75th Legislature directed the Texas Health and Human Services Commission (HHSC) to create the Office of Investigations and Enforcement (OIE). The 78th Legislature strengthened HHSC's authority to combat waste, abuse and fraud in health and human services programs by creating the Office of Inspector General (OIG). Section 531.102 of the Government Code, contains provisions to improve the detection and prevention of waste, abuse and fraud by providers, recipients, contractors, and employees who participate in the delivery and receipt of health and human services programs, including the state Medicaid program.

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

The OIG has clear objectives, priorities, and performance standards that emphasize:

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

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

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

- Reducing crime and juvenile delinquency;
- Reducing community health risks; and
- Improving regulations of human services providers.

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

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

In a Priority proposal issued by the Governor's Office, the Governor proposed adding $14.6 million in general revenue to create a new inspector general office at the Texas Education Agency and other large agencies. This proposal also restored funding to 2004 –2005 levels for the inspector general functions at the HHSC and the Department of Criminal Justice.

In this priority proposal the Governor provides the following justification:

> "The Governor believes that government has a sacred trust to guard taxpayers' dollars and maintain the highest standard of integrity, impartiality, and conduct. Contractors for the state services have a fiduciary responsibility to prevent, detect, and report fraud."
>
> "Offices of Inspectors General will enable state agencies to combat fraud, waste, and abuse in agencies entrusted with large amounts of taxpayer dollars, such as the unemployment insurance program and the health care system."

We fully support the Governor's proposal and recognize the importance of combating waste, abuse and fraud in administering governmental programs. The Governor's proposal is further outlined in House Bill 2854, 79th Regular Session.

OIG Recovery and Cost Avoidance Statistics

Recovery

Total recoveries[1] through the second quarter of SFY 2005 were $226,203,428 (all funds) as compared to $188,566,257 for the same period in SFY 2004. OIG continues to build on strengths achieved from consolidation activities as directed by the 78th Legislature. OIG does anticipate reaching a steady state in which recovery growth materially slows. The following page details OIG recovery activities by individual business function.

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

OIG Recovery Activity

Recovery Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Sanctions	$36,864,059	$1,670,739			**$38,534,798**
Civil Monetary Penalties (CMP)	$11,171,955	$212,505			**$11,384,460**
Utilization Review (Hospitals)	$10,694,064	$6,878,143			**$17,572,207**
Utilization Review (Nursing Homes)	$0	$1,217,469			**$1,217,469**
Third Party Recoveries	$71,744,016	$71,665,926			**$143,409,942**
Technology Analysis, Development & Support (TADS)	$526,649	$723,452			**$1,250,101**
General Investigations	$3,603,146	$8,248,450			**$11,851,596**
WIC Investigation Recoveries	$1,099	$19,990			**$21,089**
WIC Vendor Monitoring	$1,310	$14,687			**$15,997**
Audit Activity	$702,022	$241,376			**$943,398**
Internal Affairs	$2,371	$0			**$2,371**
Total Recovery Activity[2]	**$135,310,691**	**$90,892,737**			**$226,203,428**

[2] SFY 2004 recoveries for the same period were $188,566,257.

OIG Cost Avoidance

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

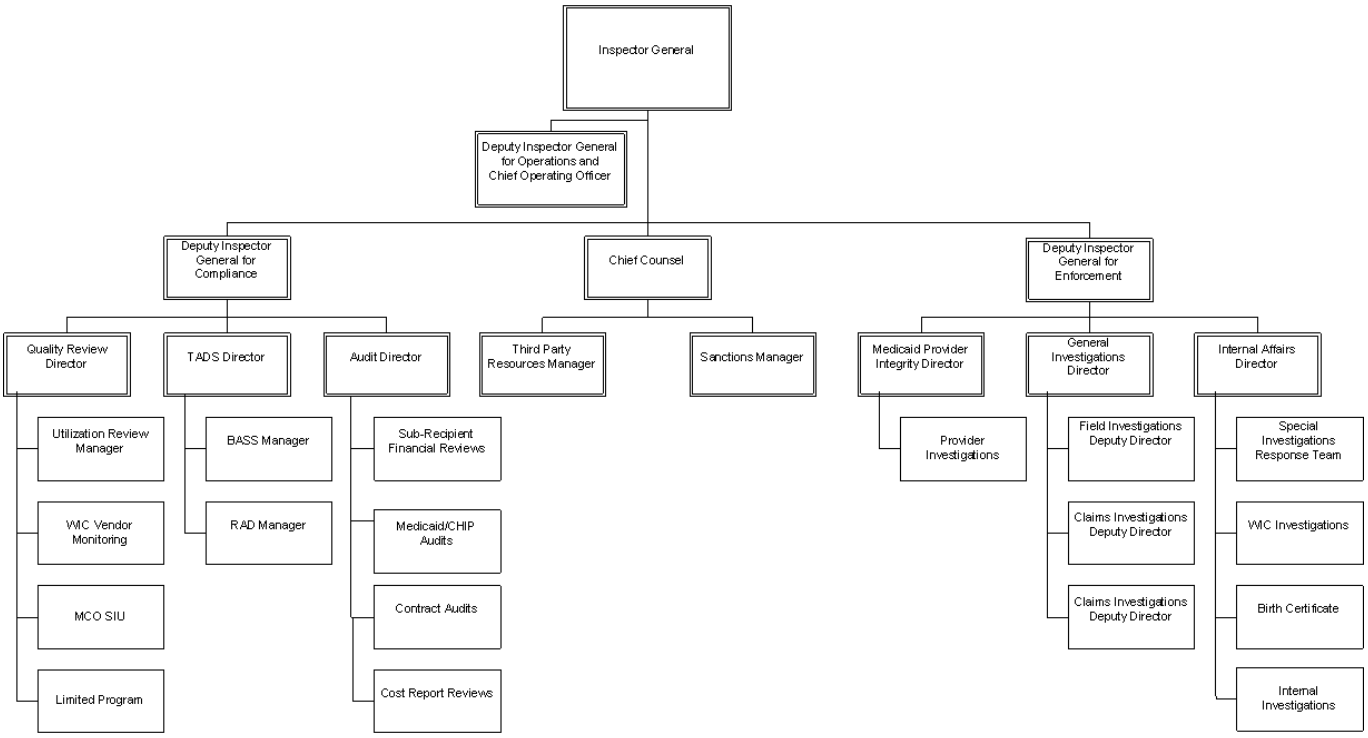
OIG Cost Avoidance

Cost Avoidance Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Sanctions	$2,987,571	$787,950			**$3,775,521**
TADS Provider Prepayment Review Process	$77,422	$55,437			**$132,859**
Third Party Resources	$64,792,165	$58,348,381			**$123,140,546**
General Investigation	$1,226,139	$808,542			**$2,034,681**
Audit Activities	$64,917,084	$6,799,035			**$71,716,119**
WIC Investigations	$70	$783			**$853**
WIC Vendor Monitoring	$1,435	$1,475			**$2,910**
Total Cost Avoidance[3]	**$134,001,886**	**$66,801,603**			**$200,803,489**

[3] SFY 2004 Cost avoidance for the same period was $231,619,607. The decrease is due to a change in the Sanctions cost avoidance methodology implemented during the second half of SFY 2004. Excluding this change, cost avoidance remains equal to SFY 2004 figures.

Key Accomplishments and Recent Developments

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



1. Technology Analysis, Development and Support (TADS)

A. There are a variety of technology accomplishments for OIG during the first half of SFY 2005, many of which are described in further detail throughout this report. Following is a list of technology accomplishments:

1. Waste, Abuse, and Fraud System

This is a web-based application available to the public for reporting waste, abuse, and fraud to OIG. The system is currently being enhanced to support a Spanish version. The Spanish translation was done in conjunction with DADS translation services.

2. Waste, Abuse, and, Fraud Electronic Reporting System (WAFERS)

This is a system available to OIG personnel to provide the following:

- OIG personnel can use WAFERS to submit referrals from the toll-free fraud hotline, fax, phone, postal mail or e-mail
- OIG sections can use WAFERS to create an internal referral from one OIG section to another
- OIG sections can use the WAFERS case management system to manage and edit referrals to their section and create reports supporting external referrals or other activity reports as needed
- Any OIG personnel can use a search feature to determine the status of a particular referral

3. Coordinated Case List

This is a search engine application allowing OIG personnel to find cases that may be under investigation by other sections within OIG including open cases from Office of Attorney General Medicaid Fraud Control Unit, General Investigations, Sanctions and WIC.

4. Single Audit Determination web system

A web-based system allowing HHS enterprise subcontractors to determine whether or not a single audit is required. If an audit is required, subcontractors can indicate the status of their audit on the system. The system is operational and will continue to be enhanced throughout the year. All HHS Enterprise agencies are currently supported and subcontractors listed by the agencies were informed of the new system.

5. MCO-SIU web portal

A web-based form available to Medicaid Managed Care Organizations (MCO) allowing them to send questions regarding MCO rules, provider/MPI issues, and recipient/General Investigation issues.

6. Redesigned OIG Toll Free Hotline

The redesigned and consolidated OIG hotline increases caller options and provides added flexibility to navigate through the hotline. Expanded menus, improved dialogue, and advanced call options now afford callers the means to more accurately choose the type of waste, abuse, or fraud to report. The redesigned hotline also allows the option of waiting for "live" operator or staff assistance. Approximately 6,875 calls per month are received on the OIG hotline.

B. OIG-TADS staff continued to work with HHSC Information Technology (IT) and OIG General Investigations staff on the development of the Automated System for the Office of the Inspector General (ASOIG). The ASOIG will replace the many current systems including the following:

- OIG Claims Integrated System (OCIS),
- OIG Claims Management System (CMS),
- Pending District Attorney Cases (PDAC); and
- Intentional Program Violation (IPV) Tracking and Correspondence System (THEMIS) systems.

When completed the ASOIG will provide/enable a one-stop application for General Investigations. This is anticipated to improve employee productivity, decrease training time, and enhance the General Investigations process.

Activities completed during this reporting period include:

- Mapping fields in the correspondences to ASOIG screens.
- Data Conversion/Migration sessions held daily. Currently cross-referencing OCIS fields to ASOIG.
- Requirements gathering and request submission for additional risk rules for the Reported Income Discrepancy System (RIDES). Business Analysis and Support Services (BASS) staff created an employer table that will be used by HHSC IT for these risk rules.

C. BASS implemented Phase I of the Single Audit Determination web system enabling providers to submit certain cost audit information on-line. Phase II, currently in

development, will allow the audit unit to track their work more efficiently using the system. BASS also implemented Replicon, a web-based timesheet application with ad hoc reporting capabilities, which provided the OIG Audit section with a more efficient system to track time.

D. Work on the Client Front End Authentication Pilot Project in coordination with the Office of Eligibility Services continued during this period. TADS continued to analyze and compare vendor biometric transaction data through the Medicaid Fraud Abuse and Detection System (MFADS) to identify potential waste, abuse or fraud. The February 2005 HHSC report and recommendations to the Legislature, Independent Evaluators Report, and other Client Frond End Authentication Pilot Project information can be found on the HHSC website at the following web address: *http://www.hhsc.state.tx.us/OIE/MIP/MIP_Updates.html*.

E. Other TADS activities included:

- Generation of 6,985 matches for General Investigations. This includes matches for Social Security Administration, Bureau of Vital Statistics, Texas Department of Criminal Justice, Prisoner Verification System, nursing home and border-states.
- Production of monthly, quarterly and annual reports for General Investigations.
- Implementation of the OIG Coordinated Case List.
- Development, testing and implementation of the Case Mix Utilization Review (CMUR) application, further discussed in the next section.
- Participation in the Medicare Medicaid data-sharing project with the Centers for Medicare and Medicaid Services contractor Tri-centurion.
- Review and revision of the MFADS targeted queries to include Health Insurance Portability and Accountability Act (HIPAA) required changes.
- Coordination of the data analysis regarding Medicaid children receiving psychotropic drugs.
- On-going activities with the claims administrator staff to improve the Surveillance and Utilization Review (SURs) process and coordination.

2. Case Mix Utilization Review Application

The Utilization Review (UR) unit is responsible for developing and maintaining an effective and efficient statewide Nursing Facility (NF) Case Mix Assessment Review process. In an effort to improve the quality of data available at on-site reviews and improve efficiencies by allowing on-site data entry by staff, UR created a Microsoft Access database with a laptop interface. This application is referred to as the Case Mix Utilization Review (CMUR) application.

Previously, nurse reviewers did not have access to claims data prior to arriving at an on-site review. Additionally, claims were reviewed through a paper process, and regional and state office staff entered review results after the review. Now, nurse reviewers download claims data to their individually assigned laptops through an interface with Department of Aging and Disability Services (DADS) claims data prior to arriving for an on-site review. This assures the review sample is derived from 100% of the claims data, rather than from the claims made available by the staff at the facility being reviewed. The nurse reviewer enters the results of record review, staff interview, and client observation directly into the CMUR application. Review results are available immediately upon completion of the review, and are provided to the nursing facility staff for educational and informational purposes. Upon return to the office, the nurse reviewer transmits updated reviews to the central CMUR repository and retrieves an updated set of reviews. This process was implemented September 15, 2004.

Enhancements to the Case Mix Utilization Review Process:

- Sample selection is current; all facilities for review are identified through initial source data.
- The predetermined sample is based on the error rate history.
- The optimal review date is based on the error rate history and is determined by the program.
- The CMUR application assists the nurse reviewers with time management and scheduling.
- The CMUR application allows nurse reviewers to perform unannounced nursing facility reviews.

- Accuracy and consistency are achieved through edits in the application that assure the nurse reviewer completes the review according to policy.
- Texas Index Level of Effort (TILE) calculation errors are minimized due to automated TILE calculation by the CMUR application. TILE levels determine nursing home claim payment amounts.
- The process allows for providers to receive immediate TILE review results with sufficient detail provided in the report to track all findings.
- Efficiency in completion of the process expedites the recoupment of dollars.
- Decrease in staff workload (16-24 hours/month) is achieved by eliminating the need for off-site data entry.
- Decrease of 50% in administrative staff time in preparing follow-up letters and responses that now occur at the time of the exit conference.
- The CMUR application also encompasses data entry requirements for hospice reviews.
- The CMUR application user identification system and password increase the security of documents and findings related to the review.

While reporting mechanisms are still in the development phase, reports from the field indicate that the record reviews are being completed more rapidly. Additionally, it is anticipated that the new application will increase the revenue generated by assuring all claims are eligible for review.

3. Managed Care Organization-Special Investigative Units (MCO-SIUs)

In accordance with House Bill 2292, 78th Legislature, all Managed Care Organizations (MCO) contracted with the State of Texas established a Special Investigative Unit (SIU) for the purpose of investigating fraudulent claims and other types of program abuse by recipients and providers. The SIUs adopted a plan to prevent and reduce waste, abuse, and fraud and filed the plan with OIG. To further combat waste, abuse and fraud in Managed Care, the MCOs and OIG agreed to meet quarterly to discuss waste, abuse and fraud in Managed Care and allow OIG to offer assistance to the MCOs in detecting, preventing and investigating waste, abuse, and fraud in Managed Care.

On November 30, 2004, OIG and the MCO-SIU representatives held its first quarterly meeting. One of the topics discussed during the meeting is how the SIUs could communicate with OIG in between quarterly meetings. It was agreed that OIG would

establish a website to be utilized solely by SIU's for submitting waste, abuse and fraud questions to OIG.

The website became operational on February 1, 2005. MCO-SIUs can now submit emails to the OIG Medicaid Provider Integrity, General Investigations, and Quality Review sections through a web-based secured email system. The new system allows the secured emails to go directly to the appropriate OIG division/section.

4. General Investigations

General Investigations staff is primarily devoted to the investigation of recipient fraud in the Food Stamp, Medicaid, and Temporary Assistance for Needy Families (TANF) programs. Recoveries totaled $11,851,596 for claims established based on General Investigation's activities for the first half of SFY 2005.

General Investigations experienced a significant increase in workload for SFY 2005, although this has not translated into an increase in the amount of funds identified for recovery. The amount of funds identified for recovery decreased while the amount of funds recovered increased. The increase in funds recovered is due to the cumulative effect of identifying funds for recovery, while the actual recovery process covers an extended period of time. The decrease in funds identified for recovery is due primarily to policy changes by the Office of Family Services (OFS).

In March of 2003, OFS implemented "Streamlined Reporting," an optional provision of the Federal Farm Security and Rural Investment Act of 2002, which brought about significant changes to the income reporting requirements for food stamp households. These reduced reporting requirements have dramatically increased the number of income discrepancy reports that General Investigations must manually review. The discrepancy reports increased 57% from SFY 2003, to SFY 2004, and 22% for the first half of SFY 2005. Despite these increases General Investigations has managed to maintain compliance with federally mandated timeliness standards in processing the discrepancy reports. Because income changes below a certain level are no longer required to be reported under Streamlined Reporting, amounts that formerly would have constituted an overpayment amount no longer constitute an overpayment. The result has been a dramatic decrease in the number of non-fraud overpayments, while fraudulent overpayments have remained relatively constant.

General Investigations is scheduled to implement automated filters by May 15, 2005, to assist in filtering out income discrepancy reports that no longer result in an overpayment due to Streamlined Reporting. Implementation of the filters should reduce the workload to prior, more manageable levels, and allow General Investigations to shift a portion of our emphasis to the recovery of overpayments and funds fraudulently obtained in other HHSC programs. Various program activities are being reviewed to determine the most efficient use of resources. It is anticipated that the decrease in funds identified for recovery due to the implementation of Streamlined Reporting will be temporary.

General Investigations has become involved in investigations that focus on matters of important public concern. Previously, General Investigations was focused exclusively on the recovery of funds obtained in error and by fraud. Productivity for the current state fiscal year was impacted when General Investigations assumed the primary responsibility for contacting and recording individual complaints involving Child Protective Services. An average of six investigators were utilized on a full time basis from September 2004 through February 2005. The resulting reduced recoveries are expected to be temporary.

The operations of General Investigations were and are expected to continue to be impacted by the loss of experienced personnel to other State agencies. The loss of experienced personnel is primarily attributed to the higher wage scale at other agencies for similar levels of expertise.

5. OIG and OAG Interagency Coordination

OIG provides oversight of HHS activities, providers, and recipients through compliance and enforcement activities designed to identify and reduce waste, abuse, and fraud, and improve efficiency and effectiveness within the HHS system.

The United States Department of Health and Human Services, Office of Inspector General, approved matching federal grant funds, which could expand the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) to as many as 236 staff by the end of federal fiscal year 2005. MFCU is currently staffed with 150 employees, and maintains field offices in Dallas, Houston, Lubbock, Tyler, El Paso, McAllen, San Antonio, and Corpus Christi. Additionally, MFCU is in the process of implementing a Houston and San Antonio based joint federal task force.

Pursuant to the requirements of Senate Bill 30 (75th Legislature), a memorandum of understanding (MOU) was executed in April 1998 between the HHSC Medicaid Program Integrity section (MPI) and the MFCU. The MOU was updated and expanded in November 2003, in accordance with House Bill 2292 (78th Legislature), which required OIG and the OAG to enter into a new MOU no later than December 1, 2003.

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

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 cases, regardless of type. Following are three charts, which provide the number of waste, abuse, and/or fraud referrals, which have been received and sent from MPI and Sanctions.

MPI and Sanctions Waste, Abuse, and Fraud Referrals Received

Referral Source	Received
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	**28**
United States Department of Justice	**2**
Center for Medicare Service (CMS)	**2**
Health and Human Services – Health Care Finance Administration	**1**
Health and Human Services – Office of Inspector General (HHS-OIG)	**38**
Texas Department of Aging & Disability Services (DADS)	**24**
Texas Department of Human Services (DHS) Long Term Care	**4**
Texas Department of State Health Services (DSHS)	**10**
Texas Department of Transportation	**1**
Law Enforcement Agency	**1**
Amerigroup	**1**
Parent/Guardian	**7**
Provider	**11**
Public	**53**
Recipient	**39**
Anonymous	**16**
Board of Dental Examiners	**16**
Board of Medical Examiners	**26**
Board of Nurse Examiners	**142**
Board of Podiatry Examiners	**1**
HHSC - Audit Division	**1**
HHSC - General Investigations	**1**
HHSC - Hot-line	**27**
HHSC - Limited Program	**1**
HHSC - Medicaid/Chip Division	**1**
HHSC - MPI-OIG Self-initiated (MPI)	**8**
HHSC - Utilization Review	**2**
Surveillance, Utilization, Review System (SURS)	**1**
Vendor Drug	**1**
Total Cases Received:	**466**

MPI and Sanctions Waste, Abuse, and Fraud Referrals Sent

Referral Source	Referred
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	**90**
Assistant United States Attorney	**3**
SSI Administration	**1**
Internal Revenue Service (IRS)	**1**
Medicare Part A& B	**18**
Drug Enforcement Agency (DEA)	**1**
Health and Human Services – Office of Inspector General	**6**
Out of State	**1**
Texas Department of Aging and Disability Services (DADS)	**1**
Texas Department of Mental Health and Mental Retardation (MHMR)	**3**
Texas Department of State Health Services	**1**
Texas Department of State Health Services/Texas Board of Orthotics & Prosthetics	**1**
Texas Department of Transportation	**1**
Board of Dental Examiners	**9**
Board of Medical Examiners	**12**
Board of Nurse Examiners	**4**
Board of Optometry	**0**
Board of Pharmacy	**5**
Claims Administrator – Educational Contract	**46**
Claims Administrator – Records Review	**1**
HHSC – General Investigation	**13**
HHSC – Internal Affairs	**1**
HHSC – RAD	**1**
HHSC – Rate Analysis – LTC	**1**
HHSC – Utilization Review	**1**
TOTAL	**222**

MPI and Sanctions Case Summary

	1st Quarter	2nd Quarter	Total
Cases Opened	110	103	**213**
Cases Closed	65	104	**169**
Providers Excluded	129	128	**257**

6. Third Party Resources (TPR)

TPR began using the National Insurance Crime Bureau (NICB) ISO ClaimSearch Data Base to identify Medicaid recipients who have not reported subrogation cases or other insurance information in accordance with Chapter 32 of the Texas Human Resources Code §32.033. During the pilot phase TPR staff searched cases with a potential recovery of at least $5,000. Of that population TPR identified 236 cases for review. Additional research yielded the following breakdown:

- 20 clients found to already have a Medicaid tort case open and active;
- 3 new subrogation identified and referred to our subrogation unit; and
- 213 clients with no reported insurance settlement.

Initial results show that the existing tort identification methods are clearly working well. The pilot phase will continue until TPR has a definite ability to determine the cost effectiveness and/or opportunity cost of researching the NCIB-ISO.

The University of Massachusetts (UMASS) in coordination with HHSC has established a process to directly bill Palmetto GBA, the Texas DMERC for pharmacy reclamation claims. This new process is anticipated to collect $15 million over the coming months as UMASS bills these claims.

7. Internal Investigations

In January 2005, the Internal Affairs section in collaboration with staff from HHSC HIPAA Project Management Office, Human Resources, and other agency representatives met to revise policy concerning the use of state owned computer resources and internet connections. The changes to this policy will be reflected in the Human Resources Manual and in the HHSC Enterprise Information Security Policy,

Standards and Guidelines. The proposed revisions are being reviewed for final executive approval.

Policy will be strengthened and standardized to ensure all HHSC employees have the same understanding of the revised policy. OIG will be the primary investigatory body for the HHS enterprise system involving cases of suspected misuse of computer resources.

8. Hotline Consolidation

In September 2004, OIG consolidated multiple legacy agency toll-free fraud hotline telephone numbers into a single fraud hotline. The consolidation enabled clients, providers, employees and the public to report waste, abuse, or fraud related to health and human service programs via a single number: (800) 436-6184. To enhance customer service and more efficiently allocate resources to manage increased call volume, the consolidated fraud hotline was redesigned in January 2005.

Prior to the January 2005 redesign, callers had limited choices when reporting waste, abuse and fraud and often very little success in reaching a "live" OIG representative. The redesigned hotline increases caller options and provides added flexibility to navigate through the hotline. Expanded menus, improved dialogue, and advanced call options now afford callers the means to more accurately choose the type of waste, abuse, or fraud to report and better distribute complaints to the appropriate OIG section for investigation. The resigned hotline also allows the option of waiting for "live" operator or staff assistance. System improvements further include detailed real-time reporting allowing high call volumes, misdirected callers and other potential barriers to be identified, addressed and remedied, improving overall customer service and support. Assistance is available in English and Spanish.

With the implementation of the redesigned, consolidated fraud hotline, OIG is receiving a higher quality of complaint. Complainants are able to provide better-detailed information with information fresh on their minds. OIG is also able to obtain improved information from anonymous sources since callers are able to speak with a representative at the time of their complaint.

9. Audit Activities

The Audit section consists of four units:

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

The Audit Section has focused on the following activities:

- Implementation of a web-based timekeeping system to capture *after-the-fact* actual time worked on each federal program,
- Coordination with HHS agencies to develop procedures and a web-based form for the single audit report review process,
- Finalization of FY04 site-visits and reviews,
- Consolidation of site-visit procedures, accomplishing cost report review deadlines, and
- Other oversight activities.

Audits performed include the various types described in the *Government Auditing Standards*, 2003 revision, "The Yellow Book." Policies and procedures are in place to ensure work meets Yellow Book standards including general, fieldwork, and reporting standards.

To accomplish state and federal mandates surrounding audit activities, OIG is continuing to hire employees needed for the Audit Section. The hiring of managers for the Sub-recipient Financial Review, Medicaid/CHIP Audit, and Contract Audit units at the beginning of February 2005 completed the Audit management team.

Sub-recipient Financial Review Team

The Sub-recipient Financial Review Team (SFRT) is responsible for:

1. Single audit report reviews,
2. Financial site-visits desk reviews of DSHS sub-recipients, and
3. Women, Infant and Children (WIC) provider fiscal monitoring functions.

A sub-recipient is any individual, business, or party that receives federal Grant funds to perform a set of services.[4] An example of a sub-recipient is a vendor who receives federal block grant money to provide substance abuse programs for children.

In January 2005, the Single Audit Review Team (SART) was able to leverage OIG internal technical resources to create a web-based system for sub-recipients to report their total federal and state expenditures by fiscal year. The web-based application allows sub-recipients to provide required reporting information on a form called "Single Audit Determination Form." Information received is used to determine whether a single audit report submission is required. The form also contains a section where sub-recipients can certify that they expended less than the threshold amount on their federal and/or state award. The system will generate a variety of reports to facilitate SART's management of the review process. Additionally, the system will allow HHS agencies to monitor the status of their sub-recipients' single audit report reviews.

Since the beginning of SFY 2005, SFRT has concentrated most of its efforts in the following areas:

- Closing out the reports on the site visits of the 50 outstanding backlog transferred from the legacy agencies,
- Conducting Fiscal Year 2005 risk assessments and planning; and
- Consolidating site visit processes from legacy agencies, including the Texas Department of Health (TDH), Mental Health and Mental Retardation (MHMR), and Texas Commission on Alcohol and Drug Abuse (TCADA).

The primary function of the SFRT is to conduct on site financial compliance reviews[5] to determine that amounts reimbursed are adequately supported by verifiable documents. Site visits are also designed to evaluate compliance with requirements of the state

[4] A sub-recipient is subject to a single audit when it has received and expended 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 (OMB Circular A-133), including the State of Texas Single Audit Circular.

[5] Financial compliance reviews or monitoring includes the review of internal controls to determine if the financial management and accounting system are adequate to account for program funds in accordance with state and/or federal requirements. It also includes an examination of cost information to ensure that all costs are reasonable and necessary to achieve program objectives.

and/or federal program, applicable laws and regulations, the provisions of the contract agreement and the achievement of performance goals associated with the Grant.

To ensure consistency for site visits and avoid duplication of monitoring reviews, it was necessary to consolidate audit processes used by legacy agencies. Upon completion of the first monitoring review, conducted under our consolidated procedures, we were pleased to receive positive commendations from sub-recipients[6]. We believe all stakeholders benefit by ensuring that all auditors receive clear guidance on the auditing standards within OIG.

The HHS Contract Council released its recommendations regarding the contract management functions on January 14, 2005. As a result of their recommendation 32.5 full-time equivalents (FTEs) from the SFRT will return to the Department of State Health Services (DSHS) effective March 1, 2005. These FTEs will retain the financial site-visit desk reviews and the WIC provider fiscal monitoring functions. When this transfer is complete, SFRT will continue to perform the single audit report reviews and will begin conducting audits of grant awards passed through to sub-recipients throughout the HHS enterprise in accordance with a risk-based audit plan.

Medicaid/CHIP

A unit manager was hired on February 7, 2005, to lead the Medicaid/CHIP Audit unit. The unit will soon begin development of a risk-based system for auditing Medicaid/CHIP contracts. Through review and analysis of information gathered from various sources[7] the unit will be able to properly assess the risks specific to each contract and prioritize and plan its audit activities accordingly. This will enable the unit to apply resources efficiently and effectively as they become available.

HHSC, Texas Medicaid & Healthcare Partnership (TMHP), and Comprehensive Outpatient Rehabilitation Facilities (CORFs) provided several recommendations to prevent future potential overpayments including a switch to a prospective payment system (PPS), creating a tiered system to determine prioritization of CORF remediation, requiring and reviewing Cost Reports and cost information from CORFs and related

[6] Reference, Hill Country Community MHMR.

[7] Audit reports, information systems and contract monitoring activities, Medicaid/CHIP Governance organizations, and other related activities.

facilities, and requiring TMHP to perform a reconciliation of CORFs receiving payment to the Log of CORF Cost Report Audits.

Additionally, a performance audit to determine setting of payment rates and oversight of Federally Qualified Health Centers (FQHCs) has been undertaken in this period and is near completion. The planning and fieldwork phases of the audit have been completed, the draft report is under review, and the exit conference is scheduled. This audit entails determining if supervising organizations are performing appropriate oversight and review to ensure that FQHCs are paid at the proper rates. Additionally, it seeks to determine if the Claims Administrator, TMHP, is performing proper audit procedures for FQHCs.

Contract Audit Unit

The Contract Audit Unit (CAU) was created to provide audit coverage for all HHS contracts other than Texas Medicaid Administrative Services (TMAS) contracts and sub-recipient contracts. A manager for this unit was hired on February 1, 2005. Staffing needs are being assessed at this time in accordance with a risk-based audit plan.

There are approximately 18,000 contracts that will fall under the purview of the CAU with an aggregate value of approximately $6.5 billion. These include contracts for nursing and hospice care, community care services, nutrition assistance, childcare, foster care, programs for the elderly, vendor drug programs, rehabilitation and assistance programs, and various consulting and professional services contracts.

The objectives of audits conducted by the CAU may 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 CAU has included finalizing eight inherited pharmacy audits resulting in the identification of $353,947 in overpayments, closeout audits, and

audits of Intermediate Care Facilities for Mental Retardation (ICFMRs)[8]. CAU has conducted thirty of these audits.

Cost Report Review Unit

The Cost Report Review unit completed on-site field audits and in-house desk reviews of provider cost reports[9]. Desk reviews of all provider cost reports are conducted to ensure that the financial and statistical information submitted in the cost reports conforms to all applicable rules and instructions. Unallowable costs are removed from the cost report and ultimately from the HHSC database that is used to determine the reimbursement rates.

The majority of this unit's 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. Approximately ten percent (10%) of the providers submitting cost reports receive an on-site audit as a result of a risk assessment analysis performed by the HHSC Rates and 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 and the resulting lower reimbursement rates. This adjusted statistical and financial information is utilized by RAD to recommend to the Legislature future reimbursement rates for program services.

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. The Cost Report Review unit 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.

[8] CAU conducts audits of ICFMRs as mandated in the Texas Administrative Code § 419.269 to monitor compliance with § 419.219 relating to provider reimbursement and Division Six relating to personal funds. Audits are performed to reasonably assure that program funds were properly used to provide contracted services to eligible recipients, ensure that recipient funds were adequately managed and serve as a deterrent to fraud and abuse within the program.

[9] TAC, Title 1, Part 15, chapter 355, subchapters D and F mandates Medicaid provider cost report and field audits.

Both ICFMR and Home and Community Based Service programs for mentally retarded individuals are required to spend at least ninety percent (90%) of the rate for direct care services to Medicaid clients. Failure to meet the ninety percent (90%) floor results in RAD recovering a portion of the rate component from the Medicaid provider. The Cost Report Review unit performs desk reviews and field audits on the cost reports submitted by the providers. Adjustments to the reported direct care cost often result in RAD recovering additional funds from the providers.

With the consolidation of the cost report units from the former MHMR, DHS and PRS, the unit is rapidly becoming cross-trained in the various program areas. This has allowed more flexibility in meeting the goals of OIG and HHSC.

Non-Audit Services

Non-audit services generally differ from audits in that auditors may (1) perform tasks requested by management that directly support the entity's operations, or (2) provide information or data to a requesting party without providing verification, analysis, or evaluation of the information or data, and therefore, the work does not usually provide a basis for conclusions, recommendations, or opinions on the information or data. These services may or may not result in the issuance of a report.

Examples of non-audit services include participation in the Governor's Fraud Initiative Subcommittee of the Governor's Management Council in developing guidelines for the state agencies Fraud Prevention and Elimination Program and assisting the Department of Aging and Rehabilitation Services (DARS) in developing their nursing home financial viability application assessment tool.

Medicaid Fraud Detection and Abuse Prevention Training

1. Texas State University Training

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

The training component includes:

- An explanation of Medicaid fraud,
- Examples of fraud and/or abuse,
- The provider's responsibility for reporting fraud and/or abuse, and
- Information on the penalties for committing Medicaid fraud.

Training is also available as a seminar. The seminar contains examples of actual schemes that have been used to defraud the Medicaid program. Participants are encouraged to ask questions and interact with the trainers. Program content can be adapted to meet the needs of specific groups or organizations. This informal and highly interactive presentation lasts approximately two hours.

2. Distance Learning Program

Developed in collaboration with TSU and OIG, 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 module is available from TSU on-line or by correspondence.

For nursing facilities with Medicaid clients, and home health agencies with community based alternative (CBA) clients, the fraud and abuse training is offered in conjunction with the Texas Index of Level of Effort (TILE) training module. The fraud and abuse prevention training module is also available on-line as a separate tool.

TILE registrations for September 1, 2004 – February 28, 2005

Type of Course	Total Enrolled
TILE Nursing Home Correspondence	439
TILE Nursing Home On-Line Computer Training	381
Community Base TILE Correspondence	152
Community Based TILE On-Line Computer Based Training	184
Total	**1156**

3. Fraud Prevention Training

HHSC believes provider education is an integral element of any waste, abuse and fraud prevention plan. As a requirement of Senate Bill 30 (75th Legislature), OIG provides free training to Medicaid providers, contractors, their employees, and staff from other state agencies that administer health and human services programs, on the identification and referral of waste, abuse or fraud in the Medicaid Program.

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

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

Training September 1, 2004 – February 28, 2005

Date	Audience	Subject	Presenter
September 20, 2004	Insurance Industry CEOs and Claim Managers	Identity theft claims	Wayne Sneed
October 28, 2004	Managed Care CEOs and CFOs Capitation Workgroup	TPR for Managed Care Organizations	Tim Broadhurst
November 5, 2004	Fraud Investigator's Association of Texas	Office of Inspector General	Brian Flood
November 17, 2004	Austin Bar Association	Office of Inspector General	Brian Flood
December 8, 2004	NW3C Financial Records Examinations & Analysis Course (FREA)	Case Reports & Preparing for Court	Bart Bevers
December 12, 2004	NW3C Financial Records Examinations & Analysis Course (FREA)	Mock Trial: Courtroom Presentation with Financial Records	Bart Bevers
January 20, 2005	The Greater Dallas Crime Commission	Overview of the HHSC OIG	Brian Flood
February 18, 2005	Health Care Compliance Associations Southwest Annual Conference	Mission, Responsibility, and Organizational Structure of OIG	Charlotte Dokes
February 28, 2005	Texas Workforce Commission Regulatory Enforcement Division	Fraud Detection	Brian Flood

Appendix A – OIG Detailed Statistics

Section I - OIG Recovery Activity

Recovery Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Sanctions	$36,864,059	$1,670,739			**$38,534,798**
Civil Monetary Penalties (CMP)	$11,171,955	$212,505			**$11,384,460**
Utilization Review (Hospitals)	$10,694,064	$6,878,143			**$17,572,207**
Utilization Review (Nursing Homes)	$0	$1,217,469			**$1,217,469**
Third Party Recoveries	$71,744,016	$71,665,926			**$143,409,942**
Technology Analysis, Development & Support (TADS)	$526,649	$723,452			**$1,250,101**
General Investigations (Food Stamps, TANF, and Medicaid Recipients)	$3,603,146	$8,248,450			**$11,851,596**
WIC Investigation Recoveries	$1,099	$19,990			**$21,089**
WIC Vendor Monitoring	$1,310	$14,687			**$15,997**
Audit Activity	$702,022	$241,376			**$943,398**
Internal Affairs	$2,371	$0			**$2,371**
Total Recovery Activity	**$135,310,691**	**$90,892,737**			**$226,203,428**

Section II - OIG Cost Avoidance

Cost Avoidance Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Sanctions	$2,987,571	$787,950			**$3,775,521**
TADS Provider Prepayment Review Process	$77,422	$55,437			**$132,859**
Third Party Resources	$64,792,165	$58,348,381			**$123,140,546**
Disqualifications (Food Stamps & TANF Recipients	$618,792	$318,948			**$937,740**
Income Eligibility Verification System (IEVS) Data Matches (Food Stamps, TANF and Medicaid Recipients)	$578,008	$296,234			**$874,242**
Recipient Data Matches (Food Stamps, TANF and Medicaid Recipients)	$29,339	$193,360			**$222,699**
Audit Activities	$64,917,084	$6,799,035			**$71,716,119**
WIC Investigations	$70	$783			**$853**
WIC Vendor Monitoring	$1,435	$1,475			**$2,910**
Total Cost Avoidance	**$134,001,886**	**$66,801,603**			**$200,803,489**

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

Section III - OIG Summary Tables

Summary Table Technology Analysis, Development & Support (TADS)

TADS Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Cases Opened	247	472			**719**
Cases Closed	515	218			**733**
Cases Referred to Attorney General	0	0			**0**
Dollars Recovered	$526,649	$723,452			**$1,250,101**
Cost Avoidance Due to Provider Prepayment Review Process (all OIG)	$77,422	$55,437			**$132,859**

Summary Table Internal Affairs (IA)

IA Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Complaints Received	77	65			**142**
Investigations Completed	29	26			**55**
Dollars Recovered	$2,371	0			**$2,371**
Cases Referred	7	6			**13**

Summary Table Women and Infant Children (WIC) Investigations

WIC Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Referrals/Complaints Received*	30	36			**66**
Cases Opened	72	69			**141**
Cases Closed	142	280			**422**
Claims Established	$33,125	$37,058			**$70,183**
Collections	$1,099	$19,990			**$21,089**
Cases Adjudicated	0	4			**4**
Cost Avoidance	$70	$782			**$852**

Summary Table Medicaid Provider Integrity (MPI)

MPI Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Cases Opened	110	103			**213**
Cases Closed	65	104			**169**
Cases Referred to Attorney General	39	49			**88**

Summary Table Third Party Resources (TPR)

TPR Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Cost Avoidance	$64,792,165	$58,348,381			**$123,140,546**
Other Insurance Credits	$45,689,021	$51,154,914			**$96,843,935**
Provider/Recipient Refunds	$1,553,611	$1,893,651			**$3,447,262**
Texas Automated Recovery System (TARS)	$5,670,045	$4,999,709			**$10,669,754**
Pharmacy	$2,505,061	$2,450,231			**$4,955,292**
PPRA	$2,192,995	$975,359			**$3,168,354**
Credit Balance Audit	$5,012,786	$3,377,743			**$8,390,529**
Tort	$7,415,286	$4,808,612			**$12,223,898**
Cash Medical Support	$1,705,211	$2,005,709			**$3,710,920**
Total Third Party Recovery Activity	**$136,536,181**	**$130,014,307**			**$266,550,490**

Summary Table Limited Program

Lock-In Summary Category	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June	July	Aug.
Fee-for-Service (FFS)	322	336	338	328	328	331						
STAR[10] (Rx Only)	149	142	133	137	128	135						
STAR+PLUS (Rx Only)	39	40	39	41	46	48						
Total	510	518	510	506	502	514						

[10] STAR – State of Texas Access Reform

Summary Table General Investigations Activities (Food Stamp, TANF, and Medicaid Recipients)

General Investigations Summary Activity	1st Quarter	2nd Quarter	3RD Quarter	4th Quarter	Total SFY 2005
Collections	$3,603,146	$8,248,450			**$11,851,596**
Disqualification Cost Avoidance	$618,792	$318,948			**$937,740**
Cost Avoidance Income Eligibility Verification System (IEVS) Data Matches	$578,008	$296,234			**$874,242**
Cost Avoidance Recipient Data Matches	$29,339	$193,360			**$222,699**
Referrals/Complaints Received	16,297	18,302			**34,599**
Cases Completed	12,760	15,282			**28,042**
Percent of Cases Completed w/in 180 Days	95.2%	95%			**95%**
Cases Referred for Prosecution	968	894			**1,862**
Admin. Disqualification Hearings (ADH) Cases Completed	723	997			**1,720**
Cases Adjudicated	309	350			**659**
Civil Disqualifications	1,452	746			**2,198**
Income Eligibility and Verification System (IEVS) Matches Cleared	62,079	57,390			**119,469**
Recipient Data Matches Cleared	1,011	6,663			**7,674**

Summary Table Sanctions

Sanctions Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Cases Opened	162	88			**250**
Cases Closed	187	168			**355**
Cases Referred to Attorney General	1	0			**1**
Dollars Recovered	$36,864,059	$1,670,739			**$38,534,798**
Exclusions	129	128			**257**
Payment Holds	1	2			**3**
Civil Monetary Penalties Recovered	$11,171,954	$212,505			**$11,384,459**
Cost Avoidance	$2,987,570	$787,950			**$3,775,520**

Summary Table Utilization Review (UR)

UR Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Hospitals - Recoveries	$10,694,064	$6,878,143			**$17,572,207**
Hospitals – Underpayments	$40,305.00	$61,990			**$102,295**
Nursing Homes – Recoveries	0	$1,217,468			**$1,217,469**
Nursing Homes – Underpayments		$209,988.42			**$209,988**
Nursing Homes– Facilities Visited	152	299			**451**
Nursing Homes - # of Forms Reviewed *	7,577	14,513			**22,090**
Nursing Homes - # of Facilities Placed on Vendor Hold	0	0			**0**
Hospitals – Mail-ins	245	135			**380**
Hospitals – Facilities Visited	89	55			**144**
Hospitals - # of Claims Reviewed	6,882	2,320			**9,202**

Summary Table Audit Activities

Audits Summary for HHS Agencies	Number of Audits	Number of Site Visits	Number of Desk Reviews	Recoupment & Recovery	Cost Avoidance	Recipient Refunds	Rejected Single Audits[11]
Sub-Recipient Financial Review							
1st Quarter	N/A	9	182	$674,110	$15,412	N/A	26
2nd Quarter	N/A	7	5	$84,209.59	N/A	N/A	25
3rd Quarter							
4th Quarter							
Total							
Medicaid/Chip Audits	1	N/A	N/A	N/A	N/A	N/A	N/A
1st Quarter	N/A	N/A	N/A	N/A	N/A	N/A	N/A
2nd Quarter							
3rd Quarter							
4th Quarter							
Total							
Contract Audit							
1st Quarter	N/A	11	N/A	$27,912	N/A	$8,414	N/A
2nd Quarter	37	N/A	N/A	$157,166.85	N/A	$49,885	N/A
3rd Quarter							
4th Quarter							
Total							
Cost Report Review	119	N/A	875	N/A	$64,901,671	N/A	N/A
1st Quarter	27	N/A	519	N/A	$6,799,035	N/A	N/A
2nd Quarter							
3rd Quarter							
4th Quarter							
Total							
Totals	**184**	**27**	**1,581**	**$943,398**	**$71,716,118**	**$58,299**	**51**

[11] 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 sub-recipients 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.

Summary Table WIC Vendor Monitoring

WIC Vendor Monitoring	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Number of Compliance Buys Conducted	82	89			**171**
Number of In-Store Evaluations	72	63			**135**
Number of Audits Closed	2	5			**7**
Vendor/Grocer Overcharges	$1,435	$1,475			**$2,910**
Dollars Recouped	$0	$435			**$435**
Civil Monetary Penalties	$1,310	$14,252			**$15,562**

Section IV – Other OIG Activities

Education and Prevention

Type of Course	Total Enrolled
TILE Nursing Home Correspondence	439
TILE Nursing Home On-Line Computer Training	381
Community Base TILE Correspondence	152
Community Based TILE On-Line Computer Based Training	184
Total	**1,156**

TILE Registrations for September 01, 2004 – February 28, 2005

Appendix B – OIG Division Summary Excluding TPR

	SFY 2004 (Sept. 1 - Aug. 31)		SFY 2005 Year to Date (Sept. 1 - Feb. 28)	
OIG Division, Section, Unit	**Recoupment**	**Cost Avoidance**	**Recoupment**	**Cost Avoidance**
Compliance Division	N/A	N/A	N/A	N/A
Quality Control Section	N/A	N/A	N/A	N/A
Utilization Review	N/A	N/A	N/A	N/A
Hospitals (DRGs)	$22,137,349	g	$ 17,572,207	g
Nursing Homes (Case Mix Review)	$8,240,785	g	$ 1,217,469	g
TEFRA Claims	N/A	N/A	N/A	g
Children's Summary	$2,601	f	i	g
Psychiatric Summary	$4,575	f	i	g
Compliance Monitoring and Referral [a]	N/A	N/A	N/A	N/A
Technology, Analysis, Development, and Support Section	N/A	N/A	$1,250,101	$132,859
RADS	N/A	N/A	N/A	N/A
Surveillance and Utilization Review Subsystems	$1,529,597	g	j	g
Medicaid Fraud and Abuse Detection System	$2,470,200	g	j	g
Audit Section [b]	$2,501,961	$93,373,034	$943,398	$71,716,119
Enforcement Division	N/A	N/A	N/A	N/A
Medicaid Provider Integrity Section	$23,358,098	$45,068,837	h	h
General Investigations Section [c]	$22,617,280	$3,266,126	$11,851,596	$2,034,681

OIG Division, Section, Unit	Recoupment	Cost Avoidance	Recoupment	Cost Avoidance
Internal Affairs Section	k	k	$2,371	N/A
WIC Vendor Monitoring	k	k	$15,997	$2,910
WIC Investigation Recovery [d]	$27,447	f	$21,089	$853
Chief Counsel Division	N/A	N/A	N/A	N/A
Sanctions Section	l	l	$38,534,798	$3,775,521
Civil Monetary Penalties	$14,184,150	N/A	$11,384,460	N/A
Total Recoupment	**$97,074,043**	N/A	**$82,793,486**	N/A
Total Cost Avoidance	N/A	**$141,707,997**	N/A	**$77,662,943**

Foot Note Table:

a= Function discontinued in 2003.
b= Data captured by legacy agencies until 2003.

c= Data for cost avoidance and savings captured by legacy agencies until 2004

d= Unreported data not available from legacy agency.
e= The Case Mix (Nursing Home) Utilization Review laptop application was implemented 9/15/04. Recovered dollars are not available for this report and will be reported when available.

f= Cost avoidance and savings methodology under review.
g= OIG has taken a more conservative approach to the calculation of cost avoidance, and therefore a comparison to prior years is not possible. After a review of all OIE cost avoidance methodologies during the Optimization Phase of Transformation, OIG has removed cost avoidance savings for UR, MFADS, and SURS. We believe that including cost avoidance, in addition to recovery activity, for these areas was too aggressive of a measure.

h= MPI dollars are reported under Sanctions

i= Children's and Psychiatric Summaries consolidated and reported under Utilization Review (Hospital)

j= SURS and MFADS recoveries are reported within TADS

k = not previously captured

l = Previously reported under MPI

HEALTH AND HUMAN SERVICES COMMISSION

End of Report