Albert Hawkins, Executive Commissioner

Office of Inspector General Semi-Annual Report

September 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

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

BACKGROUND 2

OIG RECOVERY AND COST AVOIDANCE STATISTICS 4

1. Recovery 4
2. OIG Cost Avoidance 6

KEY ACCOMPLISHMENTS AND RECENT DEVELOPMENTS 7

1. Compliance Division 7
   - Quality Review 7
   - Technology Analysis, Development and Support 9
   - Audit Activities 12
2. Chief Counsel 19
   - Third Party Resources 19
   - Sanctions 20
3. Enforcement Division 20
   - OIG and OAG Interagency Coordination 20
   - General Investigations 24
   - Internal Investigations 25
4. Staff Development, Education, and Training Services 26
5. OIG and UTD Information Analysis Initiative 26
6. OIG Strategic Planning Development 27
7. Special Activities 28
   - OIG Disaster Relief Help 28

MEDICAID FRAUD DETECTION AND ABUSE PREVENTION TRAINING 30

1. Texas State University Training 30
2. Distance Learning Program 30
   - TILE registrations for March 1, 2005-August 31, 2005 31
3. Fraud Prevention Training 31
   - Training September 1, 2004 – August 31, 2005 32

APPENDIX A – OIG DETAILED STATISTICS 33

Section I - OIG Recovery Activity 33
Section II - OIG Cost Avoidance 34
Section III - OIG Summary Tables 35
- Summary Table Utilization Review (UR) 35
- Summary Table WIC Vendor Monitoring 35
- Summary Table Limited Program 36
- Summary Table Technology Analysis, Development & Support (TADS) 36
- Summary Table Audit Activities 37
- Summary Table Third Party Resources (TPR) 38
- Summary Table Sanctions 38

Summary Table Medicaid Provider Integrity (MPI) 39
Summary Table Internal Affairs (IA) 39
Summary Table WIC Investigations 39
Summary Table General Investigations (Food Stamp, TANF, and Medicaid Recipients) 40
Section IV - Other OIG Activities 41
Education and Prevention 41
Staff Presentations 42
APPENDIX B – OIG DIVISION SUMMARY EXCLUDING TPR 43
APPENDIX C – SFY 2005 SEMI-ANNUAL REPORT FIGURES 45

HEALTH AND HUMAN SERVICES COMMISSION

Executive Summary

SEPTEMBER, 2005

The Office of Inspector General (OIG) is pleased to issue the semi-annual report for the second state fiscal year (SFY) 2005 of operation, which ended August 31, 2005. This report contains a year-to-date synopsis of OIG recoveries and cost-avoidance, provides an overview of our key accomplishments this fiscal year, and presents a look at future OIG activities.

In SFY 2005, OIG recovered $441,551,341 and cost avoided $362,489,120. As these funds are directed back into health and human services programs, we know that the $804,040,461 is providing needed healthcare and other assistance to many Texans. Total recoveries for the period increased by 26 percent over SFY 2004. With OIG operating on a budget of $34.6 million, the State's total return on investment in SFY 2005 was over $23 for each dollar spent on OIG.

OIG saved $65 million in SFY 2005, which exceeded the $57.6 million required savings assigned in the Legislative Appropriations Request as a result of House Bill 2292, 78th Legislature. Of the $65 million, $52 million was in cash deposit recoveries.

An increase in staffing was approved by the 79th Legislature for SFY 2006. This will aid in providing additional staff to assist with audit functions, contract compliance, overpayment recoveries, and investigation activities.

OIG continues to manage and streamline the integrated fraud and abuse prevention and detection functions for all Health and Human Services agencies. We remain focused on enhancing our computer programs and technical infrastructure to increase efficiency, enrich the quality of work papers, and improve the ability to recover overpayments.

Further, OIG strengthened its working relationships with the Medicaid/CHIP division and the Office of the Attorney General Medicaid Fraud Control Unit enabling the State to achieve cost savings in a variety of Medicaid related areas. To ensure quality, OIG operates in accordance to the National Association of Inspector's General green book standards.

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 programs, the 78th Texas Legislature created 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.

OIG provides program oversight of health and human service (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.

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 supporting evidence and the greatest potential for monetary recovery; and
- Maximizing the opportunities for referral of cases to the Office of the Attorney General (OAG).

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

1. Recovery

Total recoveries[1] for SFY 2005 were $441,551,341 (all funds) as compared to $349,593,248 for SFY 2004. This represents a 26% increase of recoveries over SFY 2004. OIG continues to build on strengths achieved from consolidation activities as directed by the 78th Legislature and Governor's Executive Order RP 36 issued July 12, 2004. 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	$7,525,152	$768,198	**$46,828,148**
Civil Monetary Penalties (CMP)	$11,171,955	$212,505	$1,661,378	$0.00	**$13,045,838**
Utilization Review (Hospitals)	$10,694,064	$6,878,143	$2,187,212	$3,108,132	**$22,867,551**
Utilization Review (Nursing Homes)	$0	$1,217,469	$3,443,307	$5,788,021	**$10,448,797**
Third Party Resources	$71,744,016	$71,665,926	$91,401,383	$88,534,354	**$323,345,679**
Technology Analysis, Development & Support (TADS)	$526,649	$723,452	$636,876	$773,151	**$2,660,128**
General Investigations (Food Stamps, TANF, and Medicaid Recipients)	$3,603,146	$8,248,450	$6,592,794	$2,898,439	**$21,342,829**
WIC Investigation Recoveries	$1,099	$19,990	$14,949	$10,213	**$46,251**
WIC Vendor Monitoring	$1,310	$14,687	$1,222	$3,132	**$20,351**
Audit Activity	$702,022	$241,376	$0	$0	**$943,398**
Internal Affairs	$2,371	$0	$0	$0	**$2,371**
Total Recovery Activity	**$135,310,691**	**$90,892,737**	**$113,464,273**	**$101,883,640**	**$441,551,341**

2. OIG Cost Avoidance

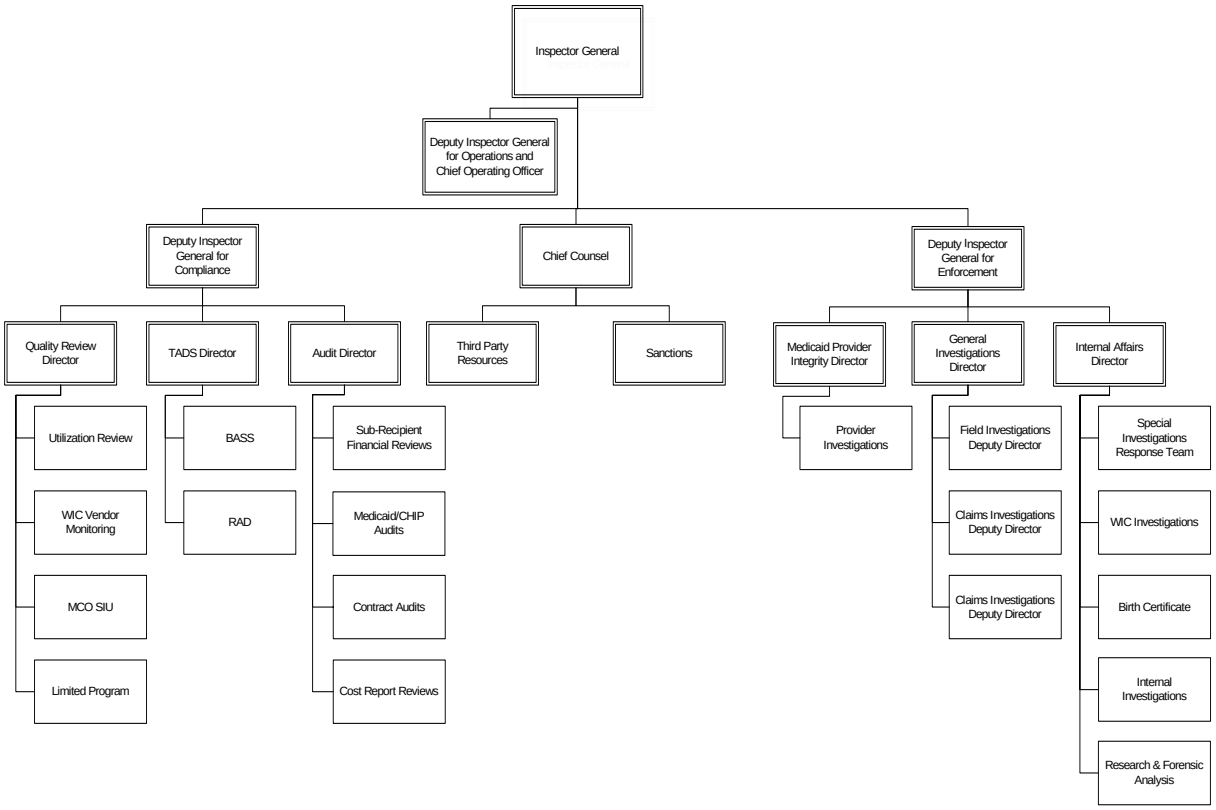
Cost avoidance is a reduction to a state expenditure that would have occurred, or was anticipated to occur, without OIG intervention.

OIG Cost Avoidance

Cost Avoidance Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Sanctions	$2,987,571	$787,950	$106,263	$0.00	**$3,881,784**
TADS Provider Prepayment Review Process	$77,422	$55,437	$78,580	$122,373	**$333,812**
Third Party Resources	$64,792,165	$58,348,381	$67,110,881	$65,476,546	**$255,727,973**
Disqualifications (Food Stamps & TANF Recipients)	$618,792	$318,948	$418,236	$566,412	**$1,922,388**
Income Eligibility Verification System (IEVS) Data Matches (Food Stamps, TANF and Medicaid Recipients)	$578,008	$296,234	$295,559	$328,749	**$1,498,550**
Recipient Data Matches (Food Stamps, TANF and Medicaid Recipients)	$29,339	$193,360	$87,698	$127,340	**$437,737**
Audit Activities	$64,917,083	$6,799,035	$15,679,398	$11,284,430	**$98,679,946**
WIC Investigations	$70	$783	$0	$0	**$853**
WIC Vendor Monitoring	$1,435	$1,475	$2,128	$1,039	**$6,077**
Total Cost Avoidance	**$134,001,885**	**$66,801,603**	**$83,778,743**	**$77,906,889**	**$362,489,120**

Key Accomplishments and Recent Developments

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



1. Compliance Division

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

Quality Review

The Quality Review section ensures money is properly spent in the state's Medicaid and WIC programs. The section has four units:

- Utilization Review;
- Special Supplemental Nutrition Program for Woman, Infants, and Children (WIC);

- Medicaid Limited Program; and
- Managed Care Organizations Special Investigative.

Utilization Review

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 onsite reviews and improve efficiencies by allowing onsite data-entry by staff, UR created a computer database with a laptop interface. This application is referred to as the Case Mix Utilization Review (CMUR) application.

Version 1.4 of the application was implemented on September 6, 2005. This version enables nurse reviewers to quickly identify NFs where the first review resulted in an error rate of 25 percent or greater. Once identified, nurse reviewers conduct a second review of the NFs within a seven-month time period to determine if they have corrected the identified deficiencies. If during the second review, a nurse reviewer finds that the NF error rate is 20 percent or greater; the NF will be placed on vendor hold. Version 1.4 also enables the administration assistant staff to generate correspondence notifying the provider of the vendor hold requirements and status of forms reviewed. Additionally, the CMUR sample was refined to exclude forms that typically do not result in errors.

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

In accordance with section 531.113 of the Government Code, all Managed Care Organizations (MCO) contracted with the State of Texas are required to adopt a plan to prevent and reduce waste, abuse, and fraud and file the plan annually with OIG for approval. The plans are required to be submitted to OIG by July 1st and must have approval from OIG by September 1st.

Effective September 1, 2005, all plans were reviewed and approved.

WIC Vendor Monitoring

The Special Supplemental Nutrition Program for Women, Infants, and Children—better known as the WIC Program—serves to safeguard the health of low-income women, infants, and children up to age 5 who are at nutritional risk by providing nutritious foods to supplement diets, information on healthy eating, and referrals to health care.

The WIC Vendor Auditors conduct covert compliance buys to test if vendors are providing WIC approved items.

During the time period of March 1, 2005 through August 31, 2005, compliance buys conducted by the WIC auditors identified numerous violations that resulted in an unusually high number of vendors being disqualified from the WIC program. The disqualifications varied in duration from one-month disqualifications to three-years. From March through August, twelve disqualifications were processed. An additional three disqualifications were processed through Fair Hearings and are pending rulings. Also during this time period, WIC auditors conducting follow-up compliance buys noticed a large number of vendors, who were not disqualified after their initial compliance buys, are now complying with WIC policies. This has enabled the auditors to close numerous active investigations.

In addition, WIC auditors converted all of their manual processes to an electronic process utilizing a laptop to enhance the quality of their work papers and increase the efficiency of their investigations. Prior to the conversion, WIC auditors maintained all of their working papers manually.

Technology Analysis, Development and Support

The Technology Analysis, Development and Support (TADS) section is responsible for directing and monitoring the development, implementation and coordination of policies and procedures encompassing OIG information technology systems. There are a variety of technology accomplishments for OIG during SFY 2005, many of which are described in further detail throughout this report. Following is a list of some technology accomplishments:

Waste, Abuse, and Fraud System

A web-based application that is available to the public for reporting waste, abuse, and fraud to OIG. Operational since June 4, 2004, the application is continually updated and enhanced during the fiscal year from user feedback, suggestions and evaluation to intensify its value and efficiency. http://www.hhs.state.tx.us/OIG/index.shtml.

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

A web-based application available to OIG personnel since April 2005 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, manage and edit referrals to their section, and create reports supporting external referrals or other activity reports as needed.
- OIG personnel can use a search feature to determine the status of a particular referral.

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 continues to be enhanced throughout the year. All HHS enterprise agencies are currently supported, and subcontractors listed by the agencies have been informed of the new system.

Phase I of this project included:

- Solicit, receive, and analyze contract data from HHS enterprise agencies for use in a web form that was specified in a mailing to a population of potential auditable entities;
- Create, test, and deploy a website that allowed those who received the mailing or heard about the website to go online and inform the Single Audit Department whether or not they will be submitting an audit; and if not, why; and
- Identify all for-profit entities and state agencies from the contract data list so they will not be included in future mailing.

While implementing this phase, we identified the Texas Identification Number (TIN) as a unique number for each entity and were given access to the Comptroller's TIN database, which helped correct invalid TINs in the original dataset.

Approximately 2,255 entities have submitted information on the website, leaving 143 entities not yet responding. Phase I is complete.

Phase II of the project, implemented May 2005, included:

- Create a database system for processing audit packages as they are received. An audit package may or may not match with information received through the website.
- The database should support standard reports to draw attention to the following:
    - List of Audit Packages due;
    - List of records where a reminder letter to send in the packet is due;
    - Number of Desk Reviews overdue;
    - Number of Desk Reviews due in 90 days or less; and
    - Number of Desk Reviews due in 150 days to 91 days.

This database is being used daily by the Single Audit department and is secured in an access-restricted folder. In addition, a correct user identification and login is required to open the database. Phase II is complete. http://www.hhs.state.tx.us/OIG/index.shtml.

This work with the Single Audit department continues, and we are in the process of gathering new datasets from the HHS enterprise agencies for the next round of mailings.

MCO-SIU Web Portal
A web-based form that is available to Medicaid Managed Care Organizations (MCO) since February 2005 allowing them to send questions regarding MCO rules and provider or recipient issues.

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 Inspector General (ASOIG). The ASOIG will replace 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).

When complete, ASOIG will provide an integrated, one-stop application for General Investigations that is anticipated to improve employee productivity, decrease training time, and enhance the General Investigations process.

Activities completed during this reporting period include:

- ASOIG hardware/software issues addressed;
- All correspondences and reports identified;
- Referral and Eligibility screens completed;
- Food Stamps/Temporary Assistance for Needy Families (TANF)/Medicaid budget summary/details defined;
- Multiple ASOIG screen reviews and feedback sessions held for General Investigations;
- ASOIG demo at OIG summit provided;
- Maintenance on ASOIG/RIDES (Reported Income Discrepancy System) to change/update the Federal Poverty Income Limits amounts and employer tables; and
- ARTS (Accounts Receivable Tracking System), Electronic Benefit Transfer (EBT) Archive and the System for Application, Verification, Eligibility, Referrals and Reporting (SAVERR) interfaces in development.

Other TADS activities included working in cooperation with Medicaid/CHIP and HHSC IT to develop a process to identify sex offenders that are Medicaid recipients. The purpose of this process is to deny claims for Erectile Dysfunction drugs at the point-of-sale for reported sex offenders. In addition, HHSC IT will remove any prior approvals that would allow these individuals to receive refills for Erectile Dysfunction drugs.

This process combined with data-matches from the Social Security Administration, Department of State Health Services Bureau of Vital Statistics, Texas Department of Criminal Justice, Prisoner Verification System, nursing home and border-states generated 7,938 matches for General Investigations.

Audit Activities

The Audit section conducts audits and reviews of health and human services system contracts and grants to determine contractors' and grantees' compliance with federal,

state and agency requirements, and/or reduce the potential for waste, abuse and fraud of federal and/or state funds.

The Audit section consists of four units:

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

In addition to its regular functions, the Audit section participated in HHS Contract Council and OIG workgroups to achieve legislative mandates.

The director of audit participated in regular meetings of the HHS Contract Council to achieve its charge of developing an efficient and effective contract oversight process. Audit staff participates in the following workgroups established by the HHS Contract Council:

Contractor Performance System Workgroup – This is a query-driven system, intended for contractor performance information management to assist HHS agencies in managing their contracts and making contracting decisions with consideration given to a contractor's current and/or prior performance. The system collects data that provides for the review of a contractor's record of conforming to contract requirements and standards of good workmanship, as well as the identification of patterns of chronic problems impacting the delivery of services and/or goods. Also, the system is intended to provide a mechanism for tracking, reviewing, and reporting ongoing contractor performance within timeframes indicated through risk assessment, but not less than biennially (i.e., every two years) and at the close of the contract. It is also to be used for providing assessments of the contractor's overall performance upon contract renewal, completion and/or termination.

Contractor Risk Assessment Workgroup – This workgroup develops guidance for enterprise contract risk management throughout the contracting life cycle. The workgroup will develop a guide that can be used throughout the enterprise by those involved in any phase of the contracting cycle to help conceptualize, develop, and implement appropriate and useful contracting risk management methodologies. The

group will categorize the guide using the seven contract types already accepted by the HHS Contract Council and the nine contracting life-cycle phases included in the HHSC Contracting Process and Procedures Manual. Whenever appropriate, the work group will integrate existing risk management policies, procedures, and guidelines to leverage best practices already developed within the enterprise, the state, and elsewhere.

External Stakeholder Communications Workgroup – This workgroup makes recommendations to the Contract Council on methods to communicate the work of the Contracts Council to the external stakeholders and solicit feedback from the external stakeholders. The External Stakeholder Communications Workgroup recommended two methods for communications: the use of a website with the Council's information and links to information sources and the use of an email distribution to the various contractors.

Contract Tracking and Reporting System Workgroup – This workgroup develops a central depository of contract information that will be used for reporting purposes. Each agency will provide required data elements for their contracts into the Contract Tracking and Reporting Database (CTRD). Staff also participates in a sub-workgroup of this workgroup. The sub-workgroup examines all the external reports that are required to be reported by HHSC (e.g., LBB report, 100K, etc.) to determine required data and establish requirements for consistency to ensure every HHS agency provides the same data.

Contract Life Cycle Matrix Workgroup – This workgroup identified the responsible party for every stage in the life cycle of a contract in a summary matrix format. OIG Audit provided the information to explain the responsibilities of the various HHS audit areas.

Internally to OIG, the Audit section led a workgroup to implement the new reporting requirements of Section 531.102 of the Government Code as amended by Senate Bill 1188, 79th Legislature, effective September 1, 2005. The new Reporting Module governs all investigations and audits conducted within the scope of the enacted bill and addressed the required reporting expectations. The final module was published in the online OIG Policy and Procedures Manual, with the policy statement on August 30, 2005, and consists of: Form OIG0002, Final Report; Form OIG0003, Internal Summary; and Definition of Closed Cases.

Sub-recipient Financial Review Unit

The Sub-recipient Financial Review Unit (SFRU) is responsible for desk reviews of single audit reports (financial statements and federal/state requirements) submitted by sub-recipients, quality control reviews of certified public accountant (CPA) firms that audit the single audit reports, and limited–scope audits of sub-recipients. The quality control reviews conducted on the CPA firms and the limited-scope audits are based on a risk assessment process, while desk reviews are conducted on all single audit reports submitted by sub-recipients of all HHS agencies.

A sub-recipient is subject to a single audit when it received and expended a minimum of $500,000 in state and/or federal funds. 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], including the *State of Texas Single Audit Circular*.

As a result of increased staffing approved by the 79th Legislature, SFRU will hire six additional auditors in SFY 2006 to achieve its mandates.

Desk Reviews

In addition to the routine desk reviews of the single audit reports, SFRU increased accountability by performing self-assessments and implementing the following enhancements to processes:

- Including additional review steps in the desk review audit program to evaluate the sub-recipient's financial condition, such as 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. The results of these analytical procedures are forwarded to HHS department program personnel for use in their monitoring efforts, as they may indicate instances of waste, abuse or fraud;
- Updating the single audit web-based system to track desk review deadlines. The updates notify staff of the timing for issuance of Reminder Letters, Delinquent Letters, and/or timely follow-up with sub-recipients who do not comply with contract, grant agreements, and/or OMB Circular A-133 reporting requirements;

- Updating the single audit web-based system to track for-profit sub-recipients and other entities excluded from OMB Circular A-133 reporting requirements;
- Continuing to work in collaboration with HHS agencies to ensure all new contracts are communicated to SFRU for input into the single audit web-based system; and
- Working with KPMG Auditors in their fieldwork of SFY 2005 statewide audit of contracts issued by HHSC to the sub-recipients for compliance with OMB Circular A-133 requirements.

Quality Control Reviews

SFRU began its risk assessment process on April 1, 2005, and worked through a series of efforts to develop the quality control review process and related SFY 2006 audit plan. The objective of a quality control review is to determine whether the CPA firm conducted the single audit of the sub-recipient's financial statements and federal/state requirements in accordance with professional auditing standards; *Government Auditing Standards* issued by the Comptroller General of the United States; Generally Accepted Auditing Standards (GAAS); OMB Circular A-133; *Audits of State, Local Government and Non-Profit Organizations*; and/or the *State of Texas Single Audit Circular*. Two auditors, both of whom are CPAs, were hired to implement this program. The first quality control review begins on September 15, 2005.

Medicaid/CHIP Audit Unit

In preparation for its SFY 2006 audit plan and the full staffing of the unit, the Medicaid/ CHIP Audit Unit (MCAU) recently completed a comprehensive risk assessment of all Medicaid and Children's Health Insurance Program (CHIP) contracts. MCAU also started work on verifying the Special Investigative Units and Fraud and Abuse Plans for a CHIP MCO.

In addition, MCAU continued to provide value-added efforts to the ongoing financial and performance audits being performed by outside audit firms on various CHIP and Medicaid contractors. These efforts included ensuring adherence to applicable standards as well as full disclosure of questioned costs.

As a result of increased staffing approved by the 79th Legislature, MCAU will hire thirteen additional auditors in SFY 2006 to achieve its mandates.

Contract Audit Unit

The Contract Audit Unit (CAU) continues its mission to provide audit coverage for all HHS contracts other than Texas Medicaid Administrative Services (TMAS) contracts and sub-recipient contracts.

As a result of increased staffing approved by the 79th Legislature, CAU will hire six auditors in addition to current vacancies, including the unit manager vacancy, in SFY 2006 to achieve its mandates.

The objectives of audits conducted by 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.

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

CAU is updating its policies, procedures, authorities, and work papers to conform to the latest Yellow Book standards. In addition, staff is being trained in the use of TeamMate automated auditing software. Additional policies, procedures, authorities, and work papers will be developed for the different types of contracts to be audited.

Cost Report Review Unit

The Cost Report Review Unit (CRRU) completed onsite field audits and in-house desk reviews of provider cost reports[2]. Desk reviews of all provider cost reports are conducted to ensure the financial and statistical information submitted in the cost reports conforms to all applicable rules and instructions. Unallowable costs are

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

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 is in accordance with program rules and regulations. The unit's goal is to perform onsite audits of approximately ten percent of the cost reports submitted by Medicaid providers. The selection is 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 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. 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 Intermediate Care Facilities for Mental Retardation (ICFMR) 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. Failure to meet this requirement results in RAD recovering a portion of the rate component from the Medicaid provider. CRRU 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.

CRRU conducts investigative audits in conjunction with the OIG Medicaid Provider Integrity section to facilitate recoveries of funds and/or aid in the prosecution of providers who may have committed fraud.

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, assisting the Department of Aging and Rehabilitation Services (DARS) in developing their nursing home financial viability application assessment tool, and answering various technical questions for HHS staff.

2. Chief Counsel

The Office of Chief Counsel includes two sections: Third-Party Resources (TPR) and Sanctions.

Third Party Resources

TPR completed two contracts, which will aid in the recovery of state funds. TPR signed a contract with the OAG's Medical Support Unit continuing an agreement to identify Medicaid clients with access to private health insurance through their medical support enforcement activities. Additionally, TPR successfully negotiated and signed a contract with Express Scripts Incorporated (ESI), a Pharmacy Benefit Manager (PBM), that will enable Texas to data match Medicaid eligibility files with ESI eligibility files. TPR is proud to execute this data match agreement, one of the first in the nation and which is anticipated to enhance Vendor Drug Program (VDP) recoveries and serve as a model for contracts with other PBMs.

Medicaid/CHIP selected First Health to perform claims processing for the VDP. As a result of the Request For Proposals (RFP) being awarded, TPR initiated the Cost Avoidance project for VDP claims. Historically, Texas performed pay and chase for the VDP. Implementing a cost avoidance program in addition to the pay and chase program is expected to increase savings to the VDP. TPR collects approximately $12 million per year in VDP pay and chase claims.

TPR is also working with Accenture, the Integrated Eligibility and Enrollment (IEE) vendor, as call centers are rolled out to ensure the continued referral of Medicaid client insurance information. The base infrastructure is already established through our work with Texas Integrated Eligibility and Enrollment System (TIERS) over the past 2 years. TPR will be working with the IEE vendor to ensure their proprietary software interfaces appropriately with TIERS, for insurance purposes, and their TPR collection methods adequately meet the needs of the State of Texas.

Sanctions

Effective June 21, 2005, Sanctions implemented an enhanced computer program and reporting system that tracks the receipt of Medicaid provider settlement payments. The system alerts Sanctions staff when providers fail to timely submit agreed Medicaid reimbursements to OIG. This process will improve Sanctions' ability to recover Medicaid overpayments.

Sanctions will hire five new, full-time positions, including four new sanction specialists. These new positions will provide Sanctions with additional manpower to pursue and recover overpayments resulting from fraud, waste or abuse of the Medicaid program.

3. Enforcement Division

The Enforcement division has three sections: Medicaid Provider Integrity (MPI), General Investigations, and Internal Affairs.

OIG and OAG Interagency Coordination

The United States Department of Health and Human Services' Office of Inspector General approved matching federal grant funds, which could expand the OAG'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 170 employees, including 40 commissioned peace officers, and maintains field offices operating 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. Joint federal task forces have been established in Dallas, Houston, and San Antonio.

In November 2003, a memorandum of understanding (MOU) was executed between OIG and the OAG in accordance with section 531.103 of the Government Code as

amended by House Bill 2292, 78th Legislature. This MOU updated and expanded the April 1998 MOU between HHSC and MFCU.

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 between March 1, 2005 and August 31, 2005.

MPI and Sanctions Case Summary

	3rd Quarter	4th Quarter	Total
Cases Opened	265	257	**522**
Cases Closed	150	230	**380**
Providers Excluded	51	104	**155**

MPI and Sanctions Waste, Abuse, and Fraud Referrals Sent

Referral Source	Referred
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	64
Medicare Part A& B	4
Palmetto GBA	2
Health and Human Services – Office of Inspector General	2
Department of Family and Protective Services (DPRS)	1
Out of State	1
Texas Department of State Health Services	2
Texas Worker Compensation Commission	1
Board of Chiropractic Examiners	1
Board of Dental Examiners	13
Board of Medical Examiners	6
Board of Nurse Examiners	1
Board of Pharmacy	2
Board of Psychologists	1
Board of Social Worker Examiners	1
Claims Administrator – Educational Contract	41
HHSC – General Investigation	1
HHSC – Internal Affairs	1
HHSC – TPR	2
Vendor Drug	3
TOTAL:	**150**

MPI and Sanctions Waste, Abuse, and Fraud Referrals Received

Referral Source	Received
Office of the Attorney General's Medicaid Fraud Control Unit (MFCU)	27
Governor's Office	1
State Legislator	5
Center for Medicare Service (CMS)	1
Citizens Commission on Human Rights	1
Dallas District Attorney's Office	1
Health and Human Services – Office of Inspector General (HHS-OIG)	4
Texas Department of Aging & Disability Services (DADS)	33
Texas Health Steps	3
Texas Department of State Health Services (DSHS)	13
Texas Medicaid Healthcare Partnership (TMHP)	3
Texas Department of Mental Health and Mental Retardation (MHMR)	1
Law Enforcement Agency	1
Managed Care Organizations /SIU's	12
2003 PAM II Study (Comptroller's Office)	18
Parent/Guardian	6
Provider	24
Public	38
Recipient	96
Anonymous	31
Board of Dental Examiners	2
Board of Medical Examiners	28
Board of Nurse Examiners	129
Board of Pharmacy	3
HHSC - Audit Division	1
HHSC – Compliance	1
HHSC - General Investigations	3
HHSC – Internal Affairs	7
HHSC - Sanctions	2
HHSC - Medicaid/Chip Division	1

Referral Source	Received
HHSC - MPI-OIG Self-initiated (MPI)	10
HHSC - Utilization Review	10
Surveillance, Utilization, Review System (SURS)	2
Vendor Drug	1
Total Cases Received:	**519**

General Investigations

General Investigation staff is primarily devoted to the investigation of recipient fraud in the Food Stamp, Medicaid, and Temporary Assistance for Needy Families (TANF) programs. Collections totaled $21,342,829 for claims established based on General Investigations activities for SFY 2005.

General Investigations experienced a significant increase in workload for SFY 2005. The amount of funds collected decreased marginally, while the amount identified for recovery decreased significantly. The decrease in funds collected and identified for recovery is due primarily to policy changes by the Office of Family Services (OFS). The change is also the primary cause for the decrease in referrals received, cases completed, Civil Disqualifications, and Administrative Disqualification Hearing cases completed.

In March of 2003, OFS implemented "Streamlined Reporting," an optional provision of the Federal Farm Security and Rural Investment Act of 2002, which significantly changed the income reporting requirements for Food Stamp households. The reduced reporting requirements dramatically increased the number of income discrepancy reports that General Investigations had to manually review for the first half of SFY 2005. Despite the increase, staff maintained 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 implemented automated filters in the second half of SFY 2005 to filter out income discrepancy reports no longer resulting in an overpayment due to Streamlined Reporting. Implementation of the filters reduced workload to prior

manageable levels and allowed General Investigations to shift a portion of our resources to an increased emphasis on funds fraudulently obtained from HHSC programs.

General Investigations' identification of funds for recovery was also significantly impacted by its involvement in investigations of matters of important public concern and assisting in the review and implementation of the Integrated Eligibility and Enrollment (IEE) project at HHSC. Previously, General Investigations focused exclusively on the recovery of funds obtained in error and by fraud. General Investigations assumed the primary responsibility for contacting and recording individual complaints involving Child Protective Services (CPS) during the course of the CPS investigation. An average of six investigators were utilized for the CPS investigation on a full time basis for approximately six months. Additionally, six investigators assisted in the review and implementation of the IEE project for approximately six months.

Internal Investigations

In March 2005, the Human Resources (HR) Manual was revised regarding the policy on the use of state owned computer resources and Internet connections. The revisions strengthened and standardized policy across the health and human services enterprise system, and required that incidents of computer misuse be reported to OIG.

An anticipated increase in referrals based on the HR policy change is being addressed with the formation of the Research and Forensic Analysis Unit that will be staffed with a lead research specialist and two computer forensic examiners. Updated computer forensic hardware and software was purchased that will enable examiners to conduct onsite and network-enabled forensic investigations. Advantages over the current approach include the non-disruptive acquiring of hard drive images, a wider investigative approach, reduced time to perform an analysis, and reduced cost to conduct the investigations.

The purchased software has the functionality to assist information technology staff in identifying and responding to suspected security incidents. This functionality will permit the elimination of rogue processes, faster response to security intrusions, and assist in identification and documentation of incidents required for HIPAA security implementation.

4. Staff Development, Education, and Training Services

OIG hosted a training session in Austin on August 22-24, 2005, to promote excellence; share best practices in agency administered programs; and also provide staff development opportunities to investigators, auditors, nurses, and other personnel who are required to annually meet specific continuing education requirements for maintaining professional certifications and licenses.

The theme for the second annual training summit was "One Team, One Mission: Synergy" and included an overview of HHSC programs, more than 40 workshops, director meetings, and presentations from such distinguished speakers as Executive Commissioner Albert Hawkins and Representative Carlos Uresti, Chairman of the House Committee on Government Reform. The keynote speaker was Representative Suzanna Hupp, Chairwoman of the House Committee on Human Services.

Workshop leaders and participants included staff from all health and human services agencies, the United States Department of Health and Human Services' Office of Inspector General, United States Attorney's Office, National Insurance Crime Bureau, Texas Office of the Attorney General, State Auditor's Office, University of Texas Medical Branch, and the Texas Department of Public Safety.

5. OIG and UTD Information Analysis Initiative

OIG is pleased to report the initial progress of its joint venture with the University of Texas at Dallas (UTD) on an innovative information analysis initiative. The cornerstone of this collaborative effort was Governor Rick Perry's July 12, 2004, Executive Order RP 36 directing state agencies to focus on eliminating fraud and abuse, and specifically directing OIG to broaden technological use.

OIG partnered with the UTD School of Social Sciences and Erik Jonsson School of Engineering and Computer Science in September 2004 to create a groundbreaking health and human services data resource that will facilitate scientific measurements and studies of numerous social services phenomena. In particular, 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 advantages resulting from our initial progress include:

- Value of linking Medicaid data to geographic information system (GIS) data: spatial patterns can be identified that are not evident from traditional database queries by linking claims and provider information to GIS map data (like census tracks, legislative districts, counties, school districts, and zip codes);
- Value of deploying a functional GIS: approved analysts and users from various local and state enforcement agencies charged with managing health and human services programs will be able to interact with the data and generate spatial reports, maps, and extractions thereby creating a synergistic effort to combat fraudulent activities; and
- Value of initial findings with respect to Medicaid claims for childbirth, diabetes, and asthma: specific research data can illustrate how such an innovative system can be used to manage expenditures by targeting and coordinating public policy.

The OIG/UTD joint venture is a pioneer initiative for the State of Texas and with the immediate ability to overlay multiple current patterns and the proactive capacity to analyze trends to predict future needs, the potential analytical and policy efficacy is virtually unlimited.

OIG is energized about its partnership with UTD and the endless possibilities this unique data resource will offer the policymakers, the health and human services community, and the people of the State of Texas.

6. OIG Strategic Planning Development

OIG is currently developing a strategic business plan to ensure the accountability and integrity of health and human services delivered to Texans. Included in the planning framework will be 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 continuously improve upon the operational process of identifying and eliminating waste, abuse, and fraud, OIG will also increase training, technology, and staff awareness of its role in supporting the overall purpose and mission. Each employee contributes to the common objective of getting quality services to citizens.

The strategic plan will accomplish the following:

- Have a common vision in OIG of where we want to go and what we want to be;
- Have a common purpose or mission that will drive all efforts towards the common vision;
- Enable further decomposition of the mission into goals, objectives, and strategies that will represent a coordinated plan of how the mission will be achieved;
- Ensure every effort in OIG directly or indirectly supports and furthers the shared vision and mission;
- Ensure all efforts are coordinated and complementary to further the effective delivery of functions and services;
- Enable the development of metrics that will allow measurement of organizational success in achieving the mission, as we highlight areas where improvement is needed; and
- Enable identification of the most critical processes that deliver functions and services, and then to keep improving these processes – thereby continually improving the OIG organization.

7. Special Activities

OIG Disaster Relief Help

OIG mobilized its staff to assist Texas Works Advisors with enrolling Hurricane Katrina evacuees for health and human services benefit programs upon arrival to disaster relief centers in Texas.

As part of the national response to Hurricane Katrina, State Office of Emergency Management requested that HHSC assist with the relief efforts by housing staff to answer the overflow 2-1-1 service telephone calls from the Houston center. Houston had been receiving over 900 calls an hour. OIG was notified on the evening of Wednesday August 31, 2005, that office space for 50 operators would be required.

OIG responded within 12 hours by providing 54 work areas, implementing emergency security procedures, and adjusting staff work schedules to accommodate the 12 hour and sometimes 24 hour work shifts of the operators. In coordination with HHSC Automation Support and Administrative Operations, 54 telephones and computers were installed.

In summary, OIG staff conducted the following disaster relief efforts:

- Assisting hurricane victims with applying for income assistance (Food Stamps, Medicaid, and TANF);
- Setting up a 24-hour, 7-day-a-week call center for more than 300 state agency volunteers helping in the 2-1-1 Texas Information and Referral Network Phone Line Center; facilitating the space and services for the volunteers at the Braker Center in Austin including security, briefings, phones, computers, and facility modifications; and
- Assisting Texas Medicaid & Healthcare Partnership (TMHP) in the Expedited Provider Enrollment Application with expeditious enrollment of new providers as qualified Medicaid providers to ensure timely and quality medical assistance.

Medicaid Fraud Detection and Abuse Prevention Training

1. Texas State University Training

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 associated with the Medicaid program. In cooperation with 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 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

In collaboration with TSU, OIG continues to offer the distance-learning 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 module is available from TSU online 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 online as a separate tool.

TILE registrations for March 1, 2005-August 31, 2005

Type of Course	Total Enrolled
TILE Nursing Home Correspondence	436
TILE Nursing Home On-Line Computer Training	1,000
CBA TILE Correspondence	209
CBA TILE Online Computer Based Training	245
Total	**1,890**

3. Fraud Prevention Training

Provider education is an integral element of any waste, abuse, and fraud prevention plan. In accordance with section 531.105 of the Government Code, 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 – August 31, 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
April 9, 2005	The Greater Dallas Crime Commission	General Fraud	Brian Flood
May 18, 2005	State Farm Insurance Company, Austin, Texas	Identity Theft Claims	Wayne Sneed
August 1-5, 2005	NW3C Financial Investigations Practical Skills (FIPS)	Investigative Practices-Identity Theft Claims	Wayne Sneed

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	$7,525,152	$768,198	**$46,828,148**
Civil Monetary Penalties (CMP)	$11,171,955	$212,505	$1,661,378	$0.00	**$13,045,838**
Utilization Review (Hospitals)	$10,694,064	$6,878,143	$2,187,212	$3,108,132	**$22,867,551**
*Utilization Review (Nursing Homes)	$0	$1,217,469	$3,443,307	$5,788,021	**$10,448,797**
Third Party Resources	$71,744,016	$71,665,926	$91,401,383	$88,534,354	**$323,345,679**
Technology Analysis, Development & Support (TADS)	$526,649	$723,452	$636,876	$773,151	**$2,660,128**
General Investigations (Food Stamps, TANF, and Medicaid Recipients)	$3,603,146	$8,248,450	$6,592,794	$2,898,439	**$21,342,829**
WIC Investigation Recoveries	$1,099	$19,990	$14,949	$10,213	**$46,251**
WIC Vendor Monitoring	$1,310	$14,687	$1,222	$3,132	**$20,351**
Audit Activity	$702,022	$241,376	$0	$0	**$943,398**
Internal Affairs	$2,371	$0	$0	$0	**$2,371**
Total Recovery Activity	**$135,310,691**	**$90,892,737**	**$113,464,273**	**$101,883,640**	**$441,551,341**

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

*Effective FY 2005, UR is reporting actual overpayments recovered. Prior to FY 2005, UR reported estimated overpayments identified.

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	$106,263	$0.00	**$3,881,784**
TADS Provider Prepayment Review Process	$77,422	$55,437	$78,580	$122,373	**$333,812**
Third Party Resources	$64,792,165	$58,348,381	$67,110,881	$65,476,546	**$255,727,973**
Disqualifications (Food Stamps & TANF Recipients)	$618,792	$318,948	$418,236	$566,412	**$1,922,388**
Income Eligibility Verification System (IEVS) Data Matches (Food Stamps, TANF and Medicaid Recipients)	$578,008	$296,234	$295,559	$328,749	**$1,498,550**
Recipient Data Matches (Food Stamps, TANF and Medicaid Recipients)	$29,339	$193,360	$87,698	$127,340	**$437,737**
Audit Activities	$64,917,083	$6,799,035	$15,679,398	$11,284,430	**$98,679,946**
WIC Investigations	$70	$783	$0	$0	**$853**
WIC Vendor Monitoring	$1,435	$1,475	$2,128	$1,039	**$6,077**
Total Cost Avoidance	**$134,001,885**	**$66,801,603**	**$83,778,743**	**$77,906,889**	**$362,489,120**

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

*During the optimization phase of the OIG transformation, the Sanctions cost avoidance methodology was changed to reflect a more conservative calculation. Therefore, the decrease in Sanctions cost avoidance is a result of a deliberate policy change and does not reflect a decrease in performance.

Section III - OIG Summary Tables

Summary Table Utilization Review (UR)

UR Summary Category	1st Quarter	2nd Quarter		4th Quarter	Total SFY 2005
Hospitals - Recoveries	$10,694,064	$6,878,143	$2,187,212	$3,108,132	**$22,867,551**
Hospitals – Underpayments	$40,305	$61,990	$14,586	$9,923	**$126,804**
Nursing Homes – Recoveries	0	$1,217,469	$3,443,307	$5,788,021	**$10,448,797**
Nursing Homes – Underpayments	0	$209,988	$248,099	$181,456	**$639,543**
Nursing Homes– Facilities Visited	152	299	229	219	**899**
Nursing Homes - # of Forms Reviewed *	7,577	14,513	12,980	12,943	**48,013**
Nursing Homes - # of Facilities Placed on Vendor Hold	0	0	0	0	**0**
Hospitals – Mail-ins	245	135	167	215	**762**
Hospitals – Facilities Visited	89	55	58	64	**266**
Hospitals - # of Claims Reviewed	6,882	2,320	5,217	4,156	**18,575**

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	139	81	**391**
Number of In-Store Evaluations	72	63	54	47	**236**
Number of Audits Closed	2	5	40	5	**52**
Vendor/Grocer Overcharges	$1,435	$1,475	$2,128	$1,039	**$6,077**
Dollars Recouped	$0	$435	0	$149	**$584**
Civil Monetary Penalties	$1,310	$14,252	$1,222	$2,983	**$19,767**

Summary Table Limited Program

Lock-In Summary Category	Sep.	Oct.	Nov.	Dec.	Jan.	Feb.	Mar.	Apr.	May	Jun.	Jul.	Aug.
Fee-for-Service (FFS)	322	336	338	328	328	331	339	346	360	357	358	202
STAR (Rx Only)	149	142	133	137	128	135	137	133	127	127	129	254
STAR+PLUS (Rx Only)	39	40	39	41	46	48	47	49	49	51	51	50
Total Limited Program Activity	**510**	**518**	**510**	**506**	**502**	**514**	**523**	**528**	**536**	**535**	**538**	**506**

Summary Table Technology Analysis, Development & Support (TADS)

TADS Summary Category	1st Quarter	2nd Quarter	3rd Quarter		Total SFY 2005
Cases Opened	247	472	759	745	**2,223**
Cases Closed	515	218	367	800	**1,900**
Cases Referred to OAG	0	0	0	0	**0**
Dollars Recovered	$526,649	$723,452	$636,876	$773,151	**$2,660,128**
Cost Avoidance Due to Provider Prepayment Review Process (all OIG)	$77,422	$55,437	$78,580	$122,373	**$333,812**

Summary Table Audit Activities

Audits Summary for HHS Agencies	Number of Audits	Number of Desk Reviews	Recoupment & Recovery		Recipient Refunds	Rejected Single Audits
Sub-Recipient Financial Review Unit						
1st Quarter	N/A	182	$674,110	$15,412	N/A	26
2nd Quarter	N/A	5	$84,209	N/A	N/A	25
3rd Quarter	N/A	N/A	N/A	N/A	N/A	11
4th Quarter	N/A	N/A	N/A	N/A	N/A	18
Medicaid/Chip Audits						
1st Quarter	1	N/A	N/A	N/A	N/A	N/A
2nd Quarter	N/A	N/A	N/A	N/A	N/A	N/A
3rd Quarter	N/A	N/A	N/A	N/A	N/A	N/A
4th Quarter	N/A	N/A	N/A	N/A	N/A	N/A
Contract Audit Unit						
1st Quarter	N/A	N/A	$27,912	N/A	$8,414	N/A
2nd Quarter	37	N/A	$157,167	N/A	$49,885	N/A
3rd Quarter	75	N/A	N/A	N/A	N/A	N/A
4th Quarter	8	N/A	N/A	N/A	$14,843	N/A
Cost Report Review						
1st Quarter	119	875	N/A	$64,901,671	N/A	N/A
2nd Quarter	27	519	N/A	$6,799,035	N/A	N/A
3rd Quarter	24	1,283	N/A	$15,679,398	N/A	N/A
4th Quarter	74	623	N/A	$11,284,430	N/A	N/A
Totals	**365**	**3,487**	**$943,398**	**$98,679,946**	**$73,142**	**80**

NOTE: 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 Third Party Resources (TPR)

TPR Summary Category	1st Quarter	2nd Quarter	3rd Quarter		Total SFY 2005
Cost Avoidance	$64,792,165	$58,348,381	$67,110,881	$65,476,546	**$255,727,973**
Other Insurance Credits	$45,689,021	$51,154,914	$65,670,823	$64,389,134	**$226,903,892**
Provider/Recipient Refunds	$1,553,611	$1,893,651	$1,592,328	$2,046,359	**$7,085,949**
Texas Automated Recovery System (TARS)	$5,670,045	$4,999,707	$4,354,730	$6,261,563	**$21,286,045**
Pharmacy	$2,505,061	$2,450,231	$6,647,121	$5,107,245	**$16,709,658**
PPRA	$2,192,995	$975,359	$544,938	$731,664	**$4,444,956**
Credit Balance Audit	$5,012,786	$3,377,743	$3,674,187	$2,930,367	**$14,995,083**
Tort	$7,415,286	$4,808,612	$4,951,700	$4,399,394	**$21,574,992**
Cash Medical Support	$1,705,211	$2,005,709	$3,965,556	$2,668,628	**$10,345,104**
Total TPR Activity	**$136,536,181**	**$130,014,307**	**$158,512,264**	**$154,010,900**	**$579,073,652**

Summary Table Sanctions

Sanctions Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Cases Opened	162	88	106	84	**440**
Cases Closed	187	168	79	159	**593**
Cases Referred to Attorney General	1	0	1	1	**3**
Dollars Recovered	$36,864,059	$1,670,739	$7,525,152	$768,198	**$46,828,148**
Exclusions	129	128	51	104	**412**
Payment Holds	1	2	1	1	**5**
Civil Monetary Penalties Recovered	$11,171,955	$212,505	$1,661,378	$0	**$13,045,838**
Cost Avoidance	$2,987,571	$787,950	$106,263	$0	**$3,881,784**

Summary Table Medicaid Provider Integrity (MPI)

MPI Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Cases Opened	110	103	159	173	**545**
Cases Closed	65	104	71	71	**311**
Cases Referred to OAG	40*	49	34	28	**151**

* Incorrectly reported as 39 in the March 2005 Semi-Annual Report.

Summary Table Internal Affairs (IA)

IA Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Complaints Received	77	65	67	106	**315**
Investigations Completed	29	26	29	65	**149**
Dollars Recovered	$2,371	$0	$0	$0	**$2,371**
Cases Referred	7	6	2	7	**22**

Summary Table WIC Investigations

WIC Summary Category	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total SFY 2005
Referrals/Complaints Received*	30	36	18	34	**118**
Cases Opened	72	69	12	54	**207**
Cases Closed	142	280	19	53	**494**
Claims Established	$33,125	$37,058	$11,758	$31,632	**$113,573**
Collections	$1,099	$19,990	$14,949	$10, 213	**$46,251**
Cases Adjudicated	0	4	2	3	**9**
Cost Avoidance	$70	$783	$0	$0	**$853**

Summary Table General Investigations (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	$6,592,794	$2,898,439	**$21,342,829**
Disqualification Cost Avoidance**	$618,792	$318,948	$418,236	$566,412	**$1,922,388**
Cost Avoidance Income Eligibility Verification System (IEVS) Data Matches**	$578,008	$296,234	$295,559	$328,749	**$1,498,550**
Cost Avoidance Recipient Data Matches	$29,339	$193,360	$87,698	$127,340	**$437,737**
Referrals/Complaints Received	16,297	18,302	16,107	17,995	**68,701**
Cases Completed	12,760	15,282	17,084	14,314	**59,440**
Percent of Cases Completed w/in 180 Days	95.2%	94%	95%	92%	**94%**
Cases Referred for Prosecution	968	894	1,072	862	**3,796**
Admin. Disqualification Hearings (ADH) Cases Completed	723	997	1,318	1,107	**4,145**
Cases Adjudicated	309	350	394	482	**1,535**
Civil Disqualifications	1,452	746	885	1,312	**4,395**
IEVS Matches Cleared	62,079	57,390	51,141	44,162	**214,772**
Recipient Data Matches Cleared	1,011	6,663	3,022	3,677	**14,373**

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

**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.

Section IV - Other OIG Activities

Education and Prevention

Type of Course – TILE Training	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter	Total Enrolled
Nursing Facilities – Correspondence Course	219	220	275	161	875
Nursing Home – On-Line Internet Course	165	216	609	391	1,381
Community Based Alternatives – Correspondence Course	76	76	107	102	361
Community Based Alternatives - Online Internet Course*	108	78	121	124	431
Total	**568**	**590**	**1,112**	**778**	**3,048**

TILE Registrations for September 1, 2004 through August 31, 2005.

* First half of SFY 2005 numbers for the CBA Online Internet Course were underreported by 2 in the March 2005 Semi-Annual Report. Corrected numbers are reflected in the above table.

Staff Presentations

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	OIG Expectations of Third Party Recovery 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
April 9, 2005	The Greater Dallas Crime Commission	General Fraud	Brian Flood
May 18, 2005	State Farm Insurance Company Austin, Texas	Identity theft claims	Wayne Sneed
August 1 to 5, 2005	NW3C Financial Investigations Practical Skills (FIPS)	Investigative practices - identity theft claims	Wayne Sneed

Appendix B – OIG Division Summary Excluding TPR

	SFY 2004 (Sept. 1 - Aug. 31)		SFY 2005 (Sept. 1 – Aug. 31)	
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	$22,867,551	g
Nursing Homes (Case Mix Review)	$8,240,785	g	$10,448,797	g
TEFRA Claims	h	N/A	h	N/A
Children's Summary	$2,601	N/A	h	N/A
Psychiatric Summary	$4,575	N/A	h	N/A
Compliance Monitoring and Referral	b	b	b	b
WIC Vendor Monitoring	c	c	$20,351	$6,077
Technology, Analysis, Development, and Support Section	N/A	N/A	$2,660,128	$333,812
RADS	N/A	N/A	N/A	N/A
Surveillance and Utilization Review Subsystems	$1,529,597	g	d	g
Medicaid Fraud and Abuse Detection System	$2,470,200	g	d	g
Audit Section	$2,501,961	$93,373,034	$943,398	$98,679,946
Enforcement Division	N/A	N/A	N/A	N/A
Medicaid Provider Integrity Section	$23,358,098	$45,068,837	e	e
General Investigations Section	$22,617,280	$3,266,126	$21,342,829	$3,858,675

	SFY 2004 (Sept. 1 - Aug. 31)		SFY 2005 (Sept. 1 – Aug. 31)	
OIG Division, Section, Unit	**Recoupment**	**Cost Avoidance**	**Recoupment**	**Cost Avoidance**
Internal Affairs Section	c	c	$2,371	N/A
WIC Investigations	$27,447	c	$46,251	$853
Chief Counsel Division	N/A	N/A	N/A	N/A
Sanctions Section	f	f	$46,828,148	$3,881,784 i
Civil Monetary Penalties	$14,184,150	N/A	$13,045,838	N/A
Total Recoupment	**$97,074,043**	N/A	**$118,205,662**	N/A
Total Cost Avoidance	N/A	**$141,707,997**	N/A	**$106,761,147**

a= Used in previous reports and charts; not applicable to this chart.
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 cost avoidance methodologies used prior to the creation of OIG, cost avoidance savings for UR, MFADS, and SURS were removed.
h= TEFRA Claims and Children's and Psychiatric Summaries consolidated and reported under Utilization Review Hospitals.
i= During the optimization phase of the OIG transformation, the Sanctions cost avoidance methodology was changed to reflect a more conservative calculation. Therefore, the decrease in Sanctions cost avoidance is a result of a deliberate policy change and does not reflect a decrease in performance.

HEALTH AND HUMAN SERVICES COMMISSION

Appendix C – SFY 2005 Semi-Annual Report Figures

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

MEMORANDUM

TO: Tom Suehs, Deputy Executive Commissioner for Financial Services

FROM: Brian Flood, Inspector General

DATE: September 22, 2005

SUBJECT: SFY 2005 Semi-Annual Report Figures

This is to inform you that the SFY 2005 OIG Semi-Annual Report will show the following:

- OIG saved $65 million (All Funds) in SFY 2005, which exceeded the $57.6 million (All Funds) HB 2292 SFY 2005 Fiscal Savings assigned in the OIG LAR and Strategy. $52 million of the $65 million was in cash deposit recoupments.
- OIG in SFY 2005 recovered $441.5 million (All Funds) and cost avoided $362.5 million (All Funds) for a total of $804 million, an increase in recoveries of 26% over SFY 2004 ($749 million All Funds).
- The return on investment in SFY 2005 was over 23:1.
- Return on investment 12.76:1 for recoupments - $441 million in recoupments deposits divided by $34.6 million OIG budget (All Funds). The OIG SFY 2005 IBP of $35,957,804 was reduced by the transfer of $1,375,318 and 32 FTEs to DSHS in SFY 2005.
- Return on investment 10.48:1 for Cost Avoided funds - $362.5 million in cost avoided funds divided by $34.6 million OIG budget (All Funds)
- Return on Investment 23.24:1 for $804 million - $804 million divided by $34.6 million OIG budget (All Funds).

The SFY 03 –04 figures showed a cash recovery of 10:1 return on investment and cost avoidance of 11:1, for a total of 21:1 return on investment.

Should SFY 06-07 levels be set or the SFY 05 savings reported, we would appreciate being copied so we can plan accordingly.

Attachment

c: Albert Hawkins, Executive Commissioner
Chris Traylor, Chief of Staff

HEALTH AND HUMAN SERVICES COMMISSION

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

ALBERT HAWKINS
EXECUTIVE COMMISSIONER

February 1, 2005

Mike Morrissey, Director
Governor's Office of Budget, Planning, and Policy
1100 San Jacinto, 4th Floor
Austin, Texas 78701

John O'Brien, Deputy Director
Legislative Budget Board
1501 Congress Avenue, 5th Floor
Austin, Texas 78701

Ken Welch, Director of Fiscal Management
Comptroller of Public Accounts
111 East 17th Street
Austin, Texas 78774

John Keel, State Auditor
State Auditor's Office
1501 Congress Avenue
Austin Texas 78701

Re: Section 28 Final Savings Allocation Plan

Dear Mr. Morrissey, Mr. O'Brien, Mr. Welch, and Mr. Keel:

As required by Section 28 of Article II, Special Provisions Relating to All Health and Human Services (HHS) Agencies, House Bill 1, 78th Legislature, Regular Session, 2003, attached is the final allocation plan for savings related to implementation of H.B. 2292. Actual savings identified total $94.3 million in general revenue. I believe this represents a significant accomplishment on the part of HHS agencies not only to make a smooth transition in consolidating agencies, but also to identify efficiencies in the process. In addition to the savings achieved this biennium, greater savings could be realized in the future as many of the major H.B. 2292 initiatives are fully implemented, including integrated eligibility determination and human resources outsourcing.

Please let me know if you have any questions or need additional information. Tom Suehs, Deputy Executive Commissioner for Financial Services, is serving as the lead staff on this matter and can be reached at 512/424-6526 or by e-mail at thomas.suehs@hhsc.state.tx.us.

Sincerely,

Albert Hawkins

AH:TS:dk:mm

Attachment

cc: HHS Commissioners and Chief Financial Officers

Sec. 28 Savings by Agency

GENERAL REVENUE	DADS	DARS	DFPS	DSHS	HHSC	Total
Consolidated Support	2,582,851	467,334	2,295,397	5,663,877	4,282,368	15,291,827
Recovery of third party reimbursements (pharmacy recovery)					5,065,365	5,065,365
Office of Inspector General					22,544,441	22,544,441
Revenue Maximization	22,121,075					22,121,075
NHIC Settlement					9,534,710	9,534,710
Unexpended Balances		2,110,000	1,577,979	10,950,000	279,000	14,916,979
Star+PLUS recoupment					639,567	639,567
Worker Safety	1,635,462	29,468	108,297	2,163,384	400,333	4,336,944
Remaining reductions required by Sec. 28					85,649,092	85,649,092
Total Savings	**$ 26,339,388**	**$ 2,606,802**	**$ 3,981,673**	**$ 18,777,261**	**$ 128,394,876**	**$ 180,100,000**

ALL FUNDS	DADS	DARS	DFPS	DSHS	HHSC	Total
Consolidated Support	7,155,311	2,446,042	2,554,521	9,755,480	8,130,440	30,041,794
Recovery of third party reimbursements (pharmacy recovery)					12,944,965	12,944,965
Office of Inspector General					57,614,212	57,614,212
Revenue Maximization	22,121,075					22,121,075
NHIC Settlement					25,400,000	25,400,000
Unexpended Balances		2,110,000	1,577,979	10,950,000	279,000	14,916,979
Star+PLUS recoupment					1,622,032	1,622,032
Worker Safety	4,232,014	195,596	494,508	2,163,384	400,333	7,485,835
Remaining reductions required by Sec. 28					218,883,442	218,883,442
Total Savings	**$ 33,508,400**	**$ 4,751,638**	**$ 4,627,008**	**$ 22,868,864**	**$ 325,274,424**	**$ 391,030,334**

FTEs	DADS	DARS	DFPS	DSHS	HHSC	Total
	150.0	55.0	9.5	203.0	1,368.5	1,786.0

ATTACHMENT B

Health and Human Services Commission
HB2292 Savings Allocated By Strategy

	All Funds	General Revenue	FTE Impact
Fiscal Year 2004 Savings			
Fiscal Year 2005 Savings			
Consolidated Support savings	$ 8,130,440	$ 4,282,368	253.5
Call Centers and Integrated Eligibility			1,115.0
Worker Safety Improvements	$ 400,333	$ 400,333	-
Office of Inspector General	$ 57,614,212	$ 22,544,441	-
NHIC Settlement	$ 25,400,000	$ 9,534,710	
Unexpended Balances	$ 279,000	$ 279,000	-
Star-PLUS recoupment	$ 1,622,032	$ 639,567	-
Recovery of third party reimbursements (pharmacy recovery)	$ 12,944,965	$ 5,065,365	-
Remaining reductions required by Sec. 28	$ 218,683,442	$ 85,649,091	
Total Savings	$ 325,274,424	$ 128,394,875	1,368.5

	Strategy	All Funds	General Revenue	FTE Impact
Consolidated Support savings	A.1.5 Consolidated System Support (13105)	8,014,095	4,230,013	251.5
	A.1.2 Medicaid/TANF/Food Stamp Eligibility (13101)	116,345	52,355	2.0
Call Centers and Integrated Eligibility	A.1.2 Medicaid/TANF/Food Stamp Eligibility (13101)			1,115.0
Worker Safety Improvements	D.1.1 Central Program Support (13131)	400,333	400,333	
Office of Inspector General	B.1.4 Medically Needy (13109)	31,689,241	12,400,000	-
	B.2.2 Vendor Drug (13113 CPA appn)	25,924,971	10,144,441	
NHIC Settlement	B.1.4 Medically Needy (13109)	25,400,000	9,534,710	
Unexpended balances	D.1.3 Refugee Assistance (13128)	279,000	279,000	
Star-PLUS recoupment	B.1.6 Star Plus (Integrated managed care) (13111)	1,622,032	639,567	
Recovery of third party reimbursements (pharmacy recovery)	B.2.2 Vendor Drug (13113 CPA appn)	12,944,965	5,065,365	
Remaining reductions required by Sec. 28	B.1.1 Aged and Disabled (13106)	72,961,147	28,549,697	
	B.1.2 TANF (13107)	72,961,147	28,549,697	
	B.1.3 Preg Women (13108)	72,961,147	28,549,697	
Total Savings		325,274,424	128,394,875	1,368.5

Savings assumed in LAR by project	All Funds	General Revenue	FTE Impact
Fiscal Year 2005 Savings			
Consolidated Support savings	$ 5,504,107	$ 3,231,835	149.5
Office of Inspector General Medicaid Fraud	$ 31,648,800	$ 12,400,000	
Remaining Sec. 28 Reductions	$ 131,544,652	$ 131,544,652	
Remaining Sec. 28 Reductions to be identified	$ (131,544,652)	$ (131,544,652)	
Total Savings	$ 37,152,907	$ 15,631,835	149.5

HEALTH AND HUMAN SERVICES COMMISSION

End of Report