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State Auditor

An Audit Report on

**The Office of Inspector General
at the Health and Human
Services Commission**

November 2006

Report No. 07-004



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Overall Conclusion

The Office of Inspector General (OIG) at the Health and Human Services Commission is investigating fraud, waste, and abuse as required by state law (House Bill 2292, 78th Legislature, Regular Session). The OIG has also consolidated investigative functions as required by state law (House Bill 2292).

During fiscal year 2005, the OIG reported:

- Completing 59,440 investigations of recipient fraud and overpayments, recovering more than \$21.3 million, and referring 3,796 cases for prosecution.
- Completing 2,211 provider fraud and over-billing investigations, recovering more than \$36.4 million, and referring 151 cases for prosecution.

Two significant exceptions limit the OIG's ability to investigate fraud, waste, and abuse. The Health and Human Services Commission (Commission) is piloting the Texas Integrated Eligibility Redesign System (TIERS) in two counties. The OIG is not investigating potential recipient fraud and overpayments for the Food Stamp, Temporary Assistance for Needy Families (TANF), and Medicaid programs in these two counties. According to information provided by the Commission, TIERS determined eligibility for an average of 151,000 recipients per month for these programs since the pilot began in the two counties. For fiscal year 2006, TIERS determined \$103 million in benefits for the Food Stamp Program and \$4.7 million for TANF, based on information provided by the Commission. According to the OIG, data that is critical to pursuing investigations of fraud and overpayment is not readily accessible to investigators through TIERS, and the data that is accessible is not sufficient to legally pursue criminal proceedings for fraud or to recoup certain types of overpayments.

In addition, the pharmacy benefit manager contractor has not provided Medicaid Vendor Drug Program claims to the OIG since January 2006, which limits the OIG's

Background Information

The Office of Inspector General (OIG) was created on January 1, 2004, as a result of House Bill 2292 (78th Legislature, Regular Session). The OIG is required by law to investigate provider and recipient fraud, waste, and abuse within several health and human services programs, including the Food Stamp, Temporary Assistance for Needy Families (TANF), and Medicaid programs.

To accomplish this task, the OIG consolidated several functions performed at former health and human services agencies. For example, recipient fraud cases in the Food Stamp, Medicaid, and TANF programs were previously investigated by the former Department of Human Services' Office of Inspector General. Now that function is performed by the OIG—specifically its General Investigations Section.

The OIG has over 500 employees in 7 sections. For additional information, see Appendix 2.

ability to investigate potential Medicaid fraud and overpayments on a statewide basis. Therefore, the \$1 billion paid by the pharmacy benefit manager for the Medicaid Vendor Drug Program from January 1, 2006, to August 31, 2006, was not analyzed to identify potential fraud and overpayments.

Additionally, the OIG should evaluate ways to further improve the screening of cases to ensure that resources are directed toward those cases with the greatest potential to recover funds. The automated screening process designed to filter out cases in which fraud or overpayments are unlikely was improved in early 2005. Still, OIG investigators have to eliminate more than half of their cases in the early stages of an investigation because an overpayment or fraud did not occur.

There are also opportunities for the OIG's Internal Affairs and Audit Sections to improve coordination and communications with health and human services agencies. For example, the OIG's Audit Section should have periodic updates with the five health and human services agencies to improve coordination and establish a more efficient audit process.

The *Office of Inspector General Semi-Annual Report* could be improved by clarifying the Third-Party Resources line item and enhancing processes used to verify reported amounts and estimated savings.

Further, information technology controls at the Health and Human Services Commission and the OIG do not always ensure that all information is accurate and complete, and they do not protect all information from unauthorized access. To minimize the risk associated with public disclosure, this report summarizes the weaknesses in information technology security identified during the audit, but it does not reveal specific vulnerabilities.

Key Points

The OIG is limited in its ability to investigate potential fraud in two significant ways.

The OIG is not investigating potential fraud cases when the eligibility applications are processed in the two TIERS pilot counties because of difficulties in obtaining necessary information from the automated system. Additionally, the OIG was limited in its ability to identify overpayments and/or fraud for the Medicaid Vendor Drug Program statewide because it had not received the related claims data from the contractor responsible for processing the Medicaid Vendor Drug claims.

The OIG should continue to evaluate opportunities to effectively screen out potential cases in which no violations have occurred.

The OIG has improved the automated process used to screen out potential cases in which it was unlikely fraud or overpayment occurred. This screening allows the OIG to allocate resources to investigating discrepancies between a recipient's

eligibility application and information provided by third parties that are most likely to result in recovery of funds or prosecution. The OIG should continue to evaluate opportunities to further improve this process to filter out more cases in which violations have not occurred.

The OIG should document criteria used to determine whether providers that over bill Medicaid should be referred to the OIG's Sanctions Unit for possible penalties.

The OIG has not adequately documented its criteria for when providers with billing violations should be forwarded to the OIG's Sanctions Unit. Because the decision not to forward a case to the Sanctions Unit is made by individual research analysts, it is very important for the OIG to document its policies and procedures to ensure consistency.

The OIG should improve communications with health and human services agencies and clarify the *Office of Inspector General Semi-Annual Report*.

The OIG should improve communications with health and human services agencies. The OIG's Internal Affairs Section and Audit Section do not have a written and established protocol defining their responsibilities (as opposed to the responsibilities of the health and human services agencies). The Internal Affairs and Audit Sections perform services for the health and human services agencies, and improving communications and coordination would reduce possible duplication of efforts.

The *Office of Inspector General Semi-Annual Report* could be improved by clarifying certain line items and enhancing processes used to verify reported amounts and estimated savings.

Information technology controls at the Health and Human Services Commission and the OIG do not always provide for accurate and complete information or protect all the information from unauthorized access.

To minimize the risk associated with public disclosure, this report summarizes the weaknesses in security and access controls identified during the audit. Findings were noted in the areas of system access, network configuration, password and account login parameters, and account and access logging.

Summary of Management's Response

The OIG agrees with the recommendations in this report.

Summary of Information Technology Review

The Health and Human Services Commission is responsible for the security and maintenance of the OIG's Automated System for the Office of Inspector General

(ASOIG). The Health and Human Services Commission does not have proper controls in place to prevent unauthorized access to ASOIG.

The OIG uses many automated systems to conduct its business. While the audit involved several sections and many systems, the Reported Income Discrepancy Examination System (RIDES), which is part of ASOIG, was the only system audited. Systems not audited include:

- Medicaid Fraud Abuse Detection System, the data warehouse used to analyze claims, was not audited because it is maintained by a contractor that was not engaged in the audit.
- The OIG Claims Integrated System (OCIS) and Case Management System (CMS), which are used to track recipient fraud and overpayment cases, were not audited because these systems will be replaced in April 2007.

Summary of Objectives, Scope, and Methodology

The objectives were to determine whether (1) the Health and Human Services Commission's OIG is investigating fraud, waste, and abuse as intended by state law (House Bill 2292, 78th Legislature, Regular Session); (2) the OIG maintains complete and accurate records of complaints and investigations in the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS); and (3) the OIG is effectively coordinating and communicating with sister agencies and departments such as the Office of the Attorney General, the Health and Human Services Commission's Rate Analysis Division, and the health and human services programmatic contract monitors.

The scope of the audit included the OIG's activities from January 2004 (when the OIG was created) through June 2006. The audit included the activities and communications of the OIG's provider and recipient fraud investigations, as well as the communications and activities for the Audit and Internal Affairs Sections. The audit did not include the Quality Assurance Section. The audit did not include an audit of the automated systems used to track recipient and provider fraud—Medicaid Fraud Abuse Detection System, OCIS, CMS—because the provider system is maintained by an external contractor and the recipient systems will be replaced in April 2007. Objective 2 was not included in the audit because the WAFERS system did not track all cases as was originally understood.

The audit methodology consisted of collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating the results of the tests, and conducting interviews with the OIG's management and staff.

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Detailed Results

Chapter 1

The Office of Inspector General Is Limited in Its Ability to Investigate Potential Fraud in Two Significant Ways

The Office of Inspector General (OIG) is not investigating potential fraud or overpayment cases in the two pilot counties where eligibility was processed in the automated Texas Integrated Eligibility Redesign System (TIERS) because of difficulty in obtaining all necessary information from the automated system. Additionally, the OIG is limited in its ability to identify overpayments and/or fraud in the Medicaid Vendor Drug Program because it has not received the related claims data from the pharmacy benefit function contractor. The Medicaid claims processor also has not provided the OIG data needed to accurately analyze long-term care claims to identify potential over billing and fraud.

Chapter 1-A

The OIG Does Not Investigate Cases Processed Through TIERS for Potential Recipient Fraud or Overpayments

The OIG stopped pursuing all criminal cases in November 2004 for eligibility applications processed through TIERS (see text box), and in April 2005, it

stopped investigating all cases processed through TIERS. TIERS determined eligibility for an average of 78,000 recipients per month from September 1, 2004, through August 31, 2006, for the Food Stamp and Temporary Assistance for Needy Families (TANF) programs, which accounted for \$265.5 million in benefits paid. TIERS also determined eligibility for an average of 70,000 Medicaid recipients during the same time period.

Texas Integrated Eligibility Redesign System (TIERS)

TIERS is used to process and store eligibility applications for Food Stamp, Temporary Assistance for Needy Families (TANF), and Medicaid recipients in pilot offices.

The State began a TIERS pilot in June 2003 in eligibility offices located in Travis and Hays counties. Eligibility for recipients living in the pilot areas is processed through TIERS. TIERS is scheduled to eventually replace the System for Application, Verification, Eligibility, Referral, and Reporting (SAVERR), the current health and human services eligibility system that is still used in the non-pilot offices in the majority of the state.

The OIG is responsible for investigating recipient fraud, waste, and abuse for the Food Stamp, TANF, and Medicaid programs. To do this, OIG compares recipient eligibility information obtained during the initial application process to information received from third-party sources, including the U.S. Internal Revenue Service, Texas Workforce Commission, and U.S. Social Security Administration. The OIG uses an automated process to identify discrepancies and flag cases of potential fraud and overpayments.

According to the OIG, data that is critical to pursuing investigations of fraud and overpayment is not readily accessible to investigators through TIERS, and the data that is accessible is not sufficient to legally pursue criminal proceedings for fraud or to recoup certain types of overpayments. Furthermore, TIERS lacks interfaces to the automated systems at the U.S. Internal Revenue Service, U.S. Social Security Administration, and the Texas Workforce Commission. These interfaces are necessary to obtain data used to identify potential fraud and overpayments, conduct further investigation, and recoup funds.

According to the OIG, there are several shortcomings in TIERS:

- Certain data is retained only in TIERS audit trail tables that are not accessible during the ordinary course of business.
- Although historical data for a recipient's household that is retained is in TIERS audit trail tables, OIG has not yet been able to verify this data is sufficient or is sufficiently linked to enable OIG investigators to determine why a decision to establish eligibility was made, or why the benefits were set at a particular amount.
- TIERS does not store the application and eligibility determination data as a "snapshot" in time and does not store the rules used to determine eligibility.
- OIG is of the opinion that TIERS does not comply with federal regulations¹ that require Food Stamp records be detailed and easily retrievable to permit a reviewer to determine the reasonableness and accuracy of the benefit decision. As a result, the OIG is not investigating potential fraud or overpayments for a monthly average of 151,000² recipients whose eligibility is established through TIERS. Although the OIG investigates recipient fraud for the Food Stamp, TANF, and Medicaid programs, the majority (76 percent) of the cases are generated from the Food Stamp program.

The OIG has met numerous times with the Health and Human Services Commission and the contractor responsible for making changes to the system to identify the record management issues and develop solutions. The Health and Human Services Commission has initiated requests for at least three change orders to improve records management within TIERS. As of September 30, 2006, the change orders were still in the discussion phase.

Recommendation

The OIG should continue to work with the Health and Human Services Commission and the contractor programming TIERS to ensure that potential recipient fraud and overpayments can be investigated and prosecuted in all areas of the state.

Management's Response

The HHSC Office of Inspector General (OIG), which is responsible for recoupment of overpayments and pursuit of fraud in HHSC, noted that in

¹ Title 7, Code of Federal Regulations, Section 274.11 (a), and Title 7, Code of Federal Regulations, Section 273.2 (f) (6).

² According to information from the Health and Human Services Commission.

TIERS present configuration, not all of the information required to perform recoupment and fraud investigation is readily available, and certain information in TIERS lacks the level of data integrity required to support court cases. In April 2005, OIG suspended recoupment efforts and its investigation and pursuit of fraud cases for clients living in zip codes serviced through TIERS, pending the completion of the appropriate TIERS improvements.

The Office of Eligibility Services, OIG, Information Technology, and the Integrated Eligibility and Enrollment Services vendor (Texas ACCESS Alliance) are working together to complete changes to TIERS and related business processes to ensure that required information is readily available and meets the appropriate level of data integrity to support the investigation and prosecution of fraud, and that key interfaces OIG uses to identify potential overpayments and fraud are in place.

Once TIERS functionality and interfaces meet these requirements, OIG will have access to the information it needs to pursue the recoupment of overpayments and to investigate fraud cases prospectively. Changes in TIERS that will enable OIG to begin overpayment and fraud investigations are scheduled for completion in March 2007. The key interfaces required for OIG are scheduled for completion by August 2007. After these changes are implemented, OIG will determine whether overpayment cases will be retroactively pursued.

Estimated Completion Date:

- *March 31, 2007 - completion of historical report*
- *August 31, 2007 - completion of key interfaces*

Title of Responsible Person:

HHS Chief Information Officer

Chapter 1-B

The OIG Cannot Analyze Some Claims Using the Medicaid Fraud Abuse Detection System Because Two Contractors Did Not Provide the Necessary Data

The OIG has not received data from external contractors necessary to analyze payments for the Medicaid Vendor Drug Program and long-term care programs for possible fraud or over billing. The lack of data from these contractors increases the risk that potential fraud or over billing in the Medicaid Vendor Drug Program could go undetected, and that some long-term care providers could be unnecessarily identified for investigation.

The OIG has not received pharmacy claims data from the Medicaid Vendor Drug Program claims processor since January 2006. On January 1, 2006, a contractor became the

Pharmacy Benefit Manager

The pharmacy benefit manager is responsible for providing outpatient prescription drug benefits to clients of Health and Human Services Commission's programs across the state through contracted pharmacy service providers.

As of January 2006, the pharmacy benefit manager functions are shared by the Health and Human Services Commission and a contractor.

Medicaid Vendor Drug Program claims processor, one of the functions of the pharmacy benefit manager. One of the contractor's responsibilities includes providing a monthly transfer of claims data to the OIG. The contractor, however, has not provided this information since it took over the benefit management function.

Because the OIG did not receive the claims data, it could not conduct its usual analysis using the Medicaid Fraud Abuse Detection System (MFADS) to identify potential fraud and overpayments within the Medicaid Vendor Drug Program. Therefore, the \$1 billion paid by the Medicaid Vendor Drug Program claims processor from January 1, 2006, to August 31, 2006, was not analyzed to identify potential fraud and over billing.

Medicaid Fraud Abuse Detection System (MFADS)

MFADS is a data warehouse of information from the Medicaid claims processing system (Compass 21), Medicaid transportation system, Medicaid long-term care system, Medicaid vendor drug system, and death files from the Department of State Health Services. A data dump is received from each system monthly.

The OIG's Technology, Analysis, Development, and Support (TADS) Section, in conjunction with the MFADS maintenance contractor, analyzes the data to determine whether the payments were appropriate.

The OIG did not receive complete claims data for the Medicaid long-term care programs, which prevented it from accurately analyzing the program claims through MFADS. The OIG did not receive data on the claims adjustments for the long-term care programs from the State's Medicaid claims processor, which is an outside contractor. Therefore, the OIG cannot accurately analyze the long-term care claims data using MFADS to identify overpayments and potential fraud (see text box).

A claim adjustment occurs when a provider's payment is reduced by the amount of a prior overpayment. The adjustment is made in the Medicaid processing system, but the long-term care claims data provided to the OIG does not include all adjustments. Therefore, the OIG may be using inaccurate data to conduct its analysis in MFADS. This increases the risk that some long-term care providers may be incorrectly identified as subjects for fraud, waste, or abuse investigations.

Recommendation

The OIG should continue to work with the Health and Human Services Commission to obtain all necessary information from the Medicaid Vendor Drug Program claims processor and the State's Medicaid claims processor.

Management's Response

We agree with the SAO's recommendation. OIG Technology, Analysis, Development and Support (TADS) Section staff will continue to work with the Pharmacy Benefit Manager Contractor and Medicaid Vendor Drug Program staff to resolve data issues identified during the review of test files. TADS staff have been working with these areas since the fall of 2005. This has

involved participation in various meetings, review of various test files, identification of issues with the test files and data, and resolution of other issues. As of October 27, 2006, all critical issues with the vendor drug claim extract have been resolved. The contractor will be sending a test file in early November for verification of the last correction. Once verified, they will begin sending monthly catch-up files for January 2006 through current date. It may take several months for them to send the files and for the MFADS vendor to load the files. Once the files are loaded, the data will be subjected to the normal MFADS reviews.

The OIG has submitted a request to State Medicaid Claims Processor to provide the missing Long Term Care adjustment information and correct the data extraction process so that the adjustment data is provided with all future claim extracts. The change request was submitted on October 18, 2005 and State Medicaid Claims Processor placed the project on a priority list. The State Medicaid Claims Processor completed the initial Business and User Requirements document in July 2006, and the final document was approved by the OIG in September 2006. The OIG anticipates that State Medicaid Claims Processor will implement the change in the coming months. MFADS users were advised of this data issue and to take it into consideration when using the Long Term Care data.

Estimated Completion Date:

OIG anticipates receiving both Medicaid Vendor Drug Program and Medicaid Long-Term Care data beginning in December 2006.

Title of Responsible Person:

- *Medicaid Vendor Drugs Program Claims - Deputy Director, Vendor Drug Program*
- *State Medicaid Claims Processor - Deputy Director, Medicaid/CHIP*

The OIG Should Evaluate Opportunities to Effectively Screen Out Potential Cases in Which No Violations Have Occurred

In May 2005, the OIG improved the process used to screen out cases in which it is unlikely fraud or overpayments occurred. An effective screening process ensures that resources are allocated to investigations that are most likely to

result in recovery of funds or prosecution of recipients. The OIG should continue to evaluate opportunities to further improve this process. Currently, the OIG investigators still have to eliminate more than half of the discrepancies identified by automated systems in the early stages of an investigation because there is not an overpayment or fraud.

Recipient Fraud Investigations

The General Investigations Section received 68,701 complaints and referrals and completed 59,440 cases during fiscal year 2005. Of these, 3,796 cases were referred for prosecution during fiscal year 2005.

Source: *Office of Inspector General Semi-Annual Report* for fiscal year 2005.

The OIG's General Investigations Section is responsible for investigating recipient fraud, waste, and abuse. Its investigations are conducted by using both automated and manual processes (see Table 1). The majority of the cases investigated are identified by the automated process.

Table 1

Recipient Fraud Investigation Process	
Steps in a Recipient Fraud Investigation	Description
Identify discrepancies	Using an automated process, the OIG identifies discrepancies between recipient eligibility information provided during the initial application process and information received from third-party sources.
Apply automated filters	Automated filters are applied to the discrepancies to eliminate those that are most likely not the result of an overpayment or fraud. The remaining discrepancies are sent to investigators for further evaluation.
Manual review of discrepancies by investigators (phase one)	Investigators conduct several activities to research the discrepancies, including contacting employers to verify wage data. The investigator can eliminate the discrepancy if it is unlikely an overpayment or fraud occurred or the investigator may forward the discrepancy to the next phase for further review. Discrepancies are tracked in the Reported Income Discrepancy Examination System (RIDES).
Further review of discrepancies by investigators (phase two)	Investigators usually complete the investigation and calculate the overpayment during this stage. However, investigators can also complete the research started during phase one and eliminate cases during phase two if it is determined no overpayment or fraud occurred. Discrepancies are tracked in the OIG Claims Integrated System (OCIS).

The automated filters used to evaluate the discrepancies were improved in May 2005. The OIG reported implementation of new and revised filters in May 2005 that improved the automated process. For example, filters were added to eliminate discrepancies associated with instances in which the household income is not above the threshold set for fraudulent activity. The improved filters are

eliminating more discrepancies in the initial screening phase (see Table 2). Improving these automated filters will give OIG investigators more time to pursue cases that are more likely to involve overpayment or fraud.

Table 2

Automated Filtering of Discrepancies		
Discrepancies between Application and Third-party Information	September 2004-April 2005 (before improvements)	September 2005 - April 2006 (after improvements)
Total identified	201,305	228,460
Total eliminated by filters	71,239	131,768
Percentage eliminated	35%	58%

Investigators are eliminating the majority of the discrepancies during the initial manual review (phase one). Although the number of discrepancies that must be reviewed by investigators decreased (as noted above), the majority of discrepancies, which are identified by the automated systems after filtering, still do not result in fraud or overpayment and are manually eliminated by investigators in the first phase. For example, investigators eliminated a total of 84,140³ (76 percent) of the 110,804 discrepancies between September 2005 and April 2006.

The OIG does not track the reasons cases are eliminated by investigators after the cases were filtered through its automated system. Adding a column to the Reported Income Discrepancy Examination System (RIDES) requiring investigators to provide this information would help the OIG evaluate whether additional filters or changes to the existing filters are warranted.

More effective pre-screening by the automated filters could (1) reduce the amount of time spent by investigators on cases when it is clear no fraud or overpayment occurred, and (2) help investigators meet timeliness standards required by federal regulations⁴, which require an initial review be completed within 45 days.

Investigators are also eliminating more than half the discrepancies in phase two because no fraud or overpayment occurred. Between September 2004 and June 2006, an average of 58 percent (61,707 of 105,834) of potential cases in the second phase of investigation was eliminated because no overpayment or fraud was identified. A potential case should reach the second phase of investigation only if the potential for an overpayment or fraud is likely. It is not apparent why more than half the cases are eliminated in the second phase.

³ Because investigators have 45 days to complete the manual review of discrepancies, the cases reported in this section also include cases that were identified in August 2005 (the month prior to the one noted).

⁴ Title 7, Code of Federal Regulations, Section 272.8.

Recommendation

The OIG should add a column to its Reported Income Discrepancy Examination System and OIG Claims Integrated System automated systems to track the reasons investigators are eliminating potential fraud and overpayment cases and continue to evaluate opportunities to effectively screen out cases when no violations have likely occurred.

Management's Response

We agree that the OIG should continue to evaluate opportunities to effectively screen out cases where a violation has not occurred, but do not agree that a column should be added to RIDES. The OIG has and will continue to appropriately identify and develop automated filters to screen out discrepancies for potential cases where no violation has occurred. Although, there is a federal requirement to process the IEVS, there is no requirement to establish the filters. The reason OIG instituted and continues to monitor and

refine the filters is to effectively eliminate unnecessary work and increase efficiency. The efforts in this area are a continuous process that the SAO has already acknowledged in its report, stating that great improvements have been accomplished by OIG from September 2004 through April of 2006. According to our records presented to SAO, the level of automated filtering of discrepancies and other remarkable progress is recapped in the textbox below. Caution must be taken in developing new and more complex filters to ensure that cases with possible recoveries are not eliminated. The OIG Claims Integrated System currently contains reasons for eliminating a potential fraud and overpayment case. The SAO's recommendation of adding a "reason field" to the RIDES would require automation changes and increase the workload of investigators during processing. The OIG's current practice of utilizing workgroups of subject matter experts in developing automated filters is working as intended, and appears more practical. Our office considers its accomplishments in this area to be worthy of recognition. It is management's intention to continue to develop and introduce workload management initiatives that benefit the program. While there is benefit to reducing workload

Progressive Improvements in Filters Achieved by OIG From 2004 to 2006

- *Total Discrepancies Identified between September 2004 and April 2005 = 201,305 compared to 228,460 between September 2005 and April 2006*
- *Total Discrepancies Eliminated between September 2004 and April 2005 = 71,239 compared to 131,768 between September 2005 and April 2006*
- *Percentage of Discrepancies Eliminated between September 2004 and April 2005 = 35% compared to 58% between September 2005 and April 2006*

Percentage cleared by the filters:

- *May 2004 = 42%*
- *May 2005 = 60%*
- *May 2006 = 66%*

Drops In Number of Matches (Percent of matches manually no claimed):

- *From September 2004 to September 2005 = 81.57% to 73.09%*
- *From June 2005 to June 2006 = 73.15% to 65.99%.*

as suggested, there is also considerable risk that excessive or inappropriate use of filters may eliminate a significant number of valid referrals. The risk is significant considering that the General Investigations Section receives over half of all referrals through the clearance of the IEVS.

Estimated Completion Date:

The development and adjustment of IEVS clearance filters is an ongoing process that is generally dictated by policy changes outside the control of OIG.

Title of Responsible Person:

Director, General Investigation Section

The OIG Should Document Criteria Used to Determine When Providers That Over Bill Medicaid Should Be Referred to the OIG's Sanctions Unit for Possible Penalties

The OIG has not adequately documented its criteria for when information regarding providers with billing violations should be forwarded to the OIG's Sanctions Unit, which is responsible for assessing and collecting penalties. The OIG's Technology, Analysis, Development, and Support (TADS) Section analyzes Medicaid payments using MFADS to determine whether payments are in compliance with policies and to identify overpayments.

TADS Section and Sanctions Units

The TADS Section analyzes Medicaid provider claims data to ensure compliance with policies. The Sanctions Unit assesses civil monetary penalties.

During fiscal year 2005, the OIG reported that the TADS Section identified and opened 2,223 cases and completed 1,900 cases, resulting in more than \$2.6 million recovered in overpayments. The Medicaid claims processor recovers the overpayments.

Source: *Office of Inspector General Semi-Annual Report* for fiscal year 2005.

The decision to forward a case to the Sanctions Unit for possible penalty is made by the individual TADS research specialist. The research specialist reviews the information available to determine whether a provider's payment is in compliance with policies. If the provider's payment is not in compliance, the research specialist calculates the over-billing and initiates the process to recover the funds. The research specialist must also determine whether the provider's case should be referred to the Sanctions Unit. The cases that the research specialist decides should be referred to the Sanctions Unit are discussed in a monthly meeting with TADS management to finalize whether the case should be forwarded to

the Sanctions Unit. The Sanctions Unit decides whether to assess a penalty against the provider.

The criteria governing when a case should be referred to the Sanctions Unit are not documented in writing. Because the decision to forward a case is left to individual research analysts, it is very important for the OIG to document its policies and procedures to ensure consistency in criteria used in making referral decisions.

Recommendation

The OIG should document criteria regarding when TADS should refer a provider identified as over billing Medicaid to the Sanctions Unit for possible penalties or sanctions.

Management's Response

OIG agrees with this recommendation. However, there are existing criteria for referring TADS cases to Sanctions for the possible imposition of administrative penalties. The criteria are not formally documented by OIG in the format that SAO would like to see it. In the existing practice, cases are referred to the Sanctions Unit for the possible imposition of administrative penalties, if the following criteria are met: (1) the totality of the circumstances

indicates that the provider knew, or should have known, that the submitted claims were false; (2) TADS staff determines that, before submitting the claim(s) at issue, the provider had prior notice from OIG that the manner of billing was inappropriate; and (3) the TADS management staff determines that the consideration of the above, suggests that the case is referable to Sanctions for the possible imposition of administrative penalties and/or sanctions.

Estimated Completion Date:

The OIG has begun the formal documentation of these criteria. This documentation will be completed by December 2006.

Title of Responsible Person:

Director, Technology Analysis, Development, and Support Section

The OIG Should Improve Communication with Health and Human Services Agencies and Clarify the Office of Inspector General Semi-Annual Report

The OIG should improve its communications with state agencies, including the five health and human services agencies, and the public. The OIG's Internal Affairs Section does not have a written and established protocol to assist with defining their responsibilities (as opposed to the responsibilities of the health and human services agencies).

Additionally, the OIG should clarify the semi-annual report it provides to the Legislative Budget Board and the Governor's Office and makes available to the public through its Web site.

Chapter 4-A

The OIG's Internal Affairs and Audit Sections Should Improve Communication and Coordination with Health and Human Services Agencies

The OIG's Internal Affairs Section did not adequately document its procedures to facilitate communications and coordination between the section and the five health and human services agencies. Written procedures would assist in defining the section's responsibility for investigating cases involving fraud, waste, or abuse and reducing potential duplication of effort. Additionally, the section provided incomplete case status reports to five health and human services agencies during fiscal year 2006.

The OIG Audit Section and the five health and human services agencies also would benefit from improved communications. The health and human services agencies' program monitoring personnel, rate setting personnel, and internal auditors indicated a need for improved communication and timelier sharing of information by the OIG Audit Section.

Internal Affairs Section

The OIG's Internal Affairs Section is responsible for investigating fraud, waste, and abuse complaints involving state employees within health and human services agencies. Complaints and investigations are tracked in a database called Case Management System (CMS).

During the first half of fiscal year 2006, the OIG reported that the Internal Affairs Section received 175 complaints and completed 86 investigations. Six of the completed cases were referred to the appropriate law enforcement agency.

The Internal Affairs Section did not adequately document procedures for determining responsibility for investigating cases involving fraud, waste, or abuse. The OIG's Internal Affairs Section does not have a documented protocol to assist with determining whether the OIG or one of the health and human services agencies should investigate a case.

The OIG's Internal Affairs Section receives complaints from several sources, including the public. These complaints vary from violations of a policy or procedure, which are best handled by the health and human services agencies, to complaints of fraud, waste, and abuse, which are best handled by the OIG's Internal Affairs Section. Some complaints involve both policy violations and possible fraud. One of the health and human services agencies had

concerns that the OIG's Internal Affairs Section was investigating policy-related cases that did not involve fraud, waste, and abuse.

The OIG's Internal Affairs Section drafted interagency policies and procedures that address the respective roles of the OIG and the respective health and human services agencies for investigating complaints. However, the policies and procedures have not been finalized and approved. The Internal Affairs Section should discuss these written procedures with the five health and human services agencies before finalizing them to ensure that the procedures are workable for both the health and human services agencies and the OIG.

During fiscal year 2006, the Internal Affairs Section provided incomplete case status reports to five health and human services agencies. A comparison of the Internal Affairs Section's case-tracking database and the monthly case status reports the OIG provided to each of the health and human services agencies indicated that the monthly reports were incomplete. Although the OIG used a database to track the cases investigated by its Internal Affairs Section, the reports were not generated from that database. As a result, the reports provided to the health and human services agencies were inaccurate. For example, one health and human services agency's reports did not include 24 cases that were in the Internal Affairs Section's database. The reports provided to another agency did not include 185 cases.

The reports were intended to communicate the status of the Internal Affairs Section's investigations to the health and human services agencies. Because of the inaccuracies, however, the health and human services agencies are not aware of all the cases being investigated by the section. This prevents the agencies from taking appropriate action regarding employees under investigation.

The OIG Audit Section and the five health and human services agencies would benefit from improved communications. The health and human services agencies' program monitoring personnel, rate setting personnel, and internal auditors indicated a need for improved communication and timelier sharing of information by the OIG Audit Section. Some of the health and human services agencies programs' responsibilities depend on activities conducted by the OIG Audit Section. For example, the OIG Audit Section conducts the federally required single audits for the five health and human services agencies as well as completing audits of cost reports submitted by various contract providers for the Health and Human Services Commission. Periodic updates on the status of the OIG Audit Section's activities would assist the agencies in managing their respective areas of responsibility.

Audit Section

OIG's Audit Section is responsible for completing audits for several functions within the health and human services agencies. These include:

- Subrecipient financial reviews - responsible for completing the federally required single audits.
- Contract audits of the Intermediate Care Facilities for Mental Retardation and Medicaid Vendor Drug Program contractors (added in fiscal year 2006).
- Medicaid/Children's Health Insurance Program contract audits. (This unit was created in late fiscal year 2005.)
- Cost report audits.
- Outpatient/Managed Care Organization audits. (This unit was created in fiscal year 2006.)

As of April 24, 2006, the Audit Section had completed 1,311 audits and desk reviews since September 1, 2005.

Recommendations

The OIG should ensure that:

- Its Internal Affairs Section finalizes and maintains procedures to determine which cases will be investigated by the OIG.
- Its Internal Affairs Section provides accurate status reports to health and human services agencies.
- Its Audit Section improves its coordination and communications with health and human services agencies by providing periodic updates of its activities.

Management's Response

- *OIG agrees with the SAO recommendation and had already drafted and submitted the procedures on January 31, 2006, for approval prior to the audit. They are pending final approval by the Health and Human Services Enterprise (herein referred to as the "Commission"). As a matter of compliance with the statutory requirements (the 79th Legislative Session, and House Bill 2292), the Office of Inspector General is subject to the Commission and is not granted the authority to enact or change the Commission policy and/or procedures. On various operational matters, the OIG has made proposals and recommendations to enhance its activities, but the approval and finalization of those recommendations and proposals rests solely within the Commission and Executive Commissioner.*

As a matter of evidential support to OIG's efforts concerning this matter, the Internal Affairs Section (IAS) began in January of 2006 submitting proposed referral policy and procedure language and recommendations to the Commission. The OIG drafted, developed, and established a formal internal policy and procedure relating to determining who is responsible for investigating cases involving fraud, waste, abuse or misconduct by employees, contractors, sub-contractors, vendors and clients. As of today, the formal approval to the policy and procedures referenced in this audit comment is still pending with the Commission's Office. The following are summary meetings and dates that the OIG met with the Commission to discuss the approval of the Enterprise proposed policy and procedures. The supporting documentations of discussions during the meetings were submitted to the SAO auditors and is available with the Director of Internal Affairs Section of OIG.

- *Tuesday, January 31, 2006 - The OIG delivered and proposed a written policy and procedures on the Internal Affairs Section roles and responsibilities in investigating who is responsible for investigating*

cases involving fraud, waste, abuse or misconduct by employees, contractors, sub-contractors, vendors and clients to the Director of Operations in the Administrative Services for the Health and Human Services (HHS) system.

- *March 01, 2006 - The HHS Director of Operations in Administrative Services for the Health and Human Services (HHS) system accepted and held meeting with the OIG to discuss the proposed written policy and procedures to identify the OIG-Internal Affairs Section roles and responsibilities in investigating cases involving fraud, waste, abuse or misconduct by employees, contractors, sub-contractors, vendors and clients.*
- *March 06, 2006 - The Internal Affairs Section Director and Manager met with the Manager of the HHS Building Facilities and the Director Operations in the Administrative Services for the Health and Human Services system to discuss the Internal Affairs Section proposed policy and procedures. The Director Operations in the Administrative Services assured the OIG that a request would be made for Enterprise approval of the OIG proposed policies and procedures to establish written roles and responsibilities in investigating and who is responsible for investigating cases involving fraud, waste, abuse or misconduct. The proposed policy was an attachment to this email.*

Estimated Completion Date:

April 2007

Title of Responsible Person:

Director, Internal Affairs Section.

- *OIG agrees with the SAO recommendation. As discussed with the auditors, the specific items identified as inaccurate were minor anomalies. As background, the Internal Affairs Sections (IAS) did not receive a computerized case management system from any legacy agency in the January 2004 HHS agency consolidation. The case status reports referenced in the SAO findings was developed and initiated by the IAS to inform the agencies of the cases that were received through both internal and external complaints.*

In January 2006, the IAS began to develop and design a “Case Management System”, which provides benefits and meets the needs of the IAS to track investigative activities and provide the HHS agencies with accurate investigative status updates.

Estimated Completion Date:

May 1, 2007

Title of Responsible Person:

Director, Internal Affairs Section

- *OIG agrees with the SAO recommendation to the extent that it reiterates the lines of communication with and periodic updates of Audit Section's activities to HHS agencies that already exist in a variety of ways. Since this finding only appeared in the final draft of the SAO report and was not communicated to the OIG during the course of the audit, OIG believes the information presented below provides sufficient, competent, evidential support to convey the level of regular communications and periodic updates of activities between the Audit Section and the HHS agencies and internal auditors. The level of communication has even increased since FY 2006, after the Audit Section underwent significant growth and changes, including staffing two new units and expanding existing units by recruiting 40 new staff, a 51% increase. The Audit Section was able to develop functions that have been areas of interest to HHS agencies and the internal auditors which did not exist prior to the 79th Legislature approving additional staffing for the Audit Section.*

The existing units have established, well documented, and effective relationships with the HHS agencies, including HHSC Internal Audit. The new units are continuously evolving these relationships with both internal and external Stakeholders. One example would be the newly staffed Medicaid/CHIP Audit Unit (MCAU) which even prior to receiving permanent staff, provided the enterprise internal audit directors copies of its FY 2006 audit plan. The MCAU also participated in an enterprise-wide risk assessment of the Medicaid Program along with all of the enterprise internal audit departments. Additionally, the MCAU attends regular scheduled recurring meetings with the Medicaid Program and Children's Health Insurance Program (CHIP) management to coordinate the oversight of external audit contracts and provide updates on Audit Section activities. Another example would be the newly formed Outpatient/MCO Audit Unit (OMAU) which immediately began attending regular meetings with the Texas Medicaid Healthcare Partnership (TMHP) Audit Department and the HHSC Rate Analysis Division (RAD) staff to coordinate efforts and identify risks. In addition, the OMAU has made presentations, along with RAD staff, to interested provider groups.

The Audit Section takes its responsibilities seriously and agrees that open communication and strong relationships with the HHS agencies and the public are essential to carrying out its mission. As a result, special care was taken to establish written protocols and processes for all established functions and to provide information about the OIG and the Audit Section

to provider organizations. The remaining Audit Section Units communicate and interact with HHS agencies as follows:

Subrecipient Financial Review Unit (SFRU)

- The SFRU coordinated and held monthly then quarterly meetings with the HHS agency staff to develop and document in a written form protocol for each participant in the single audit review process. These meetings are supported by written agendas and memos describing specific resolutions by all parties that attended the meetings. The responsibility for other monitoring functions and the clarification of the Audit Section's functions are contained in the January 20, 2005, Action Memorandum for the Executive Commissioner.*
- The SFRU developed the Single Audit Database for effective real time communication and updates of audit activities to the HHS agencies and subrecipients. HHS agencies have read only access to this database to monitor the status of each subrecipient's desk review.*
- Upon completion of a desk review on the single audit reports submitted by a subrecipient, the SFRU issues a Management Decision Letter to the subrecipient and sends a copy to the HHS funding agencies, the internal auditors of each funding agency, other non-HHSC agencies that funded the same subrecipient, and to the HHSC Internal Auditor.*
- Upon completion of a quality control review of the working papers of the subrecipient's certified public accountant (CPA), the SFRU sends a copy of the quality control review report to the CPA, subrecipient, HHS funding agencies and its internal auditor, and the HHSC Internal Auditor.*
- On a regular basis, some of the HHS agencies staff request technical assistance or other clarifications on certain matters related to other issues – including information on Single Audit requirements.*
- The SFRU has provided periodic updates on the status of the consolidated single audit review process to the Federal Auditors of the HHSC Special Nutrition Programs Administrative Management Services.*
- The single audit work of the SFRU is known to have prevented or mitigated instances of statewide audit findings in the past, because of audit evidence and updates provided by the SFRU to the auditor contracted to perform the federal compliance work on the statewide audit.*

Cost Report Review Unit (CRRU)

- *The CRRU meets regularly, in the past weekly and now at least monthly with the Rate Analysis Division (RAD) to establish timelines for the completion of desk reviews and field audits. These meetings are supported by written agendas and minutes describing specific action items and agreed upon decisions. Status reports are shared regarding current and upcoming projects. Written workload plans are developed and communicated between the CRRU and RAD management. Additionally, meetings are conducted as needed, to discuss changes in processes, sampling methodology, potential risks associated with various programs and/or to discuss specifics about program cost report instructions and Texas Administrative Code (TAC).*
- *The Team Leaders and other audit staff communicate directly with rate analysts about questions that concern the Automated Cost Report Evaluation System updates.*
- *Copies of audit reports are distributed to the internal audit directors and to the funding agency contact who manages the contracts with each provider group. Team Leaders communicate with management at the Department of Aging and Disability Services (DADS) to discuss potential findings related to programs that are managed within the agency. Other communication occurs with the providers on a real-time basis as needed, to request information regarding cost reports, to communicate potential findings and obtain feedback, and to provide a final field audit report.*
- *The Audit Section coordinated a meeting of attorneys from all HHS agencies to discuss protocol for requesting assistance with the appeal and hearing processes related to cost report audits and reviews.*

Contract Audit Unit (CAU)

- *The CAU established a documented protocol for requesting Intermediate Care Facilities (ICF) Trust Fund Audits with DADS contract management. The CAU meets annually with the DADS ICF/MR staff to discuss the agreed upon procedures for the audits of ICFs and to resolve any other issues that may have arisen during the course of the year. Periodic updates are provided by both parties through e-mails and telephone calls on a regular basis.*
- *The CAU coordinates with the Vendor Drug Program (VDP) regional pharmacist and technicians for the purpose of achieving efficiencies in testing of high dollar claims and brand name only prescriptions, and to gather input on pharmacies that are considered to be high risk. The CAU also meets with the VDP staff, when needed, to obtain*

clarification and/or interpretation of certain TAC rules, and to participate in the informal hearing process.

- In preparing the FY07 risk assessment, HHS internal audit shops (IA) were contacted for input to identify risk factors and to avoid duplication of efforts. Contracts that will be reviewed by IA are excluded from the CAU's risk assessment.*
- The appropriate HHS agency and IA are issued a copy of all audit reports, unless they request, otherwise. The CAU makes referrals to the appropriate IA when there are opportunities to improve HHS agency processes in areas where deficiencies are noted during an audit.*

On a variety of occasions, HHSC agencies have requested the Audit Section to assist them in conducting special reviews of a provider to support the state's legal proceedings on such provider, and/or assist them in reviewing the financial records of providers in the area that the funding agencies lack expertise. Additionally, the Audit Section provided technical assistance to DADS in the Nursing Facility Financial Viability Project.

As stated above, this finding only appeared in the final draft of the SAO report. OIG believes the information presented above conveys that substantial periodic updates of activities between the Audit Section and the HHS agencies and internal auditors are occurring. The Audit Section will continue its efforts in this area, as in prior years, to ensure that open communication and strong relationships exist with the HHS agencies and the public.

Estimated Completion Date:

November 3, 2006 – OIG will continue to provide periodic updates to HHS agencies.

Title of Responsible Person:

Director, Audit Section

Auditor Follow-up Comment

On August 15, 2006, and August 17, 2006, the need for improved communications between the Audit Section and the five health and human services agencies was communicated to the Audit Section Director and executive management. During those meetings, it was communicated that the health and human services agencies did not feel that the Audit Sections communications were adequate.

The Third-Party Resources Line Item in the *Office of Inspector General Semi-Annual Report* to the Governor and Legislative Budget Board Should Be Clarified

Semi-Annual Report

The OIG prepares a semi-annual report that includes a narrative of OIG's activities, as well as tables documenting the number of complaints received, the number of cases investigated, and the resulting costs recovered or avoided.

The report is provided to the Legislative Budget Board and the Governor's Office. The report is also made available to the public on the Health and Human Services Commission's Web site.

The *Office of Inspector General Semi-Annual Report* could be improved by clarifying the Third-Party Resources line item and enhancing processes used to verify reported amounts and estimated savings. The changes include:

- Clarifying the Third-Party Resources line item.
- Improving the process in place to verify that the amounts reported in the semi-annual report agree with the source information.
- Documenting and reviewing the methodology used to establish a rate used in the semi-annual report.

The cost recovery line item entitled "Third-Party Resources" does not include funds that were actually paid out by the State.

Although there is no definition for cost recovery in related federal or state regulations, external users would benefit from some explanation and additional clarification of this line item because of the complex nature of cost recovery.

The "Third-Party Resources" line item in the semi-annual report's cost recovery table, for example, includes dollars that were paid out by a third

Third-Party Resources

Third-party resources are reported as either a cost recovery or a cost avoidance in the OIG's semi-annual report.

The semi-annual report defines a cost recovery as actual collections, recoupments, or hard dollars saved by the OIG. A cost avoidance is a reduction to a state expenditure that would have occurred, or was anticipated to occur, without OIG intervention.

Third-party resources' cost recoveries accounted for 73 percent (\$323 million) of OIG's total cost recoveries in fiscal year 2005 and 81 percent (\$178 million) in the first half of fiscal year 2006.

Source: *Office of Inspector General Semi-Annual Report* for fiscal year 2005 and the first half of fiscal year 2006.

party. It does not represent dollars that were paid by the State and later recovered. For instance, if a Medicaid-eligible recipient is involved in a car accident and the car insurance company pays the recipient's medical bills (as opposed to Medicaid paying the bills), the dollars paid by the car insurance company are reported in the semi-annual report as a cost recovery rather than as a cost avoidance. The OIG chooses to report this type of savings as a cost recovery rather than a cost avoidance because these resources represent a direct reduction in Medicaid claims and are hard-dollar savings to the program.

Additionally, the process to identify the amount reported as a cost recovery is a coordinated effort between the OIG and the State's Medicaid claims processor, an outside contractor.

Although the Third-Party Resources line item is defined in the Recovery and Cost Avoidance Statistics section of the report, to reduce potential confusion, external users would benefit from an explanation defining the "Third-Party Resources" line item in the cost

recovery table and a clarification of the parties involved in the identification of the dollars involved.

The OIG did not always have a process in place to verify that the amounts reported in the semi-annual report agree with the source information.

Although the OIG has a process to compile the amounts reported in the semi-annual report, this process did not always include verifying that reported amounts agree with the source information for all sections. The State Auditor's Office reviewed 82 percent of the cost recovery and cost avoidance amounts reported for fiscal year 2005 and the first half of fiscal year 2006 and found that they did materially agree with the source information, with one exception. Additionally, the Income Eligibility Verification System (IEVS) cost avoidance rate was established incorrectly (see next section for additional details).

The reported sanctions cost recovery amount of \$46.8 million was overstated by \$13 million, or 39 percent, in the semi-annual report for fiscal year 2005. The amount reported included the cost recovery amounts for both sanctions and civil monetary penalties. The civil monetary penalties, however, were also reported as a separate line item.

**Income Eligibility Verification
System Data Matches
Cost Avoidance Rate**

The Income Eligibility Verification System (IEVS) data matches cost avoidance rate was established by a study conducted by the OIG.

The study consisted of a sample of 373 cases. The OIG researched each case to establish the cost avoidance for each case within the sample. The total cost avoidance was then divided by 373, the total number of cases.

The resulting cost avoidance rate was \$74.92. The IEVS's data matches cost-avoidance total is then calculated by multiplying the number of action notices generated to the eligibility case workers by \$74.92.

Source: *Office of Inspector General Semi-Annual Report* for the first half of fiscal year 2006.

The State Auditor's Office reviewed four line items⁵, which accounted for 87 percent of the \$661 million of total cost recovery amounts in the semi-annual reports for fiscal year 2005 and the first half of fiscal year 2006. As noted in the preceding paragraph, the fiscal year 2005 sanctions cost recovery amount, which accounted for 11 percent of the total fiscal year 2005 cost recovery amount, did not agree with the source information.

The SAO also reviewed three line items⁶, which accounted for 75 percent of the approximately \$540 million of the cost avoidance amounts in the semi-annual reports for fiscal year 2005 and the first half of fiscal year 2006. Of the three line items reviewed, there was one that was incorrectly reported as noted in the following paragraph.

The OIG did not have a documented methodology or an established review process for the IEVS data matches cost avoidance rate.

The OIG did not review the results of the study used to establish the IEVS cost avoidance rate (see text box). As a result, the IEVS cost avoidance rate is

⁵ Sanctions; Civil Monetary Penalties; Third-Party Resources; and Technology Analysis, Development and Support cost recovery line items.

⁶ Third-Party Resources; Income Eligibility Verification System (IEVS) Data Matches (Food Stamp, TANF, and Medicaid Recipients); and Recipient Data Matches (Food Stamp, TANF and Medicaid Recipients) cost avoidance line items.

incorrect. The State Auditor's Office found that 3 of the 10 clients sampled from the study had overstated cost savings, which means that the total cost savings is incorrect.

Because the rate is incorrect, the IEVS cost avoidance in the semi-annual reports for fiscal year 2005 and the first half of fiscal year 2006 are incorrect as well. The IEVS cost avoidance reported in both fiscal year 2005 and the first half of fiscal year 2006 was less than 1 percent of the reported cost avoidance.

Additionally, the methodology used to calculate the rate was not documented. As a result, the OIG could not recalculate the cost savings without conducting research.

Recommendations

The OIG should:

- Indicate in the Cost Recovery Table of the its semi-annual report:
 - Its definition of the Third-Party Resources line item.
 - The role of the State's Medicaid claims processor in identifying the Third-Party Resources cost recovery amount.
- Implement a process to verify that the amounts reported in the semi-annual report agree with the source information.
- Document its methodology and recalculate the IEVS data matches cost avoidance rate. The OIG should also review the results of the study before finalizing the rate.

Management's Response

- *The clarification requested by the SAO was for one line item, in one table, for Third Party Resources, in the Semi-Annual Report.*

At the time of the audit, OIG already explained how "Other Insurance Credits" are accounted for in the "OIG Recovery and Cost Avoidance Statistics" section of the Semi-Annual Report. This explanation has now been expanded for the latest Semi-Annual Report. It now states:

"Third Party Resources (TPR) other insurance credits, represent insurance collections made by the provider as a result of known other insurance information. OIG includes this category of recoveries because these are actual savings which are measurable by TPR. A claim may still receive payment, unlike the cost-avoided figure, and we report other

insurance credits as part of the recovery figures to the Centers for Medicare and Medicaid Services (CMS) on the federal CMS 64.9 report required quarterly.”

The table titled “OIG Recovery Activity” will also be footnoted with a short version of this explanatory note. The decision to include other insurance credits as a recovery is governed by industry standards.

Finally, the OIG understands that the complex relationships involving contractors can be confusing. We have well developed policies and defined roles for our interactions with the State Medicaid claims processor. We appreciate the opportunity identified by the SAO recommendation and will include language in our Semi-Annual reports explaining the Medicaid processor’s roles.

Estimated Completion Date:

November 3, 2006 – Included in draft semi-annual report for state fiscal year 2006, pending publication.

Title of Responsible Person:

Deputy Inspector General for Operations and Chief Operating Officer

- *As discussed and documented during the SAO audit, the OIG process of reviewing the Semi-Annual Report begins from the time data are gathered for compiling the report (approximately 10 days after the end of the State Fiscal Year), to the time of issuance of the report. The step-by-step processes are as follows:*
 - *Each section of the OIG (Quality Review, TADS, Audit, TPR, Sanctions, MPI, General Investigations, and State Investigations Unit) is responsible for updating their quarterly numbers into the Word table created and stored on the common automated system drive.*
 - *The Manager of each section verifies the accuracy of the data entered by tracing it to the source documentation, validates the timeliness of the data entered, and provides an explanation of any significant variations or updates to the data.*
 - *The Manager confirms on an annual basis, the source and procedures used in obtaining the data.*
 - *The quarterly data is then added to the semi-annual report in Excel for automatic calculation of financial and numerical information.*
 - *The Operations staff verifies the accuracy of the Excel formulas used in the report and the numbers each section provided by adding the totals for each quarter and year-to-date in the Excel report.*

- *The Operations staff crosschecks that the reported numbers in the Recovery Activity and Cost Avoidance tables match the numbers reported in section summary tables, and the numbers in the text portion of the report to ensure consistency with the numbers in the tables.*
- *The Operations staff crosschecks a second time, the numbers in the tables by adding the totals for each quarter and year-to-date. If there are any discrepancy, questions, and/or concerns, the operations staff discusses the data in question with the appropriate Section Manager. If necessary, detailed explanations will be added to the Semi-Annual Report, either in the text or as a footnote.*
- *After the operations staff has completed their initial review of the numbers, the Deputies are provided a copy of the report for review. The Deputies provide feedback either electronically or in a hard copy for their designated sections. Upon completion of the Deputies reviews, the Operations staff make any necessary changes provided, and then route a copy of the report to the Deputy Inspector General and Inspector General for their final reviews.*
- *After approval by the Inspector General, the report is submitted electronically to the HHSC Executive Clerk, for review by the Executive Commissioner and other delegated staff. Any edits or changes received from the HHSC Executive Commissioner will be incorporated into the report, and a revised Semi-Annual Report will be resubmitted to the Inspector General, and upon his approval, sent to the HHSC Executive Clerk. Upon final approval by the Executive Commissioner, the Semi-Annual Report is submitted for on-line posting at (http://www.hhs.state.tx.us/OIG/OIE_Reports.asp), and copies are made and distributed according to the statute and to appropriate internal and external stakeholders. The copies of the distributed reports are maintained at the OIG and available upon request. The distribution list is maintained by the operations staff and updated periodically as deemed necessary.*

However, OIG agrees with the opportunity raised by the SAO to improve our review process of the Semi-Annual Report.

Estimated Completion Date:

November 3, 2006 – These procedures were followed for the draft semi-annual report for state fiscal year 2006, pending publication.

Title of Responsible Person:

Deputy Inspector General for Operations and Chief Operating Officer

- *The OIG already has a documented methodology of how the cost avoidance was determined, and reestablished the exact method used to develop the amount of savings determined for each case in the sample. It is OIG's plan to conduct a new study with complete documentation in the future. However, it is important to note that the OIG and SAO discussed this matter during the course of the audit and agreed that the amount of error in the study represents less than two-tenths of one percent of the total cost savings reported by OIG, if the error is extrapolated to the full population. Consequently, the error carries no significant risk of misstatement or otherwise, considering that the number involved is only an estimate.*

Estimated Completion Date:

September 2007

Title of Responsible Person:

Director, General Investigation Section

Information Technology Controls at the Health and Human Services Commission and the OIG Do Not Always Ensure Accurate and Complete Information or Protect All the Information from Unauthorized Access

To minimize the risk associated with public disclosure, this report summarizes the weaknesses in information technology security identified during the audit, but it does not reveal specific vulnerabilities. State law (Texas Government Code, Section 2059.55) stipulates that confidential network security information only be released to officials responsible for the network and to agency officials.

The data that is at risk is highly confidential. The following issues increase the risk of unauthorized access:

- A lack of data integrity in two systems used to investigate waste, fraud, and abuse.
- Weaknesses in access controls that place the data within the systems at a high risk of unauthorized access.

Other information technology weaknesses identified include:

- The absence of either a business continuity or disaster recovery plan.
- The storage of OIG backup tapes on site, rather than off site.
- Inaccurate and incomplete cost calculations for a new information system.

Chapter 5-A

The Health and Human Services Commission Does Not Properly Restrict Access to Certain Systems and Does Not Have Proper Audit Trails to Monitor Changes to System Access

The Health and Human Services Commission's access controls did not provide adequate protection for the information systems the OIG uses to detect fraud, waste, and abuse. Issues were found in the following areas:

- Account management.
- Network operations.
- Password and account login configuration.
- Audit logging.

Recommendation

The Health and Human Services Commission should address the vulnerabilities in access controls and implement the recommendations from the information technology review.

Management's Response

Some of the recommendations relating to account management, network operations, and password and account login configuration are already addressed, with action plans under development to address the remaining issues. The audit logging recommendation will be implemented by April 2007, with the deployment of the complete ASOIG application and Novell Identity Manager.

Estimated Completion Date:

August 2007

Title of Responsible Person:

- *Commission IT/Director, Commission Application Development and Maintenance*
- *Enterprise IT/Infrastructure Management & Operations/Distributed Systems/IT Manager, Enterprise Database Services*

Chapter 5-B

The OIG Does Not Have Detailed Forms or Procedures to Grant Application Access to the Automated System of the Office of Inspector General

The OIG does not document the level of access granted to the Automated System of the Office of Inspector General (ASOIG) application. Documented

The Automated System of the Office of Inspector General

The Automated System of the Office of Inspector General (ASOIG) is used by the OIG investigators and client eligibility staff. The system currently includes the Reported Income Discrepancy Examination System, which allows for the distribution, investigation, clearance, and storage of external income discrepancies used to investigate recipient fraud for the Food Stamp, TANF, and Medicaid programs.

forms provide evidence that an employee's access was approved as required in Title 1, Texas Administrative Code, Section 202.21, and should detail what level of access the employee was granted. Although there is a form documenting the right to access the initial web application login page, it does not include the specific application level access extended to a specific employee. Procedures along with a form would help ensure that access to the application is granted to the appropriate employee. Additionally, procedures governing access are important because multiple areas share responsibility for and have the ability to grant access to the application, increasing the risk of a user being

granted inappropriate access for this application, which contains highly confidential tax information.

Recommendations

The OIG should ensure forms and procedures for granting access to the ASOIG are accurately documented and used to grant access.

Management's Response

OIG agrees with the SAO recommendation, however there are policies in place and outlined in the Office of Inspector General Online Procedure Guide to request access to ASOIG/RIDES. Individuals, who request access to RIDES which contains the IEVS data, must complete an HHSC Form 4743 Request for Application and System Access and sign the IRS portion of the HHSC Form 4014 Computer Security Agreement, noting the date the 4014 was signed on the 4743. The forms are reviewed and approved by a manager who determines the system permission level. Managers enter the forms in Security Administration System (SAS) for tracking and assignment of the request to HHSC Enterprise Help Desk. HHSC Enterprise Help Desk completes the request providing Non-IEVS Worker access. When additional ASOIG functionality is required for a new OIG user, a request is sent to the ASOIG security administrator.

Estimated Completion Date:

November 3, 2006 – Forms and procedures are accurately documented and in use.

Title of Responsible Person:

Director of General Investigations Section

Chapter 5-C

The Health and Human Services Commission and the OIG Do Not Have Required Controls to Help Recover from a Disaster

The Health and Human Services Commission or the OIG should improve information technology in three areas. Specifically, there is an absence of either a business continuity or disaster recovery plan, the OIG backup tapes are not stored off site, and accurate and complete budgeted and actual cost information for a new information system was not calculated.

The Health and Human Services Commission and the OIG do not have a disaster recovery or business continuity plan to help recover operations in the event of a disaster. A documented disaster recovery plan or business continuity plan would help provide the necessary information to allow for the restoration of the information technology resources and continue the actual business functions

of the OIG and the Health and Human Services Commission. A disaster recovery plan and business continuity plan are required by Title 1, Texas Administrative Code, Chapter 202, and are critical to restoring the operations of the Health and Human Services Commission should a disaster occur. It should be noted that the Health and Human Services Commission hired a consultant to design both a disaster recovery plan and business continuity plan.

The OIG backup tapes are not stored off site. The OIG is storing the backup tapes for its servers located at the facility on the premises. If the facility were destroyed, the OIG would not have backup tapes to restore the servers and data allowing it to continue operations. It is critical to ensuring the continuity of business operations to have the backup tapes for the servers stored off site. In the event that the facility was destroyed, the OIG could establish an alternate operating site, recall and load the backup tapes to restore the data, and resume operations.

The Health and Human Services Commission does not maintain accurate and complete cost information for the new ASOIG in development. The initial 2003 budgeted cost information for the ASOIG in development contained only staff hours that ranged from 11,000 to 30,000 hours, with no rate information to estimate total cost. The staff hours would be for a mix of development, functional, and other staff who would likely have different cost rates. The initial budget did not include any hardware, software, or database costs associated with the system that is currently hosted on two servers at the Health and Human Services Commission. In addition, the budget did not include the development and test environments.

Additionally, the actual costs reported for the project include 19,530 hours of staff time at \$50 an hour with the following caveat: "The cost figures differ greatly depending on the point-in-time of the report or data extraction." These cost figures also did not include any hardware or software costs. Without accurate numbers, it is not possible to accurately report financial information, measure performance, or help evaluate the success of the project.

Recommendations

The OIG should:

- Establish a disaster recovery plan and a business continuity plan.
- Store back-up files off site and ensure they are properly protected.
- Work with the Health And Human Services Commission to capture the complete budget and actual cost calculations for its new information systems.

Management's Response

- *The ASOIG application, which is the primary focus of this audit, resides on two servers maintained by HHS Enterprise IT. Current disaster recovery, business continuity, and data backup procedures are as follows:*
 - *Both servers are backed up nightly and tapes are rotated offsite in a routinely scheduled pickup.*
 - *Disaster Recover is Tape Centric with a Recovery Time Objective of 72 hours and a maximum Recovery Point Objective of 48 hours.*
 - *Recovery of the application will be to a cold site where equipment will be obtained via salvage, redistribution, vendor acquisition or lease.*
 - *DIR maintains and manages the network and will provide network capabilities following a disaster.*

In April 2007, the ASOIG application is scheduled to be moved under the management and maintenance of the OIG. In preparation for this transfer, OIG is currently purchasing and testing hardware and software and developing disaster recovery, business continuity, and backup plans and procedures. These plans and procedures will cover all servers and applications maintained by OIG.

OIG applications on servers maintained by Commission IT Operations have data backup procedures in place. Commission IT is currently developing a disaster recovery plan that will include this server environment.

Estimated Completion Date:

April 2007 – ASOIG in production at OIG data center and disaster recovery, business continuity, and backup procedures in place

Title of Responsible Person:

- *Commission IT, Director IT Application Development and Maintenance*
- *Director, Technology Analysis, Development, and Support Section*
- *OIG agrees with the SAO recommendation. OIG has procured a fire safe to protect any and all materials, backup tapes, and equipment critical to the preservation of our data. This fire safe is state of the art, weighing 700 lbs and protects to temperatures of 1000 degrees for up to 7 hours. OIG is currently coordinating with the HHSC Disaster Recovery Manager to provide offsite storage via a Full time HHSC employee who works at the*

offsite storage location. In addition, OIG will have a fire suppression system installed in FY07.

Estimated Completion Date:

April 2007

Title of Responsible Person:

Director, Technology Analysis, Development, and Support Section

- *OIG agrees with the SAO recommendation. Historically, the actual tracking of budget and cost allocations has been the responsibility of HHSC. OIG will coordinate with HHSC to determine a methodology for capturing the costs of OIG's new information systems that have already been incurred and the remaining budget amounts. Establishing costs will include consideration of the value of this effort, given limited historical information. HHSC has established procedures to ensure remaining budgets and costs for OIG information systems are accurately and fully captured from September 1, 2006 forward.*

Estimated Completion Date:

December 2006 – Budget and cost methodology and evaluation of prior costs.

Title of Responsible Person:

- *Director, Commission IT Application Development and Maintenance*
- *Director, General Investigations Section*

Appendices

Appendix 1

Objectives, Scope, and Methodology

Objectives

The objectives of this audit were to determine whether:

- The Health and Human Services Commission's Office of Inspector General (OIG) is investigating fraud, waste, and abuse as intended by House Bill 2292 (78th Legislature, Regular Session).
- The OIG maintains complete and accurate records of complaints and investigations in the Waste, Abuse, and Fraud Electronic Reporting System (WAFERS).
- The OIG is effectively coordinating and communicating with sister agencies and departments such as the Office of the Attorney General, the Rate Analysis Division, and programmatic contract monitors.

Scope

The scope of this audit covered the OIG's activities from January 2004 (when the OIG was created) through June 2006. The audit included the activities and communications of the OIG's provider and recipient fraud sections, as well as the communications and activities for the Internal Affairs and Audit Sections. The audit did not include the Quality Assurance Section. The audit did not include an audit of the automated systems used to track recipient and provider fraud—Medicaid Fraud Abuse Detection System, OIG Claims Integrated System (OCIS), Case Management System—because the provider system is maintained by an external contractor and the recipient systems will be replaced in April 2007. Objective 2 was not included in the audit because the WAFERS system did not track all cases as was originally understood.

Methodology

The audit methodology consisted of collecting information and documentation, performing selected tests and other procedures, analyzing and evaluating the results of the tests, and conducting interviews with the OIG's management and staff and staff from the five health and human services agencies.

Information collected and reviewed included the following:

- The OIG's provider overpayments and fraud investigations from January 1, 2004, through May 22, 2006.

- The OIG's Internal Affairs data from the Case Management System access database through May 12, 2006.
- The OIG's documentation regarding communications between the Audit Section and health and human services personnel.
- The *Office of Inspector General Semi-Annual Report* for fiscal year 2005 and the first half of fiscal year 2006.
- The OIG's support for the *Office of Inspector General Semi-Annual Report* from Compass 21, the Medicaid claims processing system, MFADS (the data warehouse used to track provider cases).
- Reports and the related data from the Reported Income Discrepancy Examination System (RIDES) from September 2004 through June 2006.
- Reports and the related data from the OIG Claims Integrated System (OCIS) from September 2004 through May 2006.
- Reports and the related data from the General Investigation's Case Management System from January 2004 through March 2006.
- A list of audits completed and started from September 2004 through April 14, 2006.

Procedures and tests conducted included the following:

- Analyzed the provider and recipient data.
- Compared the information reported in the OIG's semi-annual reports for fiscal year 2005 and the first half of fiscal year 2006 to the source information.
- Reviewed a sample of provider and recipient fraud cases.
- Reviewed internal controls.
- Interviewed staff and management.
- Interviewed personnel from external agencies, including the Office of the Attorney General, the Department of State Health Services, the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, the Health and Human Services Commission, and the Department of Family and Protective Services.

Criteria used included the following:

- House Bill 2292 (78th Legislature, Regular Session).
- Code of Federal Regulations.

- Texas Statutes and Texas Administrative Code.
- The OIG's policies and procedures.

Project Information

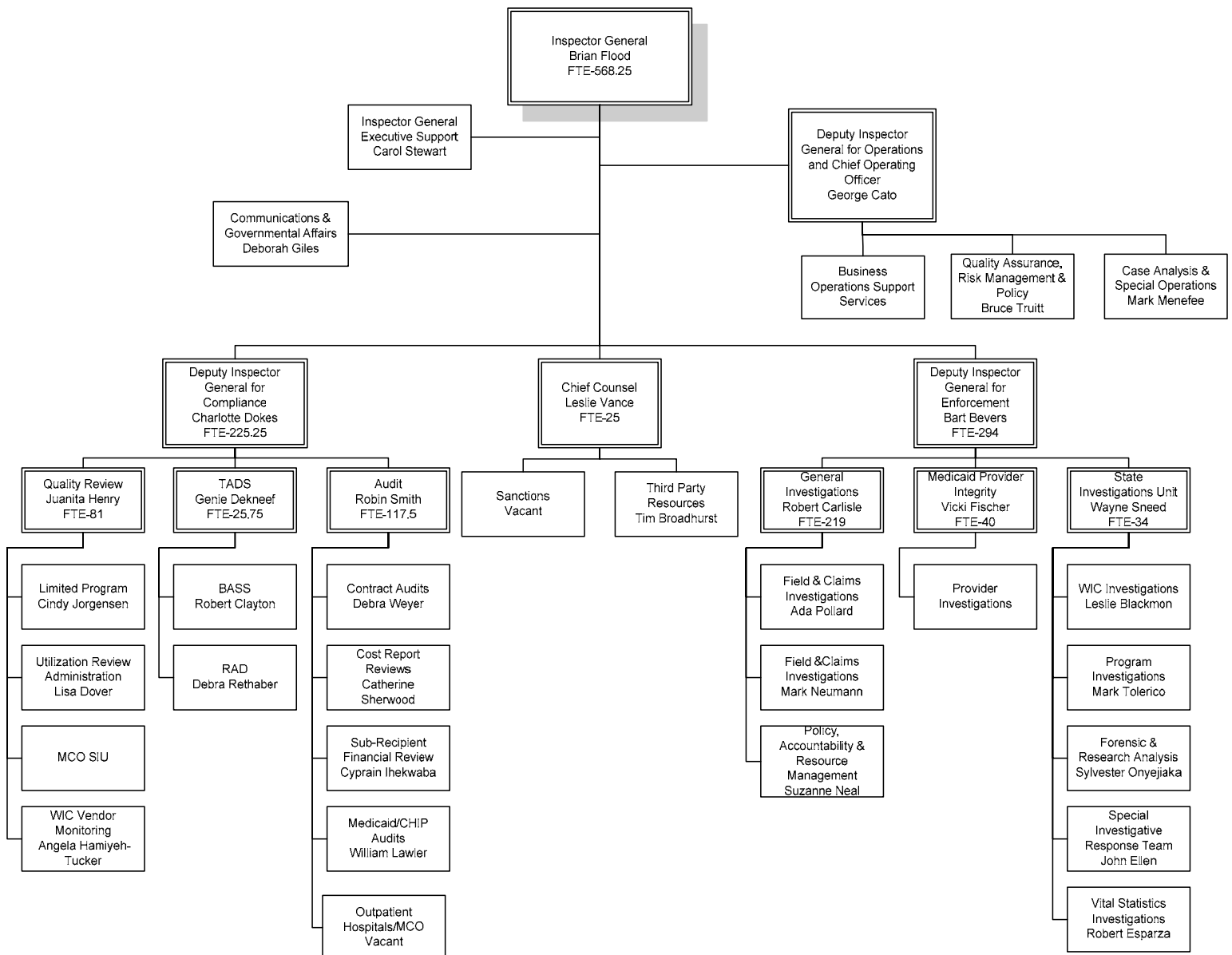
Audit fieldwork was conducted from March 2006 through August 2006. This audit was conducted in accordance with generally accepted government auditing standards.

The following members of the State Auditor's staff performed the audit:

- Angelica Martinez, CPA (Project Manager)
- Ann Paul, CPA (Assistant Project Manager)
- Nicole Elizondo
- Christine Henderson
- Stephen Garza
- Stephen Randall, MBA
- Sherry Sewell, CGAP
- Michael Yokie, CISA
- Leslie Ashton, CPA (Quality Control Reviewer)
- John Young, MPAff, CGAP (Audit Manager)

OIG Organizational Structure

The OIG has 568 full-time equivalent (FTE) employees according to their organizational charts. The Enforcement area investigates provider, recipient, and employee fraud, waste, and abuse for the health and human services agencies. Some of the programs investigated include Medicaid, Food Stamp, and Temporary Assistance for Needy Families. The Compliance area is responsible for conducting audits, analyzing Medicaid claims, and conducting other statutorily required functions.



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The Honorable Tom Craddick, Speaker of the House, Joint Chair
The Honorable Steve Ogden, Senate Finance Committee
The Honorable Thomas “Tommy” Williams, Member, Texas Senate
The Honorable Jim Pitts, House Appropriations Committee
The Honorable Jim Keffer, House Ways and Means Committee

Office of the Governor

The Honorable Rick Perry, Governor

Health and Human Services Commission

Mr. Albert Hawkins, Executive Commissioner
Mr. Brian Flood, Inspector General



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