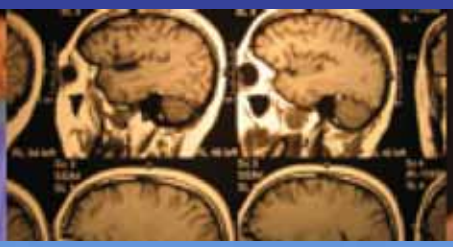
2010 Annual Report

Texas Health and Human Services Commission
Office of Inspector General





Introduction

Throughout this past fiscal year, the Office of Inspector General (OIG) worked diligently to help ensure integrity and fiscal accountability in the programs we serve, resulting in overall cost recoveries for the year of $486,658,147, and cost avoidance of $348,153,866. As these funds are directed back into the programs we serve, we know that the $834,812,013 helped to ensure needed healthcare and other state-funded assistance to many of Texas' neediest citizens.

Our office is tasked with carrying out important responsibilities, in a state of 24.7 million people covering 268,820 square miles. The health and human services system in which we are assigned "watchdog" responsibilities comprises up to a third of Texas' budget, and includes over 200 programs, 54,000 employees, 18,000 contractors, 91,000 Medicaid performing providers, and over 5 million recipients of public assistance.

In fiscal year 2010, this office exceeded its performance measures over all prior years since 2003, when we were created through the vision and foresight of the Texas Legislature and state leadership. We also made significant strides to build stronger working partnerships with Texas' health and human services agencies, while at the same time reaffirming our commitment to continuous improvement. This includes continuing to look not only outwardly but also at ourselves, so that we are doing our own part to maximize efficiency and effectiveness in our internal operations.

We are fortunate to have a devoted staff of public servants who are passionate about the work, as well as the substantial assistance and cooperation of the many public servants in the health and human services system who share our dedication to program integrity. Our vision, mission and integrity statements provide us constant guidance in carrying out our responsibilities, but even more important is our purpose for existence. That is to establish and maintain the public trust between the citizens of Texas and state government, because public trust is the glue that holds a democracy together. Especially in light of today's economic situation, such trust must be earned and is more important than ever.

We look forward to continuing our service to the State of Texas, its leadership, and Texas taxpayers by following our legislatively defined priorities. We know that especially in trying economic times, public servants just like taxpayers must "tighten our belts", redouble our efforts, and make the wisest possible use of limited resources. I thank Governor Perry and his administration, as well as the entire health and human services system leadership team, for their continued support of our mission. I'm pleased to present OIG's annual report for fiscal year 2010.

Bart Bevers
Inspector General

About OIG

The Office of Inspector General (OIG) was created in 2003 and is a division of the Texas Health and Human Services Commission. During the 78th Regular Session, the Texas Legislature approved House Bill 2292, which reorganized the Texas health and human services system. In that reorganization, the bill created the new office to prevent, detect, and pursue fraud, waste, and abuse in Texas health and human services programs. OIG is overseen by an Inspector General, appointed by the Governor.

In 2009, the Texas Legislature passed Senate Bill 643, which expanded OIG's duties. This bill required OIG to assist law enforcement agencies with criminal investigations at the state's 13 State Supported Living Centers. The new law also required the Office of Inspector General to employ and commission peace officers to assist in these investigations.

OIG has committed itself to a 'cycle of continuous improvement.' This philosophy, which encourages employees to constantly re-evaluate how OIG's processes work, allows OIG to quickly adapt to changes, making the office more efficient and effective. During fiscal year 2010, OIG reorganized in an attempt to fulfill its legislative mandate more accurately. Among the changes were the creation of a new department to house OIG's fraud, waste, and abuse hotline staff. Previously, the fraud, waste, and abuse hotline was decentralized, and staffed by members of several different OIG units. By centralizing the hotline staff, OIG's fraud, waste, and abuse reporting hotline became immediately more responsive and more efficient.

Since its creation, the Office of Inspector General has recovered, identified for recovery, or cost avoided, over $4.6 billion in erroneous, fraudulent, or wasteful payments in the state's health and human services programs.

These recovered funds are sent directly back to the state's HHS programs, allowing them to be used to help more Texans without placing additional demands on the state budget. OIG does this by:

OIG Mission Statement

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

OIG Vision Statement

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

Auditing, investigating, and reviewing the use of state or federal funds. This includes monitoring the use of contract and grant funds administered by a person or state entity receiving the funds from a health and human services agency. OIG seeks to ensure that the use of all state and federal money is in accordance with state and federal law.

Researching, detecting, and identifying events of fraud, waste, and abuse to ensure accountability and responsible use of resources. OIG uses a variety of mechanisms to achieve this goal, from provider self-reporting, and a public fraud reporting hotline, to automated detection technology, and human and artificial intelligence.

Conducting investigations, reviews, and monitoring cases internally. OIG investigates allegations of fraud, waste, and abuse committed by program recipients, health and human services agency employees, Medicaid providers, criminal incidents at state supported living centers, and fraud or misuse of vital statistics records. OIG then takes enforcement action based on the results of the investigation or review. OIG may also refer these cases to outside entities.

Issuing sanctions and performing administrative actions against providers and recipients. Sanctions may include exclusion from the Medicaid program or recoupment. For example, an OIG investigation may find that a doctor has been routinely coding a procedure incorrectly, and consequently has been receiving incorrect reimbursements from Medicaid. While the mistake may not have been intentional, federal law still requires OIG to recoup the amount overpaid to the provider.

Providing education, technical assistance, and training to the provider community. OIG's presentations to providers help to promote best practices and sustain improved relationships with providers.

Recommending policies that enhance the prevention and detection of fraud, waste, and abuse. OIG studies and recommends new prevention and detection mechanisms and policies, as well as changes to existing processes and procedures. While OIG does not have the authority to set program policy, it may enforce program policy.

In the coming year, the Office of Inspector General will continue to add new tools in its fight to stop fraud, waste, and abuse in health and human services programs. The changing federal healthcare structure also produces challenges for OIG's future. While many rules that will define and enact federal healthcare reform have yet to be written, the United States Congress created the backbone by passing the Affordable Care Act in March 2010. Among the new regulations passed by Congress is the increased criminal liability for any person that is aware of a federal healthcare overpayment and does not report it. This new requirement, as well as many others in the new law, will require OIG to adjust its priorities, procedures, and enforcement mechanisms.

About Fraud, Waste, and Abuse

Fraud is an intentional deception, or intentional misrepresentation, that a person makes in order to gain a benefit to which the person is not entitled. For example, a person commits fraud if he applies for benefits and intentionally lies on the application by saying he has five children, when he only has three children. Because the person gave false information in order to receive more benefits than he is entitled to, the person has committed fraud.

Waste is the careless, inefficient, or unnecessary use of public resources. For example, waste can occur when public money is spent on unnecessary program administration.

Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices and results in unnecessary program cost. For example, abuse can include reimbursement for services that are not medically necessary, or that do not meet professionally recognized standards. Unlike fraud, abuse can occur when there is no intentional deception or intentional misrepresentation.

Measuring Success

The Office of Inspector General uses two primary benchmarks for measuring its success. These are cost recovery and cost avoidance.

Cost recovery is money that OIG has collected or identified for collection because it was paid in error. For example, a Medicaid provider performs a routine procedure on a patient. However, when submitting the claim for payment, the provider classifies the routine procedure as an advanced procedure, which qualifies for a higher reimbursement rate. Through review of medical records, OIG determines that the provider's reimbursement should have occurred at the routine procedure rate. The provider is required to reimburse Medicaid for the difference between the amount actually paid and what should have been paid. While OIG has the responsibility to identify cost recoveries, it is not always assigned the responsibility for collecting overpayments. This report indicates when OIG pursues collection, or instead refers its findings to the entity with the responsibility for collection.

Cost avoidance is money that could have been paid in error, but was not paid due to OIG involvement. For instance, a provider submits a claim for payment. However, the patient has private insurance in addition to Medicaid coverage. Because Medicaid is the payer of last resort, the claim is sent to the private insurance company for payment. The amount of the claim sent to the private insurer is a cost that was avoided by the Medicaid program.

OIG Functions

The Office of Inspector General carries out its mission by performing its core functions. These core functions focus on the prevention, detection, and pursuit of fraud, waste and abuse, while other functions perform key quality assurance and support.

Prevention Functions

OIG's prevention functions include the Limited Program and the Health Insurance Premium Payment Program. OIG also performs prevention activities including provider enrollment screening, provider training and education.

Prevention > Limited Program

Limited Program Unit
OIG Division: Compliance
OIG Section: Quality Review

OIG's Limited Program works to prevent the inappropriate use of medical services by Medicaid recipients. The program works by limiting certain Medicaid recipients to a single primary care provider, a single pharmacy, or both. This can occur, for example, when a person uses the emergency room too often for non-emergencies. A Medicaid recipient may also be restricted to a single primary care provider if he or she engages in 'doctor shopping,' or, visiting multiple doctors in an attempt to receive prescriptions for drugs that are not medically necessary. Each of these unnecessary, multiple visits has a significant cost to the Medicaid program. By limiting these recipients to a single provider, pharmacy, or both, the Medicaid program is less likely to pay for unnecessary prescriptions and services.

Prevention > Training, Communication, and Outreach

Training, Communication, and Outreach
OIG Division: Operations
OIG Section: Center for Policy and Outreach

OIG's use of training, communication, and outreach programs also serves a preventative function. OIG provides outreach and education to legislators and their staff, external stakeholders, and members of the public. This communication and training helps educate the public on how OIG works, and helps to inform stakeholders of changes to program requirements. This helps stakeholders continue to provide services in accordance with the law.

Prevention > Health Insurance Premium Payment Program

The Health Insurance Premium Payment Program, or HIPP, reduces Medicaid program costs. In this program, the Medicaid program pays for employer or private health insurance premiums when the premiums are cheaper than providing regular Medicaid coverage for those persons. The program, administered under contract by the state's Medicaid claims administrator, is managed by OIG's Third Party Liability unit. The program compares what Medicaid would pay for a recipient's employer-sponsored health insurance premiums. If the insurance premium is less than what Medicaid would pay, the recipient qualifies for the program. Medicaid saves the difference between the amount of the insurance premium (plus coinsurance and deductibles) and the amount Medicaid would otherwise pay for the recipient's medical needs.

Health Insurance Premium Payment Program

OIG Division: Operations
OIG Section: Technology, Analysis, Development and Support

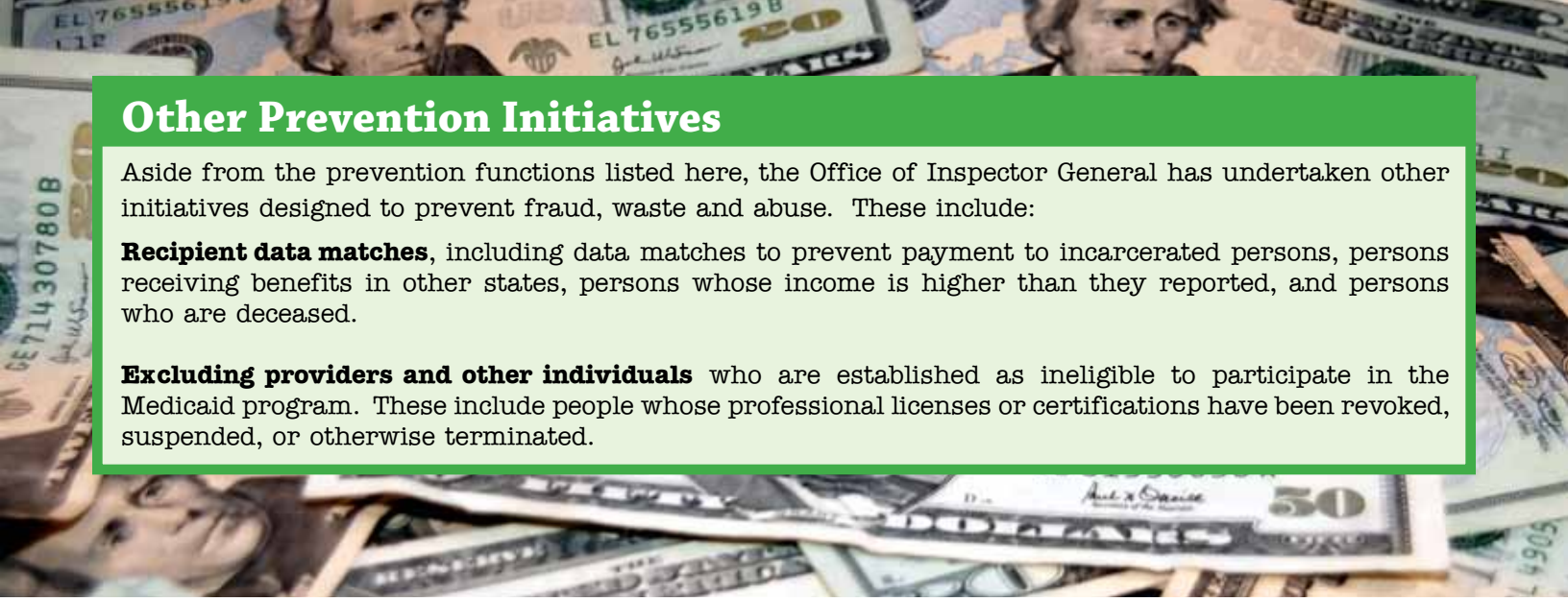
Prevention > Provider Enrollment Screening

OIG's Program Integrity Research unit, or PIR, conducts background checks on providers seeking to enroll in Medicaid and other state health insurance programs. The unit's research includes criminal checks and other verifications to ensure that the application for enrollment is accurate and the provider is eligible to participate in the program.

The PIR unit receives substantial assistance from OIG field investigators. These investigators conduct on-site inspections of providers that have applied for enrollment.

Program Integrity Research

OIG Division: Operations
OIG Section: Center for Policy and Outreach
Number of Background Checks Conducted: 36,000
OIG Division: Enforcement
OIG Sections: Medicaid Provider Integrity
General Investigations
Number of On-Site Inspections Completed: 267



Other Prevention Initiatives

Aside from the prevention functions listed here, the Office of Inspector General has undertaken other initiatives designed to prevent fraud, waste and abuse. These include:

Recipient data matches, including data matches to prevent payment to incarcerated persons, persons receiving benefits in other states, persons whose income is higher than they reported, and persons who are deceased.

Excluding providers and other individuals who are established as ineligible to participate in the Medicaid program. These include people whose professional licenses or certifications have been revoked, suspended, or otherwise terminated.

Detection Functions

The detection of fraud, waste, and abuse is another one of OIG's focuses. Detection involves using a mix of sophisticated electronic tools, human and artificial intelligence and investigation, manual reviews of provider and participant data, and audit techniques to ensure that state funds are spent wisely and in accordance with the law. OIG's detection functions fall into three distinct categories: audits, reviews, and investigations.

Detection > Audits

OIG's detection functions include detailed audits conducted on a wide variety of providers. OIG conducts these audits in accordance with Generally Accepted Government Auditing Standards, or GAGAS (more commonly known as "Yellow Book" standards.) OIG's Contract Audit Unit conducts audits of intermediate care facilities to ensure the proper management of residents' trust funds. The Contract Audit unit also audits prescription drug claims made through the Medicaid Vendor Drug program. In addition, the unit has responsibility for auditing high-risk contractors for the health and human services system. The Contract Audit Unit refers its trust fund findings to the Department of Aging and Disability Services for resolution, including any refunds to residents. In Fiscal Year 2010, the unit referred its prescription drug audit findings to the Vendor Drug Program for the recoupment of overpayments.

Contract Audit Unit
OIG Division: Compliance
OIG Section: Audit
Resident Refunds: $22,517
Dollars Identified for Recovery: $526,154

Medicaid/CHIP Audit Unit
OIG Division: Compliance
OIG Section: Audit
Dollars Identified for Recovery: $1,054,790
Number of Audits Conducted: 9

OIG's Audit Section also reviews Medicaid and CHIP vendors through its Medicaid/CHIP Audit unit. This unit reviews Medicaid and CHIP claims administrators, hospice organization billing practices, and the confidentiality of patient health information maintained by contractors. This unit also helps to ensure that Medicaid and CHIP contractors perform their duties in accordance with state law, oversight agencies, and the terms of their contracts with the state. The unit refers its findings to the part of HHSC with contract oversight authority for appropriate action.

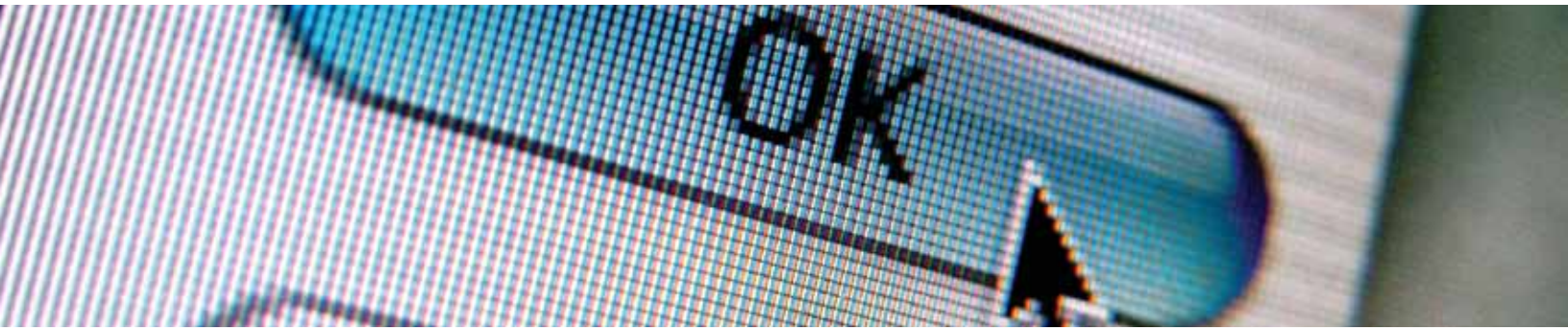
Definition
CHIP The Children's Health Insurance Program.

OIG also audits Outpatient Hospitals and Managed Care Organizations. OIG audits hospital cost reports for outpatient services to ensure that all outpatient hospital costs charged to Medicaid are reasonable, necessary, and allowable. OIG refers its findings to the Texas Medicaid & Healthcare Partnership, or TMHP, the state's Medicaid claims administrator, for recoupment or adjustment.

Outpatient Hospital/Managed Care Organizations Audit Unit

OIG Division: Compliance
OIG Section: Audit
Net Disallowed Costs: $38,790,059
Number of Audits Conducted: 31

Likewise, OIG's audits of Managed Care Organizations, or MCO's, scrutinize compliance with the fraud, waste, and abuse plans of the MCO's Special Investigative Unit, ensuring their plans meet state regulations. If the unit finds contract compliance issues, it refers its findings to Medicaid/CHIP Division Health Plan Oversight for appropriate action.



Detection > Reviews

The Research, Analysis, and Detection unit, or RAD, uses a combination of statistical modeling and computerized detection tools to detect inappropriate or incorrect payments to Medicaid providers. OIG refers its findings to the Texas Medicaid & Healthcare Partnership, or TMHP, the state's Medicaid claims administrator, for recoupment. The RAD unit also oversees the Surveillance and Utilization Review Subsystems, or SURS, a federally required fraud detection tool.

Research, Analysis, and Detection

OIG Division: Operations
OIG Section: Technology, Analysis, Development, and Support (TADS)
Number of Reviews Completed: 5,175
Dollars Recovered: $12,179,196

OIG's Cost Report Review unit conducts both audits and reviews to ensure that long-term care facilities that receive Medicaid funding are accurately reporting their service costs, and is required by law to audit or review cost reports for long-term care facilities. The HHSC Rate Analysis Division uses these cost reports, which report the actual cost of services provided, as a factor in the determination of reimbursement rates for long-term care facilities, so the accurate reporting of actual costs is important. The Cost Report Review unit may share its findings with OIG's Medicaid Provider Integrity section, which investigates fraud, waste, and abuse. While many errors found by the Cost Report Review unit are not due to fraud, the unit can help detect fraudulent intent. For example, a provider may continuously inflate its reported costs, despite repeated education, in an attempt to receive higher reimbursement rates. When this occurs, the Cost Report Review unit refers all net disallowed costs to the Medicaid Provider Integrity section for further investigation because the findings may indicate fraudulent intent. The unit refers all findings to the HHSC Rate Analysis Division for reimbursement rate adjustment or other appropriate action.

Cost Report Review Unit

OIG Division: Compliance
OIG Section: Audit
Net Disallowed Costs: $71,270,378
Number of Reviews and Audits Conducted: 3,441

Utilization Review Unit
OIG Division: Compliance
OIG Section: Quality Review
Number of Hospitals Reviewed: 1,368
Number of Records Reviewed: 47,364
Number of Nursing Facilities Reviewed: 140
Amount of Underpayments Identified: $57,309
Amount Identified for Recovery: $42,061,119

The Utilization Review Unit conducts nursing facility reviews that verify the correct reimbursement of services provided by nursing facilities. Medicaid reimburses nursing facilities at different daily rates based on a resident's level of need, which is an assessment of each resident's functional capabilities. A facility may assess a resident at a higher level of need than the resident's actual needs in order to receive higher reimbursements. These reviews validate whether the facility has correctly assessed and documented the resident's needs and received proper reimbursement. The unit refers its findings to the Department of Aging and Disability Services for the recoupment of overpayments and the adjustment of underpayments.

This unit also reviews inpatient hospital claims for services provided to fee-for-service Medicaid recipients. In these reviews, OIG evaluates whether the services were medically necessary, the patient received an adequate quality of care, and whether the facility properly classified the services for billing. The unit refers its findings to TMHP for recoupment.

Sub-Recipient Financial Review Unit
OIG Division: Compliance
OIG Section: Audit
Reviews Conducted: 464
Dollars Identified for Recovery: $1,376,540

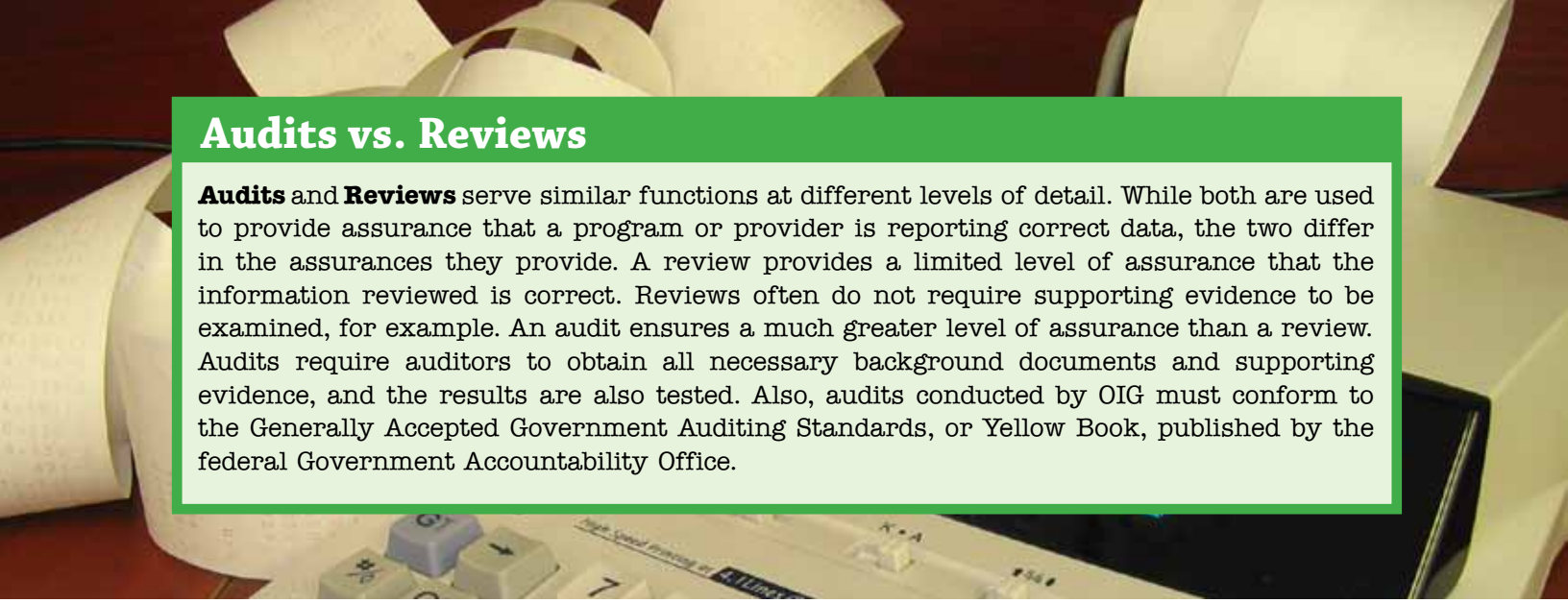
OIG's Sub-Recipient Financial Review unit performs single audit desk reviews, quality control reviews of single audits conducted by independent accounting firms, and limited scope audits of grant funds. Sub-recipients are entities who receive public funding, often in the form of a grant, to perform services for a health and human services agency. When the sub-recipient spends the funds above a certain threshold, they are required to obtain a single audit from an independent accounting firm. In performing desk reviews, the Sub-Recipient Financial Review Unit verifies these audits to determine that the single audit report was presented in accordance with federal and state requirements.

In a quality control review, the unit goes beyond the presentation of the single audit report to evaluate whether the independent accounting firm that conducted the audit work did so in accordance with professional auditing standards. Limited scope audits of grant funds look at sub-recipients whose spending fell below the threshold requirement for a single audit, to evaluate whether the sub-recipient spent and reported the grant funds in compliance with program requirements. The unit refers its findings to the health and human services agency with contract oversight authority for appropriate action.

While performing a routine desk review of a single audit of a non-profit provider, an OIG auditor verified the license of the CPA firm that performed the audit. Because the licensing board's website indicated that the firm had an expired license, the auditor contacted the CPA firm and learned that they had not actually performed the audit. Because this raised suspicion, an OIG audit team was assembled to perform an on-site review of the provider's records.

This review revealed that other single audit reports had apparently been falsified. The records reviewed also indicated that shell companies had been created to siphon funds from the provider. The provider's executive director maintained sole control over the provider's financial records, and was the only person that reported financial information to the provider's oversight board, allowing her actions to avoid detection. After this on-site review, the executive director fled the country.

The unit's review prompted the provider's oversight board to refer these findings to the Travis County District Attorney, who is currently awaiting the apprehension and extradition of the suspect.



Audits vs. Reviews

Audits and **Reviews** serve similar functions at different levels of detail. While both are used to provide assurance that a program or provider is reporting correct data, the two differ in the assurances they provide. A review provides a limited level of assurance that the information reviewed is correct. Reviews often do not require supporting evidence to be examined, for example. An audit ensures a much greater level of assurance than a review. Audits require auditors to obtain all necessary background documents and supporting evidence, and the results are also tested. Also, audits conducted by OIG must conform to the Generally Accepted Government Auditing Standards, or Yellow Book, published by the federal Government Accountability Office.

WIC Vendor Monitoring
OIG Division: Compliance
OIG Section: Quality Review
Dollars Identified for Recovery: $245,797

OIG also monitors retailers participating in the Women, Infants, and Children, or WIC, program as part of OIG's detection mission. The WIC Vendor Monitoring unit monitors grocery stores and farmers markets to ensure that all vendors are in compliance with state and federal law, administrative rules, and the WIC Vendor Agreement. This unit conducts invoice audits to identify fraudulent reimbursement claims by vendors. Additionally, the WIC Vendor Monitoring unit assists the United States Department of Agriculture Office of Inspector General with investigations of vendors. The unit also conducts announced in-store reviews and undercover compliance buys, which help to detect instances of non-compliance by WIC vendors. The unit refers its findings to the Department of State Health Services for the recoupment of overpayments and the collection of penalties.

Medicaid Fraud and Abuse Detection System
OIG Division: Operations
OIG Section: Technology, Analysis, Detection and Support (TADS)
MFADS Cases Opened: 4,908
MFADS Cases Closed: 4,904

The Medicaid Fraud and Abuse Detection System, or MFADS, is a computer system that detects, identifies, and analyzes provider billing patterns. The system sets benchmarks for what is normal based upon actual billing patterns.

The system provides local, desktop access to a wide range of information, such as claims data, reports, suspect lists, and documents, and contains a full range of tools to detect, prevent, and identify money lost to fraud, waste, and abuse. Other OIG functions, such as the Limited Program and the Quality Review section use MFADS as a tool. The Limited Program, for example, uses MFADS claim data to detect the overuse of medical or pharmacy services, while the Quality Review section uses MFADS data to conduct reviews of inpatient hospitals and nursing homes.

Detection > General Investigations

General Investigations
OIG Division: Enforcement
Referrals Received: 73,558
Referrals Closed: 65,862
Dollars Recovered: $24,567,630
Claims Established: $47,281,933*

*Includes some dollars reported above as dollars recovered

The General Investigations section, or GI, conducts investigations of health and human services recipients. Specifically, GI investigates allegations of overpayments made to recipients in the following programs: Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, Children's Health Insurance Program (CHIP), and the Women, Infants, and Children (WIC) program, or other health and human services programs.

Referrals to GI come from data match clearances performed by GI staff, referrals from the Office of Eligibility Services, and from the general public. These referrals come either through calls to the OIG Fraud Hotline or online complaints from OIG's website. This section also conducts investigations of individuals suspected of the unauthorized possession or use of an Electronic Benefit Transfer, or EBT, card. For example, a recipient may illegally sell their EBT card or SNAP benefits for cash, drugs, or weapons. In many instances these cases are worked jointly with local, state or federal law enforcement agencies.

Annual Certification of TIERS Investigations

General Investigations used the Texas Integrated Eligibility Redesign System (TIERS) Historical Case Report System (THCR) to retrieve the data necessary to investigate and refer fraud cases for prosecution. General Investigations continually works with Enterprise Applications staff to resolve issues as they are identified with the THCR system.

While not all investigations result in a finding of overpayment, an investigation may find that an overpayment has occurred for many reasons. Overpayments can occur as a result of agency error, client error, or fraud. Any dollars identified for recovery are referred for collection to HHSC's Fiscal Division through the Accounts Receivable Tracking System, or ARTS.

Detection > Medicaid Provider Integrity

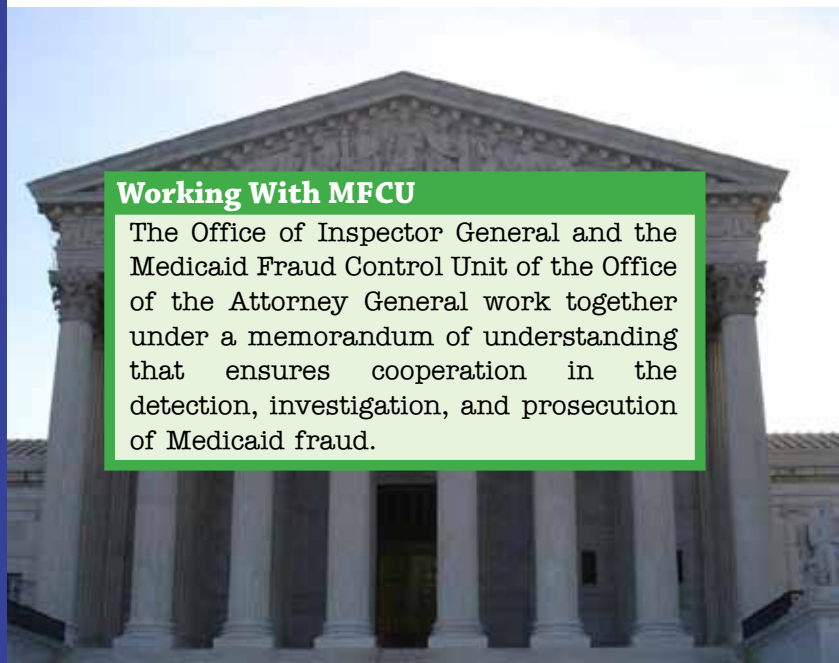
Medicaid Provider Integrity

OIG Division: Enforcement
Number of Investigations Completed: 536
Referrals to MFCU: 270
Referrals to Other Entities: 265

The Medicaid Provider Integrity section, or MPI, investigates allegations of fraud, waste, and abuse against Medicaid providers. If MPI determines that criminal conduct may have occurred, OIG has the obligation to refer the allegation to the Office of the Attorney General's Medicaid Fraud Control Unit, or MFCU, for criminal investigation. MPI may also refer the allegations to the provider's licensing board for administrative action, to the federal Medicare program, or to other regulatory or law enforcement entities. MPI also has the authority to conduct its own administrative investigations and refer its findings to the OIG Sanctions section. In addition to investigating providers, MPI offers program-integrity recommendations on proposed Medicaid policies.

In June 2010, the Medicaid Provider Integrity section began investigations of several DME providers and a billing company after MPI employees noticed suspicious billing patterns while analyzing the providers' claims for incontinence supplies. MPI's field investigators discovered that these supplies were either not medically necessary or not ordered by a physician, and that most of these supplies--which were billed to Medicaid--were never even provided.

MPI field staff shared their investigative findings with the Texas Attorney General's Medicaid Fraud Control Unit and worked with MFCU to build criminal cases against the providers and the billing company owners. All of the DME providers took plea deals, and testified in the ensuing trials against the billing company owners, who orchestrated the scheme. The owners of the billing company were convicted on July 2, 2010 of multiple felonies. One defendant was sentenced to 10 years in prison, while the other was sentenced to 6 years in prison.



Working With MFCU

The Office of Inspector General and the Medicaid Fraud Control Unit of the Office of the Attorney General work together under a memorandum of understanding that ensures cooperation in the detection, investigation, and prosecution of Medicaid fraud.

Detection > Internal Affairs

OIG's Internal Affairs section performs a wide variety of administrative and criminal investigative functions, including investigating allegations of misconduct involving health and human services employees and contractors. These investigations may involve theft, misuse of state property, and misappropriation of state funds. Internal Affairs also investigates fraud and misuse involving birth and death certificates, marriage licenses, divorce decrees, and other vital statistics records.

Internal Affairs

OIG Division: Enforcement
OIG Section: Internal Affairs
Investigations Completed: 1,480

The State Center Investigations Unit was created in September 2009 to implement the requirements of Senate Bill 643 (81st Regular Legislative Session), which addressed abuse, neglect, and exploitation in State Supported Living Centers, or SSLCs. These facilities provide residential treatment for physically or developmentally disabled persons. The Texas Legislature granted OIG the authority to assist law enforcement with the investigation of criminal allegations of abuse, neglect or exploitation of SSLC clients. This unit consists of commissioned peace officers who primarily assist law enforcement agencies in the investigation of criminal activities involving a resident or client.

Internal Affairs also analyzes computer data for alleged misconduct of health and human services employees. For example, this unit determines whether an employee has viewed or stored inappropriate images while at work, and investigates the use of state computers for personal business.

Definition

Abuse is the negligent or willful infliction of injury, unreasonable confinement, intimidation, or cruel punishment with resulting physical or emotional harm or pain to an elderly or disabled person by the person's caretaker, family member, or other individual who has an ongoing relationship with the person or sexual abuse of an elderly or disabled person, including any involuntary or non-consensual sexual conduct that would constitute an offense.

Exploitation is the illegal or improper act or process of a caretaker, family member, or other individual who has an ongoing relationship with the elderly or disabled person using the resources of an elderly or disabled person for monetary or personal benefit, profit, or gain without the informed consent of the elderly or disabled person.

Neglect is the failure to provide for one's self the goods or services, including medical services, which are necessary to avoid physical or emotional harm or pain or the failure of a caretaker to provide such goods or services.

In March 2009, the OIG Internal Affairs Special Investigations Response Unit and other Internal Affairs staff were mobilized to conduct an investigation regarding a series of incidents that occurred at the Corpus Christi State Supported Living Center involving allegations of abuse and exploitation of clients by numerous living center staff members. These incidents involved living center staff abusing residents, and encouraging and forcing residents to fight in what has become known in media stories as a "fight club." OIG investigators provided assistance to Corpus Christi Police Department and contributed to the development of evidence needed for the criminal trials of the suspects. The investigation resulted in six third degree felony convictions.

Pursuit Functions

In addition to the detection and prevention of fraud, waste, and abuse, the Office of Inspector General plays an important role in pursuing administrative enforcement activities to help ensure that the state is not burdened with paying for services that are another entity's responsibility. OIG has two entities whose focus is pursuit: Third Party Liability, and Sanctions.

Pursuit > Third Party Liability

Third Party Liability
OIG Division: Operations
OIG Section: Technology, Analysis, Development and Support
Cost Recovery: $196,314,353
Cost Avoidance: $179,908,640

The OIG's Third Party Liability unit helps to ensure that all responsible parties pay their share of recipients' expenses. Because Medicaid is the 'payer of last resort,' this is accomplished by redirecting claims to the liable third party, resulting in cost avoidance, or by pursuing a liable third party for claims previously paid by the Medicaid program, which results in cost recovery. By providing contract oversight for this function and recoupment direction to the state's claims administrator, this unit ensures that the state's Medicaid program is the payer of last resort, and avoids costs it otherwise would pay.

Third parties that may be liable for paying for a patient's care before Medicaid is utilized include private insurers, employer-provided health insurance, an absent parent, accidental injury insurance, the defendant in a court judgment, workers' compensation, or other federal programs.

Pursuit > Sanctions

Sanctions
OIG Division: Chief Counsel
Cost Recovery: $164,376,240
Cost Avoidance: $42,161,065

OIG's Sanctions section supports OIG's mission by recouping overpayments, assessing civil monetary penalties, suspending payments to providers, restricting provider reimbursement to only certain services, excluding providers from the Medicaid program, and canceling provider contracts with Medicaid. Additionally, the Sanctions section considers requests for reinstatement of excluded providers, which, if granted, means that an exclusion is lifted and the provider may reapply for enrollment. Sanctions also performs accounting, compliance, and remittance functions for penalties and overpayments collected on behalf of Medicaid.

The Sanctions section receives and processes self-disclosed reports of overpayments from providers. The Sanctions section also completes the enforcement of any sanctions imposed, and conducts informal reviews and administrative contested case hearings.

The Sanctions section may also take other administrative actions that do not result in appellate review. Such administrative actions may impose requirements for educational sessions, prior authorization of selected

services, prepayment review, postpayment review, corrective action meetings, or surety bonds.

The Sanctions section also coordinates enforcement activities with the Medicaid Fraud Control Unit and the Civil Medicaid Fraud division of the Office of Attorney General. The Office of Attorney General may report some of the same overpayments and penalties in its annual or semi-annual reports. Although both offices have valid reasons for reporting certain global settlement recoupments, the recoveries are the same, and the reported amounts should not be summed or duplicated for budgeting or decision-making purposes. Total Sanctions section non-global settlement recoveries in FY 2010 were $12,296,869.

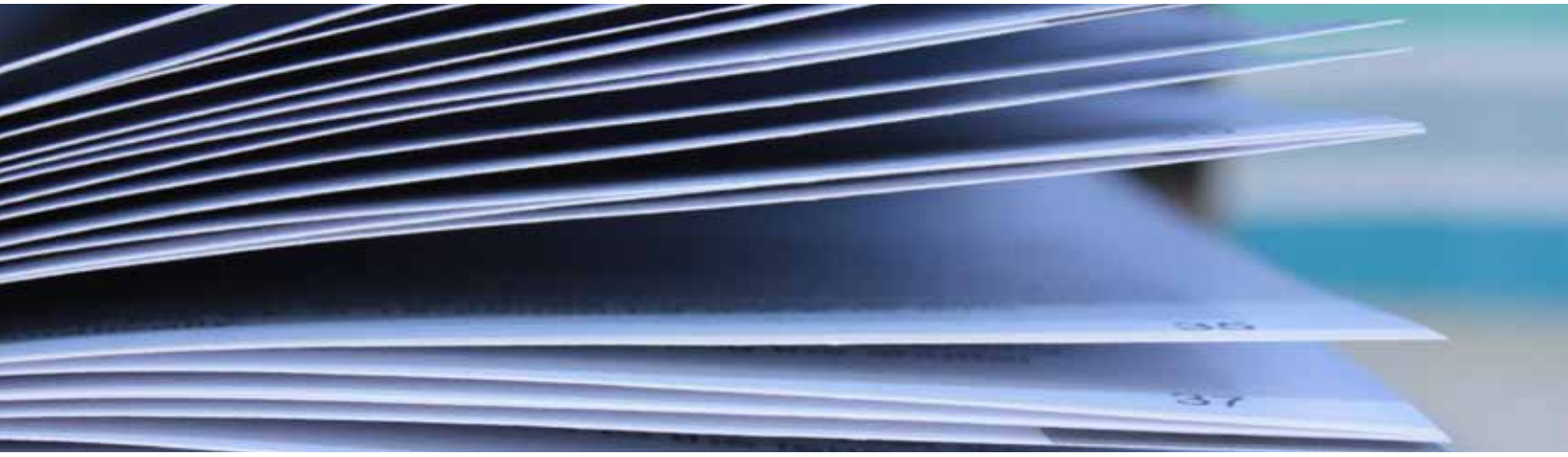
Quality Assurance and Support Functions

In addition to OIG's prevention, detection, and pursuit functions, the Office of Inspector General also includes essential support functions. These functions include administrative support, budget analysis and quality assurance, legal work, information technology management, and communications and policy development.

OIG's Quality and Decision Support unit performs essential data analysis services, including budget analysis and quality assurance. The unit also conducts quality assurance reviews of investigations and audits to help determine the validity, reliability, and integrity of each audit or investigation.

Quality and Decision Support
OIG Division: Operations
OIG Section: Business Operations

In addition, the Quality and Decision Support unit maintains the OIG Performance Measures Report System, which allows OIG management and staff to assess agency performance. The unit is also engaged in a long-term project to integrate OIG's organizational structure, strategic plan, budget, and performance measures, so OIG can monitor its return on investment.



Administrative Services Unit
OIG Division: Operations
OIG Section: Business Operations

The Administrative Services unit performs a variety of functions designed to ensure OIG's daily operations run efficiently and as smoothly as possible. The Administrative Services unit assists with human resources, contract management, and records management. The unit's human resources duties include developing job postings, creating job screening matrices, and writing interview questions. The unit ensures that OIG's contractual agreements and memoranda of understanding with other state agencies are correctly processed.

The unit also is developing OIG's central filing system which will help ensure compliance with records retention laws. This filing system will streamline OIG's records storage and retrieval process. In addition, the unit manages all OIG facilities. The Administrative Services unit configures workspace, acquires furniture, maintains heating and cooling systems, and maintains OIG's buildings. The unit also assists HHSC with building safety inspections, staffs OIG's reception desk, tracks the use and location of state property, conducts an annual inventory of all equipment, and completes purchase orders.

The unit also manages building security. The unit issues all keys and staff identification badges for OIG employees. The unit also restricts building access to authorized employees and maintains the OIG Evidence Room to ensure that its contents are kept secure and confidential.

Fraud, Waste, and Abuse Hotline
OIG Division: Operations
OIG Section: Center for Policy and Outreach

OIG's Fraud, Waste, and Abuse Hotline accepts allegations of fraud, waste, and abuse from the general public. Hotline staff works to ensure that each allegation contains enough information for OIG staff to make a well-reasoned determination on whether to open a case or take other appropriate action. The hotline staff forwards each allegation to the appropriate area of OIG. The Fraud, Waste, and Abuse Hotline is accessible toll free by calling 1-800-436-6184.

Business Analysis and Support Services
OIG Division: Operations
OIG Section: Technology, Analysis, Development and Support

The Business Analysis and Support Services unit, or BASS, supports OIG's automation and information technology processes. BASS develops software applications that streamline OIG's work processes, maintains OIG's computer and information resources, and ensures that OIG's data are secure.

Since its creation, the BASS unit has created several computer programs to assist with OIG's business operations. These include OIG's Consolidated Case List and the Waste, Abuse, and Fraud Electronic Reporting System, which allows OIG employees to create and edit case referrals and allows the public to report fraud through OIG's website.

Legal

OIG Division: Chief Counsel
OIG Section: Legal

The Legal section, led by OIG's Chief Counsel, provides legal advice and guidance to the Inspector General and OIG staff on a broad range of legal issues and questions. In addition, the Legal section helps ensure that OIG adopts legally sound policies, procedures, and practices.

Center for Policy and Outreach

OIG Division: Operations
OIG Section: Center for Policy and Outreach

The Center for Policy and Outreach, or CPO, houses functions like policy development and recommendations, communications, external relations, training, and strategic planning.

CPO policy analysts study existing federal and state law and policies, making recommendations to strengthen, clarify, or change policy. These recommendations may affect the Texas State Medicaid Plan, administrative rules, and the Medicaid provider manual. CPO also writes, and assists other areas in revising, policies and procedures for OIG's business practices, and helps to ensure that OIG's practices support its business operations. CPO also maintains and updates OIG's centralized electronic library of policies and procedures.

CPO's support responsibilities also extend to developing the OIG website, and creating publications such as OIG's annual report, and, with the Attorney General's office, a joint semi-annual report.

FY2010 Performance

Cost Recovery: Dollars Actually Recovered

	Q1	Q2	Q3	Q4	FY2010
Global Settlement Overpayments & CMPs	$39,764,927	$86,738,754	$20,477,635	$5,098,055	$152,079,371
Sanctions Overpayments & CMPs	$1,144,963	$5,359,717	$564,340	$5,227,849	$12,296,869
Third Party Liability	$40,632,704	$46,289,889	$57,859,904	$51,531,856	$196,314,353
Research, Analysis, & Detection Reviews	$5,395,596	$1,006,225	$1,317,114	$4,460,261	$12,179,196
Overpayments Collected	$3,328,383	$5,484,692	$12,286,094	$3,408,461	$24,507,630
				TOTAL	$397,377,419

Cost Recovery: Dollars Identified for Recovery

	Q1	Q2	Q3	Q4	FY2010
WIC Vendor Monitoring	$7,907	$19,615	$209,675	$8,600	$245,797
Contract Audits	$0	$170,188	$130,957	$225,009	$526,154
Utilization Review, Hospitals	$4,095,467	$14,016,619	$12,401,486	$11,022,784	$41,536,356
Utilization Review, Nursing Homes	$493,218	$31,545	$0	$0	$524,763
Sub-Recipient Financial Reviews	$35,982	$258,587	$433,410	$648,561	$1,376,540
Medicaid/CHIP Audits	$0	$999,416	$45,677	$9,697	$1,054,790
Additional Overpayment Claims Established					$44,016,328
				TOTAL	$89,280,728

Cost Avoidance

	Q1	Q2	Q3	Q4	FY2010
Sanctions, Provider Exclusions	$24,553,826	$3,209,673	$845,689	$13,551,877	$42,161,065
Provider Prepayment Review	$11,573	$35,951	$97,857	$90,553	$235,934
Third Party Liability	$50,537,807	$46,991,057	$44,174,218	$38,205,558	$179,908,640
WIC Vendor Monitoring	$257	$239	$1,960	$320,085	$322,541
Cost Report Review, Net Disallowed Costs	$21,583,048	$13,542,217	$12,001,657	$24,143,456	$71,270,378
Outpatient Hospital Net Disallowed Costs	$14,090,126	$7,784,587	$8,065,471	$8,849,875	$38,790,059
Disqualifications	$2,956,384	$2,597,314	$2,465,730	$3,070,800	$11,090,228
Income Eligibility Matches (IEVS)	$905,116	$736,234	$709,106	$585,474	$2,935,930
Other Data Matches	$287,286	$255,361	$393,813	$502,631	$1,439,091
				TOTAL	$348,153,866

Recipients Providers

Glossary

Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices and results in unnecessary program cost. For example, abuse can include reimbursement for services that are not medically necessary, or that do not meet professionally recognized standards. Unlike fraud, abuse can occur when there is no intentional deception or intentional misrepresentation.

Audit The examination of records or financial accounts to check their accuracy and compliance with rules and regulations.

Children's Health Insurance Program A federally and state-funded program, administered by the state, that provides health insurance to low-income children who do not qualify for Medicaid.

CHIP see **Children's Health Insurance Program**.

Civil Monetary Penalties Administrative monetary sanctions levied as a result of certain program violations.

Claim A provider's direct or indirect request for payment or reimbursement from the Medicaid program, or other health and human services program.

CMP see Civil Monetary Penalties

Cost Avoidance is money that could have been paid in error, but was not paid due to OIG involvement.

Cost Recovery is money that OIG has collected or identified for collection because it was paid in error.

DME see **Durable Medical Equipment**.

Durable Medical Equipment Equipment which can stand repeated use for the purpose of medical care provided in the home, such as hospital beds, oxygen equipment, and wheelchairs.

Fiscal Year September 1 of one year to August 31 of the next. Fiscal Year 2010 occurred from September 1, 2009 to August 31, 2010.

Fraud An intentional deception, or intentional misrepresentation, that a person makes in order to gain a benefit to which the person otherwise would not be entitled. Fraud is also a legal term that may have a specific definition in certain circumstances.

Health Insurance Premium Payment Program A Medicaid program that pays for employer or

private health insurance premiums, for persons who are eligible for Medicaid, when the premiums are cheaper than providing regular Medicaid coverage for those persons.

Health and Human Services Commission The single state Medicaid agency for Texas. HHSC also is the oversight agency for the Texas health and human services system.

Health and human services A term generally referring to over 200 programs of the health and human services system, including Medicaid, CHIP, WIC, TANF, and SNAP.

HHSC see **Health and Human Services Commission**

HIPP see **Health Insurance Premium Payment Program**

Limited Program A Medicaid program administered by OIG that limits certain Medicaid recipients to one designated primary care physician, one pharmacy, or both, in order to limit the inappropriate use of Medicaid funds and services.

Managed Care Organization An entity that provides, or contracts for, managed care, including Health Maintenance Organizations (HMOs), Primary Care Case Management (PCCM), and Prepaid Health Plans (PHPs).

MCO see **Managed Care Organization**

Medicaid A joint federal-state entitlement program that pays for medical care for certain groups of low-income persons. The program was enacted in 1965 under Title XIX of the Social Security Act.

Medicaid Fraud and Abuse Detection System A computer system utilizing artificial intelligence technology to detect, identify, and analyze aberrant billing patterns.

Medicaid Fraud Control Unit A division of the Office of the Attorney General that conducts criminal investigations into allegations of fraud, physical abuse, and criminal neglect by Medicaid providers.

Medicare A federally funded healthcare program, administered by the federal government, available to persons 65 or older, and for others with certain long-term disabilities.

MFADS see **Medicaid Fraud and Abuse Detection System**.

MFCU see **Medicaid Fraud Control Unit**

Office of Inspector General Division of the Health and Human Services Commission charged with preventing, detecting, and pursuing fraud, waste, and abuse in health and human services programs administered by the State of Texas.

OIG see **Office of Inspector General**

Overpayment The amount of money paid by a health and human services program to a provider or person that exceeds the amount to which the provider or person was entitled.

Provider Any person, group, or agency that provides services under the Texas Medicaid Program and other health and human services programs. This term is all-inclusive, and can include physicians, dentists, home health aides, residential centers, and DME suppliers.

Sanction An administrative remedy for a program violation, as determined by OIG, that triggers due process rights.

SNAP see **Supplemental Nutrition Assistance Program**.

SSLC see **State Supported Living Center**

State School see **State Supported Living Center**

State Supported Living Center A facility that provides residential treatment for physically or developmentally disabled persons. There are 13 State Supported Living Centers, formerly known as State Schools.

Supplemental Nutrition Assistance Program A federally-funded program, formerly known as food stamps, that provides low-income persons with money to purchase groceries.

SURS see **Surveillance and Utilization Review Subsystem**

Surveillance and Utilization Review Subsystem A federally-required exception criteria system that profiles Medicaid providers for peer comparison based upon their declared specialty.

TANF see **Temporary Assistance for Needy Families**.

Temporary Assistance for Needy Families A federally funded program that provides monetary assistance to low-income families with dependent children.

Third Party Resource An entity that is responsible for paying a portion of, or all of, a Medicaid recipient's healthcare costs, such as an insurance company.

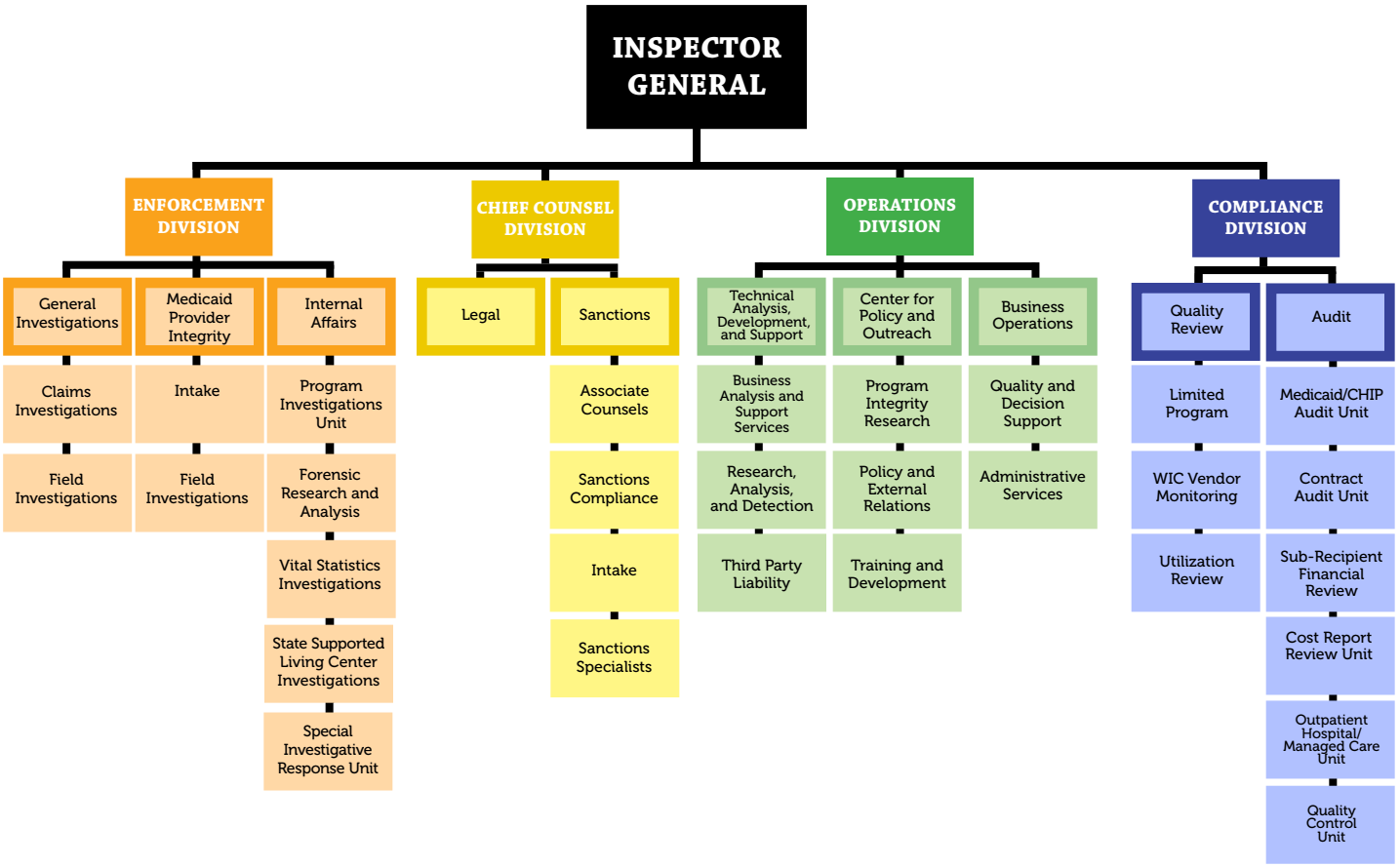
Utilization The claim history of a provider or recipient.

Waste A careless, inefficient, or unnecessary use of public resources.

WIC see **Women, Infants, and Children Program**

Women, Infants, and Children Program A federally-funded special supplemental program that provides nutritional benefits for low-income pregnant, post-partum, and breastfeeding women, infants, and children under 5 years old.

Organizational Chart



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For Legislative Inquries, Call: (512) 491-4050