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An Audit Report on

**Medicaid Fraud Control Activities
at the Office of the Attorney
General**

August 2008
Report No. 08-040



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Overall Conclusion

The Office of the Attorney General (Office) investigates criminal and civil complaints of fraud, abuse, and neglect committed by health care providers in the Medicaid program.

The Office's Medicaid Fraud Control Unit (MFCU) is fulfilling its principal responsibilities by investigating and resolving criminal Medicaid fraud, abuse, and neglect complaints (see text box). MFCU effectively screens complaints about potential fraud and abuse committed by Medicaid providers. For fiscal year 2007, MFCU reported it:

- Concluded 528 investigations.
- Referred 413 cases for prosecution.
- Identified \$58 million in overpayments made to Medicaid providers.

The Office's Civil Medicaid Fraud Division (CMF) settled 24 cases between September 1, 2005, and May 5, 2008, for a total of \$131.2 million, according to auditors' calculations. CMF received additional appropriations for fiscal year 2008 to address the increasing number of lawsuits filed by private citizens, and it has developed a plan for and made progress in reducing the number of pending cases.

Although MFCU is investigating and resolving criminal Medicaid fraud, abuse, and neglect complaints, it should improve its processes for recording certain information about the complaints in the Office's automated Case Management System so that the Office can analyze the efficiency and effectiveness of MFCU's investigative processes.

Background Information

All state agencies were appropriated \$36.2 billion for the operation of the Texas Medicaid program during the 2006-2007 biennium.

The Office's Medicaid Fraud Control Unit (MFCU) conducts criminal investigations into complaints of fraud, physical abuse, and criminal neglect committed by health care providers in the Medicaid program. MFCU grew from 43 full-time equivalent employees and \$2.2 million in appropriations in fiscal year 2004 to 193 full-time equivalent employees and \$10.9 million in appropriations in fiscal year 2007.

The Office's Civil Medicaid Fraud Division (CMF) was instituted to investigate and prosecute civil Medicaid provider fraud cases, such as price-fixing on pharmaceuticals. CMF is projected to grow from 13 full-time equivalent employees in fiscal year 2007 to 54 full-time equivalent employees in fiscal year 2008. It has a budget of \$7.1 million in fiscal year 2008.

Sources: Office of the Attorney General and the Legislative Budget board's *Fiscal Size-up* for the 2006-2007 biennium.

Key Points

MFCU screens, investigates, and resolves criminal Medicaid fraud, abuse, and neglect complaints.

MFCU's Audit/Intake Section effectively screens criminal fraud, abuse, and neglect complaints to determine whether (1) the complaint falls within MFCU's jurisdiction and (2) there is sufficient information to pursue further investigation. In addition, MFCU is fulfilling its principal responsibilities by investigating and resolving potential Medicaid fraud, abuse, and neglect complaints. The Audit/Intake Section received more than 17,000 complaints about abuse and neglect from the Department of Aging and Disability Services (DADS) in fiscal year 2007. Complaints also are received through the U.S. mail, by e-mail and telephone, and from other state and federal entities; they also may be developed internally. During fiscal year 2007, a total of 906 complaints were opened in the Audit/Intake Section's database.

CMF has reduced the number of pending civil cases and has identified \$131 million in settlements.

The number of lawsuits filed by private citizens related to civil Medicaid fraud has increased greatly in recent years due to the successful settlement of several lawsuits filed starting in 1999. As of August 31, 2007, the number of pending cases had increased to 185 pending cases. In fiscal year 2008, the Office received additional appropriations to help address this rapid growth in caseload. As of March 31, 2008, CMF had reduced the number of pending cases to 154. CMF settled 24 cases between September 1, 2005, and May 5, 2008, for a total of \$131.2 million.

MFCU should improve how it records dates related to investigations and prosecutions in its Case Management System.

MFCU does not consistently record the actual dates of significant case activities in the appropriate fields in its Case Management System. As a result, MFCU cannot ensure that reports or other information generated based on Case Management System data are accurate and complete. In addition, because accurate dates are not recorded in fields used to calculate performance measures, the Office's fiscal year 2007 reported results for four performance measures could not be certified. It is important to note that all the activities related to the four performance measures tested actually occurred.

Auditors also communicated less significant issues separately in writing to Office management.

Summary of Management's Response

The Office agrees with the recommendations in this report. Detailed management responses are included in the Detailed Results section of this report

Summary of Information Technology Review

MFCU's Case Management System needs improved functionality to fully support MFCU's day-to-day operations. Controls over the operation of the Case Management System do not provide assurance that the data is accurate, complete, and timely.

While the Office has effective general controls over some components of its technology environment, improvements are needed to ensure the protection and accuracy of data related to Medicaid fraud activities. Information technology weaknesses relate to security, system development, change management, and the Office's business continuity plan.

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

Summary of Objectives, Scope, and Methodology

The objectives of this audit were to:

- Determine whether the Office has controls to provide assurance that referrals of potential fraud by Medicaid providers are effectively and efficiently screened, investigated, and resolved.
- Determine the extent to which MFCU identifies funds subject to recovery by other entities.
- Determine whether automated systems that support MFCU, including its Case Management System, provide users with accurate, complete, and timely information, as well as the necessary functionality.
- Determine whether selected performance data, such as the amount of Medicaid overpayments identified, is accurate and complete.

- Provide information on the final resolution of cases, including the ultimate disposition of overpayments identified and the outcomes of cases referred for prosecution.
- Review the Office's plan for, and progress in, reducing the backlog of Medicaid fraud cases in CMF.
- Determine the extent to which CMF recovers funds and determine the allocation of recovered funds.

The scope of this audit covered fiscal year 2007. In addition, auditors reviewed selected case data from MFCU and CMF from fiscal years 2000 through 2008.

The audit methodology included collecting and reviewing information and documentation, conducting interviews with Office management and staff, performing selected tests, and analyzing and evaluating the results of testing and observations. In addition, auditors selected four performance measures the Office reported for fiscal year 2007; reviewed controls over the collection, calculation, and submission of data used in reporting performance measures; and traced performance measure documentation to the original source when available.

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Detailed Results

Chapter 1

The Medicaid Fraud Control Unit Screens, Investigates, and Resolves Criminal Medicaid Fraud, Abuse, and Neglect Complaints

The Office of the Attorney General (Office) investigates complaints of fraud, abuse, and neglect committed by Medicaid providers (see text box). Specifically, the Office's Medicaid Fraud Control Unit (MFCU) conducts criminal investigations into complaints of fraud, physical abuse, and criminal

neglect by Medicaid health care providers. Complaints include allegations of potential fraud or abuse, as well as referrals of allegations from other sources. The Office's Civil Medicaid Fraud Division investigates and prosecutes civil Medicaid provider fraud cases. (See Chapter 2 for more information on the Civil Medicaid Fraud Division and Appendix 2 for an organization chart.)

MFCU screens, investigates, and resolves complaints about potential fraud, abuse, and neglect committed by Medicaid providers. For fiscal year 2007, MFCU reported it:

- Concluded 528 investigations.
- Referred 413 cases for prosecution.
- Identified \$58 million in overpayments made to Medicaid providers.

MFCU effectively screens complaints about potential fraud and abuse committed by Medicaid providers. However, it should improve its processes for recording certain information

about the complaints—in particular, the dates of significant activity—in the Office's automated Case Management System so that the Office could analyze the efficiency and effectiveness of MFCU's processes (see Chapter 4 for more information).

MFCU comprises the following sections: the Audit/Intake Section, the Investigation Section, and the Prosecution Sections (see Figure 1 on the next page). The Audit/Intake Section effectively screens fraud, abuse, and neglect complaints to determine whether (1) the complaint falls within MFCU's jurisdiction and (2) there is sufficient information to pursue further investigation. If there is sufficient information to pursue, a case is opened and forwarded to the Investigation Section, which conducts further investigations and, if warranted, forwards the case to the appropriate Prosecution Section. The Prosecution Sections conduct additional review and coordinate the

Examples of Medicaid Fraud, Abuse, and Neglect Complaints Handled by MFCU

Medicaid fraud complaints include:

- Billing Medicaid for procedures or care that was never performed.
- Billing patients for services already paid for by Medicaid.
- Giving a patient a generic drug and billing for the name-brand version of the medication.
- Giving a recipient a motorized scooter and billing for an electric wheelchair chair, which can cost three times more.
- Transporting Medicaid patients by ambulance when it is not medically necessary.
- Requiring vendors to "kick back" part of the Medicaid money they receive.

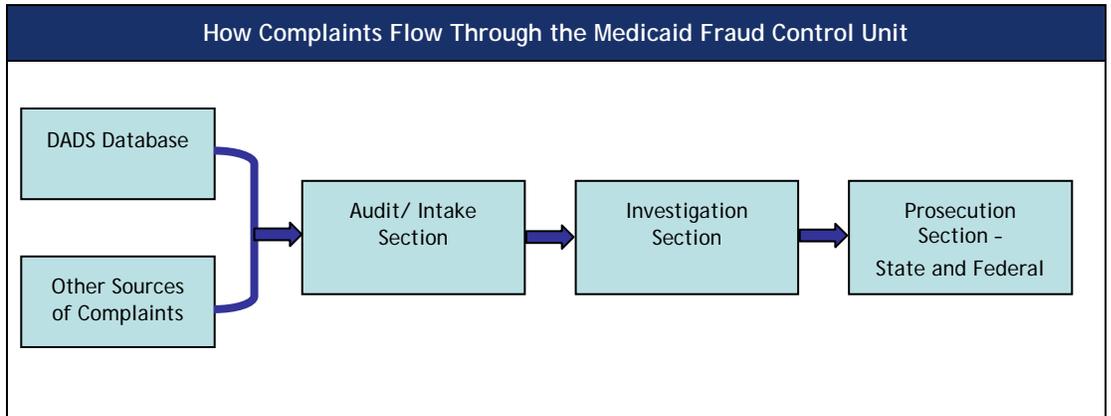
Medicaid abuse and neglect complaints include:

- Physical abuse.
- Sexual abuse.
- Criminal neglect.
- Drug diversion (theft of drugs intended for patients).

Source: Office of the Attorney General Web site.

presentation of the case to a prosecuting authority or, in some cases, conduct the prosecution themselves.

Figure 1



Chapter 1-A

MFCU Effectively Screens Complaints of Potential Criminal Fraud, Abuse, and Neglect Committed by Medicaid Providers

The Audit/Intake Section receives complaints regarding abuse and neglect from the Department of Aging and Disability Services (DADS). Complaints also are received through the U.S. mail, by e-mail and telephone, and from other state and federal entities; they also may be developed internally.

MFCU effectively screens abuse and neglect complaints received from DADS.

The DADS database contained more than 17,000 complaints of all types involving long-term care facilities in fiscal year 2007. DADS assigned these complaints a priority level from 1 (highest) to 4 (lowest). The Audit/Intake Section screens these complaints so that only the Medicaid complaints related to criminal violations (which include alleged abuse, neglect, exploitation, theft, or drug diversions) are electronically transferred to the Audit/Intake Section's database. Because priority 4 complaints rarely contain possible criminal violations, the Audit/Intake Section automatically closes these complaints. As Table 1 on the next page shows, only 193 of 17,851 (1.1 percent) complaints received from DADS in fiscal year 2007 were transferred into the Audit/Intake database for further review.

Table 1

Complaints Transferred from DADS Database to MFCU Database			
Fiscal Year 2007			
DADS's Priority Classification	Complaints Closed in the DADS Database (not transferred)	Complaints Transferred to Audit/Intake Database	Total Complaints in the DADS Database
1	1,066	53	1,119
2	7,495	106	7,601
3	3,803	34	3,837
4	5,294	0	5,294
Totals	17,658	193	17,851

Source: Audit/Intake Section's download of the DADS database.

The Audit/Intake Section effectively screened the complaints received from DADS. The Audit/Intake Section appropriately closed in the DADS database all 30 priority 1 complaints from fiscal year 2007 that auditors tested. Auditors tested an additional 30 of the 193 complaints in the DADS database that were designated for additional review, and all 30 complaints were appropriately transferred electronically into the Audit/Intake database.

MFCU effectively screens and closes fraud, abuse, and neglect complaints in its Audit/Intake database.

The Audit/Intake Section also screens fraud, abuse, and neglect complaints that MFCU receives from other sources. In fiscal year 2007, the Audit/Intake Section entered 906 complaints into the Audit/Intake database (this includes the 193 complaints received from DADS). Of these 906 complaints, 308 (34 percent) were closed because the complaints did not contain enough information, were referred to another agency, or were added to another complaint related to the same provider. The Audit/Intake Section appropriately followed its criteria for screening and closing cases in all 30 closed complaints that auditors tested.

Complaints that are not closed during the initial screening process are opened as a case in the automated Case Management System (CMS) for either preliminary or full investigation.

Chapter 1-B

MFCU Reported an Increase in the Number of Complaints Investigated and Referred for Prosecution

MFCU is fulfilling its principal responsibilities by investigating and resolving potential Medicaid fraud, abuse, and neglect complaints. The 78th Legislature appropriated additional funds and full-time equivalent positions to MFCU starting in fiscal year 2004 (see Appendix 4). As Table 2 shows, the total

number of cases opened, referred for prosecution, and closed by MFCU increased from fiscal year 2003 to fiscal year 2007. Based on data as reported in MFCU's Case Management System, MFCU referred 64 cases for prosecution in fiscal year 2003; in fiscal year 2007, it referred 413 cases for prosecution. The number of cases opened reflects the number of new cases opened during that fiscal year. The status of cases referred for prosecution is as of August 31, 2007 (see Appendix 5 for more information).

Table 2

Summary of Cases Opened, Closed, and Referred for Prosecution ^a					
Disposition of Case	Fiscal Year 2003	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007
Total Number of Cases Opened	155	329	715	802	734
Total Number of Cases Referred for Prosecution	64	124	119	274	413
Total Number of Cases Closed	150	145	366	522	518

^a Based on data as reported in MFCU's Case Management System. Auditors' analysis did not include cases that were under federal seal. Therefore, these totals may not match the numbers reported by the Office in the Automated Budget and Evaluation System of Texas, or ABEST, and the *Joint Semi-Annual Interagency Coordination Report* by the Office of the Attorney General and the Texas Health and Human Services Commission, Office of the Inspector General (HHSC-OIG).

Chapter 1-C

MFCU Reported \$58 Million in Identified Medicaid Overpayments in Fiscal Year 2007

MFCU reported that in fiscal year 2007 it identified \$58 million in overpayments made by the Medicaid Program. Because courts may not require repayment of the full amount of identified overpayments, MFCU recorded in CMS that a total of \$43.3 million in fines, restitutions, and investigation costs were ordered by courts in fiscal year 2007.

Medicaid Fraud in Health and Human Services Programs

The Office of Inspector General at the Health and Human Services Commission (HHSC-OIG) investigates complaints of waste, abuse, and fraud in all health and human services programs in Texas. HHSC-OIG refers criminal Medicaid provider fraud cases to the Office of the Attorney General's Fraud Control Unit. See Appendix 2 for more information.

The Office of Inspector General at the Health and Human Services Commission (HHSC-OIG) pursues overpayments that both it and MFCU identifies and records the monies collected. Because the Health and Human Services Commission does not specifically identify and separately record these monies in its accounting system, the amount actually collected related to overpayments identified by MFCU is not readily identifiable. The *Joint Semi-Annual Interagency Coordination Report* for March 1, 2007, to August 31, 2007, reported \$12.6 million in "sanction recoupments" for fiscal year 2007 by HHSC-OIG, which may include MFCU's identified amounts and Medicaid global settlements.

Recommendation

The Office should work with HHSC-OIG to develop a process to track the amounts collected that are related to overpayments identified by MFCU.

Management's Response

Management agrees. The MFCU will continue working with HHSC so that data is provided in a format that accurately and efficiently tracks collection of overpayments.

The Civil Medicaid Fraud Division Has Reduced the Number of Pending Civil Cases and Has Identified \$131 Million in Settlements

The Office's Civil Medicaid Fraud Division (CMF) investigates and prosecutes civil Medicaid provider fraud cases. CMF pursues cases filed by private citizens on behalf of the State, as well as cases investigated by the Office on behalf of the Medicaid program (see text box). The number of lawsuits filed by private citizens has increased greatly in recent years due to the successful settlement of several lawsuits filed starting in 1999. In fiscal year 2008, the Office received additional general appropriations to help address the rapid growth in CMF's caseload.

Civil Medicaid Fraud Division

The Office's Civil Medicaid Fraud Division (CMF) was instituted in fiscal year 1999 to investigate and prosecute civil Medicaid provider fraud cases under Chapter 36 of the Texas Human Resources Code, also known as the Texas Medicaid Fraud Prevention Act (Act). The Act permits private citizens to file lawsuits on behalf of the State against those who violate the Act. These private citizens are referred to as "relators" and they assist the State in identifying and pursuing fraudulent activity committed against the Medicaid program. Relators in successful matters receive a portion of the recovery. The Office also may pursue cases on its own on behalf of the Medicaid program.

Examples of civil Medicaid fraud include (1) various pricing schemes, such as failure to provide correct drug pricing information to the Medicaid program, that cause Medicaid to overpay for prescription drugs and (2) misrepresentations to Medicaid about the safety and effectiveness of a drug.

Source: *Joint Semi-Annual Interagency Coordination Report* by the Office of the Attorney General and the Texas Health and Human Services Commission, Office of the Inspector General (HHSC-OIG) for March 31, 2007 to August 31, 2007.

CMF has reduced the number of pending cases.

CMF had one civil Medicaid case pending in 1999. As of August 31, 2007, the number of pending cases had increased to 185. As a guideline to manage the number of pending cases, as well as staffing increases, CMF created a *Draft Business Plan* in May 2007. The *Draft Business Plan* discusses prioritizing and categorizing the pending cases, however it contains minimal dates or timelines for accomplishing those goals.

As of March 31, 2008, CMF had reduced the number of pending cases to 154. This reduction was achieved in part by CMF initially screening all cases that had been pending for six months or more and making recommendations to either close the case or continue the investigation. As of March 31, 2008, CMF was in the process of prioritizing its 154 pending cases to identify which cases represented the best opportunity for recovering funds for the Texas Medicaid Program.

CMF is projected to grow from 13 employees in fiscal year 2007 to 54 employees in fiscal year 2008. In April 2008, the Civil Medicaid Fraud Section was split from the Antitrust Division into a stand-alone division. The budget of the combined Antitrust and Civil Medicaid Fraud Division was \$1.9 million in fiscal year 2007; in fiscal year 2008, the budget for the stand-alone CMF was \$7.1 million.

CMF settled cases totaling \$131.2 million between September 2005 and May 2008.

Monies from settlements are allocated to the federal government, the Office, the Health and Human Services Commission, and, if applicable, the private citizen(s) who filed the lawsuit. CMF settled 24 cases between September 1, 2005, and May 5, 2008, for a total of \$131.2 million. For the same time period, CMF reported it participated in settlements worth \$130.7 million—a

difference of approximately \$500,000. The primary reason for this difference is that CMF did not record the interest received on its internal tracking spreadsheet. Of these settlements, the Office and the Health and Human Services Commission received a total of \$50.2 million.

Not all settlements flow through the Office for allocation. Of the 24 settlements, 21 totaling \$61.1 million were allocated through the Office's accounting system. Auditors tested all 21 settlements, and 98 percent of the total line items were properly coded in the accounting system. In order to allocate the settlements, CMF created a revenue allocation form that lays out the allocations for the settlement amounts and destination, as well as all other case information and executive approval. CMF does not have written policies and procedures that require the use of the revenue allocation form for all settlements sent to the Office's Accounting Division for disbursement. However, the Office could improve its processes by consistently using the revenue allocation form. Eight of the 21 (38 percent) settlements did not contain a copy of the revenue allocation form in the case file. Of the 13 settlement case files containing a revenue allocation form, 5 forms were incomplete. It should be noted that the majority of the cases that lacked revenue allocation forms were in fiscal years 2005 and 2006. The Office's use of the form has become more consistent since then.

CMF does not reconcile the amounts listed on the revenue allocation forms to its internal tracking spreadsheet for settlements. This increases the risk that CMF will not identify any differences between expected settlements and revenue received.

Recommendations

The Office should:

- Continue to review and prioritize cases on a regular basis.
- Reconcile the amounts it receives from settlements to its internal tracking spreadsheet to ensure that the total settlement amounts are recorded completely and accurately.
- Implement policies and procedures for the use of the revenue allocation form.

Management's Response

Recommendation 1: Continue to review and prioritize cases on a regular basis.

Management agrees. Although CMF has already retained additional staff and implemented a review and prioritization program consistent with the Auditor's recommendations, CMF will increase its focus on this initiative.

Recommendation 2: Reconcile the amounts it receives from settlements to its internal tracking spreadsheet to ensure that the total settlement amounts are recorded completely and accurately.

Management agrees. In response to the recommendation, CMF has changed its process to ensure settlements received are reconciled with figures that were recorded in its internal tracking spreadsheet.

Recommendation 3: Implement policies and procedures for the use of the revenue allocation form.

Management agrees. In response to the recommendation, CMF has implemented policies and procedures to ensure that revenue allocation forms are used at all appropriate times.

While the Office Has Some Information Technology Controls; Improvements Are Needed to Ensure the Protection and Accuracy of Medicaid Fraud Data

The Office needs to improve the functionality of its Case Management System to fully support MFCU's day-to-day operations. Controls over the operation of the Case Management System do not provide assurance that the data is accurate, complete, and timely.

While the Office has effective general controls over some components of its technology environment, improvements are needed to ensure the protection and accuracy of data related to Medicaid fraud activities. Information technology weaknesses relate to security, system development, change management, and the business continuity plan.

The Office created and filled positions for chief information officer and chief information security officer within the past two years.

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 Office is one of 27 state agencies scheduled to transition its data centers to a centralized location operated by a contractor. The Office is scheduled to complete the transfer of its servers to the new data center at the end of November 2008. As the Office transfers its servers and mainframe to the contractor, it will need to coordinate with the contractor to address some of the issues identified in this report.

Chapter 3-A

The Office Needs to Improve the Functionality of MFCU's Case Management System

The Case Management System is a mainframe system developed during the 1990s that appears to function as designed. However, due to the system's age and limited functionality, MFCU cannot rely on this system alone for its day-to-day operations. As a result, MFCU staff have developed several Microsoft Access databases and Excel spreadsheets to record case data.

The Office noted the inadequate functionality of the mainframe Case Management System in its October 2006 recertification questionnaire to the Health and Human Services Commission's Office of Inspector General:

[MFCU] has an inadequate case management system. The mainframe system dates back more than ten to eleven years and provides the minimum information to administratively track cases and accomplishments. In order to track all the information to meet our reporting requirements, we must maintain a number of stove pipe systems off-line from the mainframe.

Specific functionality that the Case Management System does not have includes:

- Adequate searching and reporting capabilities.
- Adaptability for changing federal requirements.
- Tracking of investigative activity and case evidence.
- Tracking and reporting of employee productivity.

The Case Management System also does not have several features typical of modern case management systems, such as:

- Storage of data in a relational database, which allows easy retrieval and reporting of data as needed.
- A Web-based application that is accessed using an Internet browser.
- Document imaging, which allows documents to be stored electronically.

In addition, the Office does not have a documented up-to-date data dictionary for the Case Management System. An up-to-date data dictionary can help end users understand what data should be contained within the system and help them produce more accurate reports.

Recommendations

The Office should:

- Consider performing a business case analysis to identify technology solutions for areas in which MFCU's current Case Management System does not adequately meet users' needs.
- Ensure that the Case Management System data dictionary is up-to-date, accurate, and complete.

Management's Response

Recommendation 1: Consider performing a Business Case analysis to identify technology solutions for areas in which MFCU's current Case Management System does not adequately meet users' needs.

(MFCU Response) Management agrees. Consistent with the Auditor's recommendation, the MFCU will initiate a project, such as Business Case Analysis, to identify a new or enhanced Case Management System that meets users' needs. MFCU will promptly define its needs and then work with the ITS Division to implement the appropriate solution.

Recommendation 2: Ensure that the Case Management System data dictionary is up-to-date, accurate, and complete.

(ITS Division Response) Management agrees. The ITS Division has taken steps to implement an up-to-date, accurate, and complete data dictionary by August 31, 2008.

(MFCU Response) Management agrees. The MFCU, in consultation with ITS, will update the MFCU Case Management System data dictionary to ensure it meets the standards recommended by the Auditor.

Chapter 3-B

The Office Has Some Effective General Information Technology Controls

The Office has effective general controls over some components of its technology environment. Specifically:

- Password and account lockout settings for the Office's network and some MFCU applications follow best practices.
- The Office uses an automated process to disable employee access to the network, mainframe, and e-mail systems when an employee no longer needs this access.
- Physical controls over the server room provide adequate protection from unauthorized access and environmental hazards for the mainframe containing the Case Management System.
- The Office tested its disaster recovery plan in 2007, and the plan generally allowed for recovery.
- The Office's information security program covers some of the requirements in Title 1, Texas Administration Code, Chapter 202.

Security Weaknesses Expose Medicaid Fraud Data to Increased Risk of Unauthorized Access

During its investigations of Medicaid fraud and abuse complaints, the Office compiles large amounts of confidential information that requires protection from unauthorized access. Although auditors did not identify any data that was compromised, the Office's information technology controls do not ensure that this data is protected from undetected or unauthorized access. Auditors identified security weaknesses in several areas. These include:

Owner-defined Security Requirements. The Office has not developed and documented owner-defined security controls over the Case Management System. State rules and Office policy require the owners of information resources to specify the appropriate controls needed to protect the State's information resources from unauthorized modification, deletion, or disclosure. In addition, information owners should confirm that controls are in place to ensure the accuracy, authenticity, and integrity of data as required. Information owner-defined controls are necessary to ensure that information systems and the underlying data are properly protected.

Transactional Auditing on the Case Management System. The Office has not enabled the Case Management System's transactional auditing function. Transaction auditing would track changes to data fields that the Office identifies as "high-risk." The Case Management System should log updates to high-risk information and capture who made the changes, when the changes were made, and what information was changed.

Information Security Awareness Training Program. Although the Office does provide some security awareness training to new employees, it does not have a documented and approved ongoing information security awareness program, as required by the Title 1, Texas Administrative Code, Section 202.27 (1 TAC 202.27). Information security awareness programs help keep users informed about and focused on information security issues and threats.

Software Updates. The Office has not installed the latest software updates to its information resources. Software updates or service packs are produced by vendors to address potential operational and security problems within the software. They may also be used to distribute additional functionality. It should be noted that neither auditors nor the Office was aware of any open security issues that the software updates would have addressed if installed.

Recommendations

The Office should:

- Document and implement information-owner security requirements in compliance with 1 TAC 202.27 and Office policy.
- Implement adequate transactional auditing for the Case Management System and review transactional logs on a regular basis to ensure that all changes were appropriate.
- Implement a documented, ongoing information security awareness program for all users.
- Ensure that software updates are evaluated and applied in a timely manner. The risk of compromising the information resource or software should be considered prior to installation.

Management's Response

Recommendation 1: Document and implement information-owner security requirements in compliance with 1 TAC 202.27, and Office policy.

(ITS Division Response) Management agrees. Consistent with the Auditor's recommendation, the OAG has begun implementing procedures to ensure OAG information resources users must formally agree to comply with the agency policies before access to information resources is granted.

(MFCU Response) Management agrees. The MFCU has begun implementing procedures that will implement information-owner security requirements; implement adequate transactional auditing and transactional logs reviews; implement a documented, on-going information security awareness program; and ensure that software updates are evaluated and installed in a timely manner.

Recommendation 2: Implement adequate transactional auditing for the Case Management System and review transactional logs on a regular basis to ensure that all changes were appropriate.

Management agrees. Previously implemented procedures already ensure that transaction logging is always enabled on Production ADABAS. “Before and after” snapshots are therefore captured every time a record changes. Consistent with the Auditor’s recommendations, the ITS Division will create the reporting tools necessary to manage logging data.

Recommendation 3: Implement a documented, on-going information security awareness program for all users.

Management agrees. The Office has begun implementing procedures necessary to provide all users an on-going information security awareness education program. Going forward, all newly-hired OAG employees will be introduced to information security policies and procedures during their initial new employee orientation.

Recommendation 4: Ensure that software updates are evaluated and applied in a timely manner. The risk of compromising the information resource or software should be considered prior to installation.

Management agrees. Consistent with the Auditor’s recommendation, existing procedures require that after being appropriately tested, software updates are installed in a timely manner. The Office will implement necessary measures to ensure updated procedures are followed and security updates are promptly installed.

Chapter 3-D

The Office Does Not Have a Documented System Development Life Cycle or Appropriate Change Management Processes

System Development Life Cycle. The Office has not documented and adopted a system development life cycle methodology for staff to follow when planning, implementing, maintaining, and replacing the Case Management System. A life cycle methodology would provide guidance about (1) the appropriate development and operation of the Case Management System and (2) when the Case Management System has become too costly to maintain and should be replaced with a new system.

Change Management Processes. The Office does not have documented and approved change management policies and procedures for the Case Management System. Documented change management policies and procedures help to ensure that changes to a system or application are handled efficiently and promptly and do not affect the ability of the system to produce timely, accurate, and complete information. Additionally, documented

policies and procedures should detail how the user is supposed to request a change and explain all participants' roles in the change process.

Auditors identified several other weaknesses in the Office's change management procedures. Specifically:

- The Office did not adequately monitor and approve changes made to the Case Management System's production code. The Office did not have a standard report that tracked what information was changed and who coded and approved the change. It should be noted that the Office did design and implement an ad hoc report to track production code changes during this audit. In addition, the Office does not document reviews of code changes to ensure that all changes are approved by a second person. Auditors reviewed two recent code changes in January 2008, both of which did not contain documented approval.
- The Office does not track changes made directly to the data in the Case Management System. Tracking direct changes to the data can help the Office ensure that the changes were appropriate, reviewed, and approved.
- The Office is not performing user acceptance testing before making changes to the Case Management System. User acceptance testing provides an opportunity for the end user to determine whether a system will operate as intended.
- The Office does not have separate environments (logical partitions) for developing and testing code changes to ensure that changes do not cause the Case Management System to experience down time and potential data loss or corruption.

Recommendations

The Office should:

- Document and approve a system development life cycle methodology for the Case Management System or its replacement.
- Document and approve change management policies and procedures for the Case Management System.
- Monitor and approve all changes to the Case Management System before placing them into the production environment.
- Implement proper controls over direct data changes made to the Case Management System including appropriate audit trails.
- Perform user acceptance testing.

- Implement separate environments for the development and testing of code changes.

Management's Response

Recommendation 1: Document and approve a system development life cycle methodology for the Case Management System or its replacement.

Management agrees. Although the ITS Division already has a system development life cycle process in place for all new development, this methodology will be incorporated into maintenance efforts and applied uniformly when the Case Management System is replaced.

Recommendation 2: Document and approve change management policies and procedures for the Case Management System.

Management agrees. ITS will formally document the existing change management policies and procedures for the Case Management System. This effort will be completed by December 2008.

Recommendation 3: Monitor and approve all changes to the Case Management System before placing them into the production environment.

Management agrees. Although ITS has an existing Case Management System, change monitoring and approval protocol, it will formalize requirements and the controls process governing change requests.

Recommendation 4: Implement proper controls over direct data changes made to the Case Management System including appropriate audit trails.

Management agrees. Direct changes will follow the change management process/controls.

Recommendation 5: Perform user acceptance testing.

Management agrees. Formal user acceptance testing will be incorporated into the change management policies and procedures outlined above.

Recommendation 6: Implement separate environments for the development and testing of code changes.

Management agrees. Pre-existing protocol separates development and test environments in the mainframe.

Chapter 3-E

The Office Does Not Have a Documented and Approved Business Continuity Plan

The Office is in the process of developing and documenting a business continuity plan. A business continuity plan would help ensure that in the event of a natural disaster or other business disruption, the Office can recover data in a timely manner and quickly resume mission-critical operations. To minimize disruptions, the Office should provide for redundant system environments and make plans that would allow it to set up operations in alternative locations. The Office has developed and successfully tested, with one minor issue, a disaster recovery plan, which is an important component of a business continuity plan.

Recommendation

The Office should document and approve its business continuity plan and review it periodically in accordance with Title 1, Texas Administrative Code, Chapter 202.

Management's Response

(Planning Requirements in Addition to IT Recovery) Management agrees. The Office will implement steps to develop an Action Plan that will institute the Business Continuity Plan (BCP), and the additional elements of the BCP required by Texas Administrative Code Information Security Standards 1 TAC §202.

(Recovery of IT Services) Management agrees. The Office maintains an overall business continuity plan. Within the plan, the ITS Division is responsible for restoring information technology services. Established disaster recovery agreements with the state data center vendor provide for the restoration of infrastructure resources within agreed upon timeframes. In addition, the mainframe undergoes an annual disaster recovery test.

MFCU Should Improve How It Records Dates Related to Investigations and Prosecutions in the Case Management System

MFCU should improve its processes for recording complaint information in the Case Management System so that the Office can analyze the efficiency and effectiveness of MFCU's investigations. Specifically, MFCU does not consistently record the actual dates of case activities in the appropriate fields in the Case Management System (see text box for a description of significant case activities). As a result, MFCU can not ensure that reports or other information generated based on Case Management System data are accurate and complete.

Case Management System

MFCU uses the automated Case Management System to track case activities and to manage day-to-day operations. Preliminary or full investigations conducted by MFCU are entered and tracked in the Case Management System.

Significant case activities include:

- Presentations to a prosecuting authority.
- Declinations by the prosecuting authority.
- Investigative reports for the cases.
- Case closures.

In addition, the amounts of identified overpayments are recorded in the Case Management System.

The data in the Case Management System should reflect the actual dates of significant case activities. These dates should be entered in the appropriate fields to allow MFCU to produce reports that accurately reflect case activity for a specified time period. Currently, MFCU enters some actual dates for significant case activities in a comment field, which cannot be used to run reports. (See Chapter 3 for more information on controls over the Case Management System.)

Chapter 4-A

MFCU Should Consistently Record Accurate Dates in the Case Management System

The Case Management System contains inaccurate dates because (1) the correct date is not listed on the form MFCU uses for data entry or (2) the person entering the dates into the Case Management System enters a different date than that listed on the form. For example, auditors noted:

- The dates for significant case activities listed on supporting documentation did not consistently match the dates on the accomplishment reporting form. In addition, MFCU did not consistently retain supporting documentation in the

permanent case files.

- The date typed on the accomplishment reporting form (form) is not consistently the date entered into the Case Management System. If the form is submitted for data entry during the same month that the significant case activity occurred, the typed date on the form is generally entered into the Case Management System. However, if the form is submitted after this month, the date that is entered into the Case Management System is the first day of the month that the case manager received the form for data entry. Therefore, if a case was presented to a prosecuting attorney on January 30, 2007, but the form was not submitted for data entry until April 2007, the date entered into the Case Management System as the "date presented" would be April 1, 2007.

Auditors identified multiple cases in which the dates entered into the Case Management System differed from the dates listed on supporting documentation or on the accomplishment reporting form by more than one year.

Recommendations

The Office should:

- Consistently record the actual dates of significant case activities in the appropriate fields in the Case Management System.
- Maintain support documentation for significant case activities in the permanent case files.

Management's Response

Recommendation 1: Consistently record the actual dates of significant case activities in the appropriate fields in CMS.

Management agrees. Since the MFCU's inception in 1979 it has consistently used a "cash basis" accounting methodology that has reported reliable accomplishments data to the LBB. That is, accomplishments are entered into the Case Management System (CMS), and captured for reporting purposes, only after the final accomplishment reporting form is received, reviewed, and approved in Austin. This policy has ensured the MFCU could meet short reporting deadlines imposed by both state and federal oversight agencies. The MFCU's reporting protocol was implemented so that accomplishments could be reported immediately after the close of a quarter or fiscal year, which is required by the LBB and federal oversight agencies. To meet those requirements and ensure that MFCU is reliably reporting its accomplishments, certain results (such as case presentations or convictions) that are obtained close to the end of a fiscal year may be entered as accomplishments for the following fiscal year. Such a system ensures that an accomplishment is not recorded until all due diligence is complete and final accomplishment reporting forms are processed by MFCU management in Austin.

To the extent that LBB can more clearly define the reporting periods for each performance measure, including a cut-off date, MFCU will incorporate those definitions into its accomplishments reporting policy.

Recommendation 2: Maintain support documentation for significant case activities in the permanent case files.

Management agrees. The MFCU has begun implementing measures to ensure that required support documentation is included in all case files.

The Office Should Ensure It Uses Accurate Dates to Calculate Selected Performance Measures

Background

Agencies report results for their key measures to the Legislative Budget Board's budget and evaluation system, which is called the Automated Budget and Evaluation System of Texas, or ABEST.

Results: Factors Prevented Certification

Factors prevent certification of a measure if documentation is unavailable and controls are not adequate to ensure accuracy or there is a deviation from the measure definition and the auditor cannot determine the correct performance measure result.

Results for fiscal year 2007 for the four measures that auditors tested—two key measures and two non-key measures—could not be certified because the MFCU does not consistently record accurate dates in the Case Management System fields used to calculate the measures. It is important to note that all the activities related to the four performance measures tested actually occurred; however, the dates of the activities were not consistently recorded in the appropriate fiscal year. The certification results for the four measures were “Factors Prevented Certification,” which indicates that the results may not be reliable. A performance measure result is considered reliable if it is certified or certified with qualification.

Table 3 summarizes the results of the four performance measures tested.

Table 3

Office of the Attorney General (Agency 302)				
Related Objective or Strategy, Classification	Description of Measure	Fiscal Year	Results Reported in ABEST	Certification Results ^a
D. Outcome	Amount of Medicaid Overpayments Identified	2007	\$58,025,285.85	Factors Prevented Certification
D.1.1 Output	Number of Investigations Concluded	2007	528	Factors Prevented Certification
Non-key measure	Number of Convictions Obtained	2007	97 ^b	Factors Prevented Certification
Non-key measure	Number of Cases Referred for Prosecution	2007	413 ^b	Factors Prevented Certification

Office of the Attorney General (Agency 302)				
Related Objective or Strategy, Classification	Description of Measure	Fiscal Year	Results Reported in ABEST	Certification Results ^a
<p>^a A measure is Certified if reported performance is accurate within 5 percent of actual performance and if it appears that controls to ensure accuracy are in place for collecting and reporting performance data.</p> <p>A measure is Certified with Qualification when reported performance appears accurate but the controls over data collection and reporting are not adequate to ensure continued accuracy. A measure is also certified with qualification when controls are strong but source documentation is unavailable for testing. A measure is also certified with qualification if the agency's calculation of performance deviated from the measure definition but caused less than a 5 percent difference between the number reported in ABEST and the correct performance measure result.</p> <p>A measure is Inaccurate when the actual performance is not within 5 percent of reported performance, or when there is more than a 5 percent error in the sample of documentation tested. A measure is also inaccurate if the agency's calculation deviated from the measure definition and caused more than a 5 percent difference between the number reported in ABEST and the correct performance measure result.</p> <p>A Factors Prevented Certification designation is used if documentation is unavailable and controls are not adequate to ensure accuracy. This designation also will be used when there is a deviation from the measure definition and the auditor cannot determine the correct performance measure result.</p> <p>^b The result for this measure was not reported in ABEST because it is a non-key measure.</p>				

Factors prevented certification for all four performance measures tested because MFCU did not consistently record accurate dates in the fields used to calculate the measures. Specifically, auditors identified the following:

- The differences between the dates investigations were concluded noted on the forms used for data entry and the dates entered into the Case Management System ranged from 2 days to 2.7 years.
- The differences between the dates convictions were obtained noted on the forms used for data entry and the dates entered into the Case Management System ranged from 2 days to 195 days.
- The differences between the dates cases were referred for prosecution noted on the forms used for data entry and the dates entered into the Case Management System ranged from 1 day to 5 years.
- The differences between the dates the overpayments were identified on the forms used for data entry and the dates entered into the Case Management System could not be calculated because MFCU entered any one of three different dates into the system.

As a result of these weaknesses, the ABEST results do not accurately reflect the activity occurring during a specific fiscal year. To recalculate the accurate performance measure results, each case file must be manually reviewed, which is a process that is not in alignment with the measure's methodology in ABEST. The Case Management System allows users to enter the actual date of case activity, as well as run reports used to calculate the measures at any time. To allow for complete reporting for a specific period, the Legislative

Budget Board provides agencies at least one month after the end of a quarter or fiscal year before performance measure results are due.

In addition, MFCU does not have written policies and procedures for the collection, calculation, and documented review of performance measures data. Detailed, written policies and procedures provide a basis for consistent collection and calculation of measure results. Documented review increases the likelihood of errors being identified before performance measure results are released into ABEST.

The performance measure for **Amount of Overpayments Identified** is defined in ABEST as overpayments made by the Medicaid program that the MFCU identified during an investigation. In addition to the issues noted above, MFCU should improve its controls over the entry and review of overpayments into the Case Management System. Auditors identified 2 of 63 cases tested in which the amounts of overpayments were incorrectly entered into the Case Management System; these mistakes caused the reported results for this measure to be overreported in ABEST by \$742,787. Although this amount represents a small portion of the \$58 million in overpayments identified, MFCU's failure to identify data entry errors in a timely manner increases the risk of inaccurate results being reported into ABEST.

The performance measure for **Number of Investigations Concluded** is defined in ABEST as the number of Medicaid fraud, abuse, and neglect investigations that MFCU completed during the reported period, regardless of results. The majority of investigations closed by MFCU in fiscal year 2007 were due to insufficient evidence, a prosecutor declining the case, or conviction. In addition to the issues noted above, MFCU did not consistently follow the measure's definition. Two of 64 (3 percent) concluded investigations that auditors tested were inappropriately included in the measure's reported results for fiscal year 2007. One case was "opened in error" and then closed, and the other case was re-opened after being closed.

The performance measure for **Number of Convictions Obtained** is defined in ABEST as the number of investigations referred for prosecution that result in any judgment of conviction arising from a plea or verdict. In addition to the issues noted above, MFCU deviated from the measure's definition because it did not include 4 pre-trial diversions (in addition to the 97 convictions) that the Office reported to ABEST for fiscal year 2007. Furthermore, the report used to calculate the measure is run on a date automatically assigned by the Case Management System, rather than the actual date on which a conviction was obtained.

It should be noted that the Office has requested and received approval from the Legislative Budget Board and the Governor's Office of Budget and Planning to delete one of the non-key measures tested—Number of Convictions Obtained—starting in fiscal year 2010.

The performance measure for **Number of Cases Referred for Prosecution** is defined in ABEST as the number of investigations that have been referred to an appropriate prosecuting authority with a recommendation for action. MFCU calculated the measure by the number of cases presented to a prosecutor but, as noted above, MFCU does not consistently record the actual dates in the appropriate fiscal year in its Case Management System.

Recommendations

The Office should:

- Ensure performance measure results are accounted for in the appropriate fiscal year.
- Develop and implement detailed written policies and procedures for the collection, calculation, and documented review of performance measures in alignment with measure definitions.
- Follow the measure definition in ABEST and Office policy when calculating the Number of Investigations Concluded and the Number of Convictions Obtained.

Management's Response

Recommendation 1: Ensure performance measure results are accounted for in the appropriate fiscal year.

Management agrees. See response to Recommendation 1 (page 19).

Recommendation 2: Develop and implement detailed written policies and procedures for the collection, calculation, and documented review of performance measures in alignment with measure definitions.

Management agrees. See response to Recommendation 1 (page 19).

Recommendation 3: Follow the measure definition in ABEST and Office policy when calculating the Number of Investigations Concluded and the Number of Convictions Obtained.

Management agrees. The MFCU has implemented procedures to ensure the ABEST measure definition and Office policies are consistently followed when calculating the Number of Investigations Concluded and the Number of Convictions Obtained.

Appendices

Appendix 1

Objectives, Scope, and Methodology

Objectives

The objectives of this audit were to:

- Determine whether the Office of the Attorney General (Office) has controls to provide assurance that referrals of potential fraud by Medicaid providers are effectively and efficiently screened, investigated, and resolved.
- Determine the extent to which the Office's Medicaid Fraud Control Unit (MFCU) identifies funds subject to recovery by other entities.
- Determine whether automated systems that support MFCU, including its Case Management System, provide users with accurate, complete, and timely information, as well as the necessary functionality.
- Determine whether selected performance data, such as the amount of Medicaid overpayments identified, is accurate and complete.
- Provide information on the final resolution of cases, including the ultimate disposition of overpayments identified and the outcomes of cases referred for prosecution.
- Review the Office's plan for, and progress in, reducing the backlog of Medicaid fraud cases in its Civil Medicaid Fraud Division (CMF).
- Determine the extent to which CMF recovers funds and determine the allocation of recovered funds.

Scope

The scope of this audit covered fiscal year 2007. In addition, auditors reviewed selected case data from MFCU and CMF from fiscal years 2000 through 2008.

Methodology

The audit methodology included collecting and reviewing information and documentation, conducting interviews with Office management and staff, performing selected tests, and analyzing and evaluating the results of testing and observations. In addition, auditors selected four performance measures the Office reported for fiscal year 2007; reviewed controls over the collection,

calculation, and submission of data used in reporting performance measures; and traced performance measure documentation to the original source when available.

Information collected and reviewed included the following:

- Office organizational charts.
- Random samples of MFCU investigation files.
- *MFCU Recertification Questionnaire for Unit Directors* to the federal government for federal fiscal years 2006 and 2007.
- *Annual Report for the Medicaid Fraud Control Unit* to the federal government for federal fiscal years 2006 and 2007.
- Draft MFCU policies and procedures manual.
- MFCU case data from the Office's automated Case Management System from fiscal year 2000 through fiscal year 2007.
- Business plans for MFCU and CMF.
- *Joint Semi-Annual Interagency Coordination Report* by the Office of the Attorney General and the Texas Health and Human Services Commission, Office of the Inspector General (HHSC-OIG) for fiscal years 2006 and 2007.
- Memorandum of Understanding between the Office and HHSC-OIG.
- General Appropriations Act (79th Legislature, Regular Session).
- Office of the Attorney General Web site.
- Health and Human Services Commission, Office of the Inspector General Web site.
- List of CMF pending cases from fiscal year 1999 through March 31, 2008.
- List of CMF settled cases from fiscal year 2000 through May 5, 2008.

Specific tests and procedures included the following:

- Reviewed regulations, policies and procedures, and manuals.
- Interviewed Office personnel.
- Interviewed Legislative Budget Board analyst.
- Analyzed data flow to evaluate whether proper controls were in place.

- Tested a sample of source documents, when available, to verify the accuracy of reported information for MFCU cases.
- Analyzed CMF's pending cases.
- Tested settlements received by the Office related to CMF cases.
- Reviewed all information systems that support the MFCU data.
- Audited performance measure calculations for accuracy and to ensure that they were consistent with the methodology on which the Office and the Legislature Budget Board agreed.
- Certified performance measure results in one of four categories: (1) Certified, (2) Certified with Qualification, (3) Inaccurate, and (4) Factors Prevented Certification.

Criteria used included the following:

- Texas Government Code, Chapter 531.
- Texas Human Resources Code, Chapter 36.
- Title 42, Code of Federal Regulations, Part 1007, State Medicaid Fraud Control Units.
- MFCU policies and procedures, including draft policies and procedures.
- Senate Bill 362 (80th Legislature).
- *Guide to Performance Measure Management* (State Auditor's Office Report No. 06-329, August 2006).
- Automated Budget and Evaluation System of Texas performance measure definitions.

Project Information

Audit fieldwork was conducted from March 2008 through May 2008. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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

- Ann E. Karnes, CPA (Project Manager)

- Mary Goldwater (Assistant Project Manager)
- Melissa Dozier
- W. Chris Ferguson, MBA
- Lauren Godfrey, CGAP
- Brian York
- Michael Yokie, CISA, (Information Systems Audit Team)
- J. Scott Killingsworth, CIA, CGAP, CGFM (Quality Control Reviewer)
- Sandra Vice, CIA, CGAP, CISA (Assistant State Auditor)

Office of the Attorney General Organization Chart

Figure 2

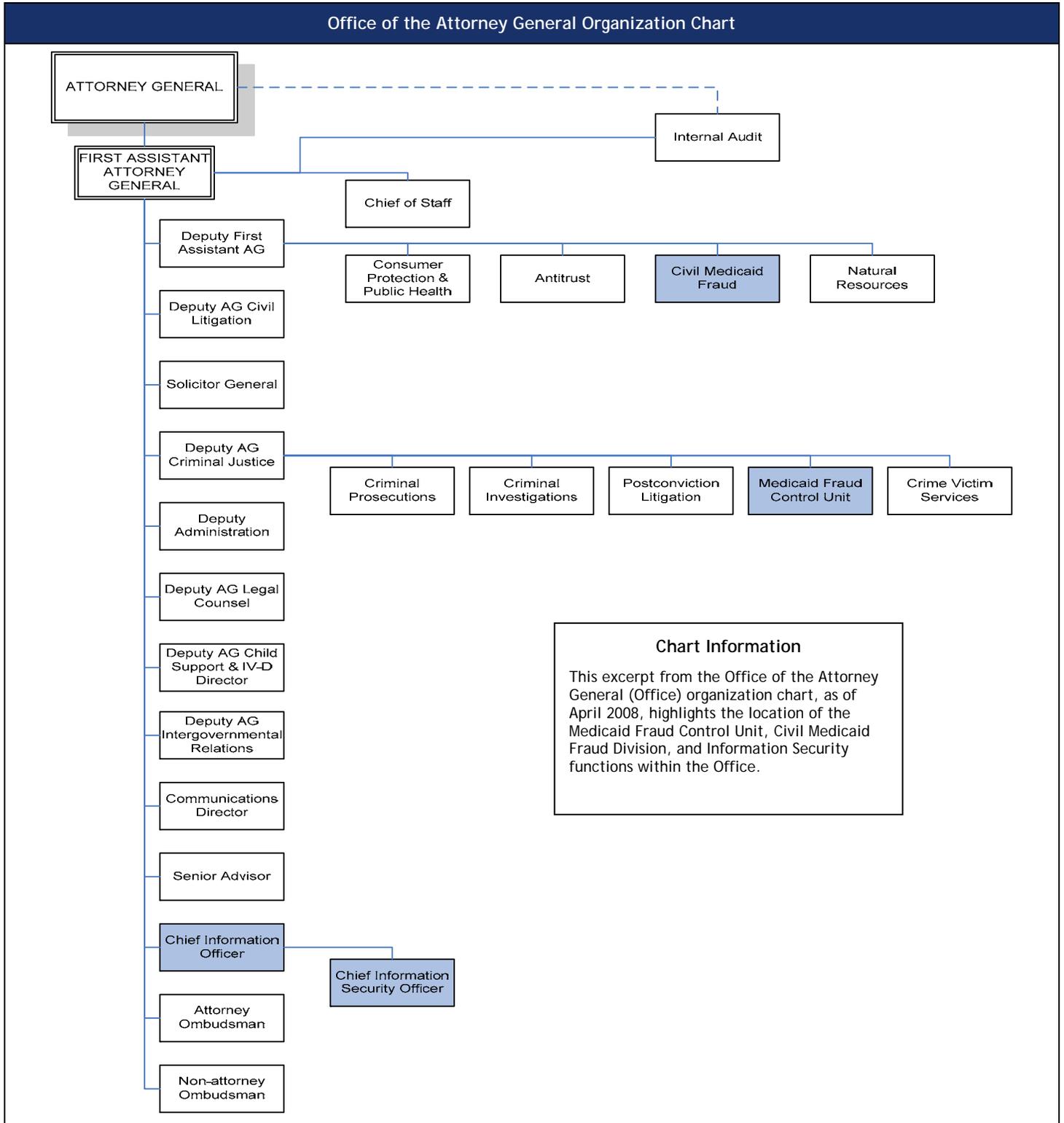


Chart Information

This excerpt from the Office of the Attorney General (Office) organization chart, as of April 2008, highlights the location of the Medicaid Fraud Control Unit, Civil Medicaid Fraud Division, and Information Security functions within the Office.

Background Information on the Medicaid Fraud Control Unit and the Civil Medicaid Fraud Division

The Web sites for the Office of the Attorney General (Office) and the Health and Human Services Commission (Commission) provide the following background information on the Medicaid program, the Office's Medicaid Fraud Control Unit and Civil Medicaid Fraud Division, and the Commission's Office of Inspector General.

What is Medicaid and who are the providers?

The Medicaid program is a federal/state cost-sharing program that provides health care to people who are unable to pay for such care. In Texas, the Medicaid program is administered by the Health and Human Services Commission.

More than 2.7 million Texans are eligible for Medicaid and there are more than 90,000 active Medicaid providers. A provider can be any person, group of people, or health care facility that supplies medical services to Medicaid recipients. Providers include doctors, medical equipment companies, podiatrists, dentists, licensed professional counselors, hospitals, adult day care centers, nursing homes, clinics, pharmacies, ambulance companies, case management centers, and others.

What is Medicaid Fraud?

These are several examples of Medicaid fraud. These include:

- Billing Medicaid for X-rays, blood tests, and other procedures that were never performed, or falsifying a patient's diagnosis to justify unnecessary tests.
- Giving a patient a generic drug and billing for the name-brand version of the medication.
- Giving a recipient a motorized scooter and billing for an electric wheelchair, which can cost three times more.
- Billing Medicaid for care not given, for care given to patients who have died or who are no longer eligible, or for care given to patients who have transferred to another facility.
- Transporting Medicaid patients by ambulance when it is not medically necessary.
- Requiring vendors to "kick back" part of the money they receive for rendering services to Medicaid patients (kickbacks may also include vacations, merchandise, and other benefits).

- Billing patients for services already paid for by Medicaid.

Activities of this nature violate federal and state criminal laws and can result in significant fines and/or incarceration. Those convicted of fraud may also lose their status as Medicaid providers.

Medicaid fraud also involves physical abuse, sexual abuse, and criminal neglect. Some warning signs include:

- Cuts, black eyes, bruises and burns.
- Patients fear being alone with caregivers.
- Reports of slapping, hitting, kicking, or biting, or of sexual abuse.
- Difficulty sitting or walking.
- Pregnancy.

Drug diversion is another form of abuse. It is the simple theft of drugs that deprives a patient of proper medication. Drug diversion includes:

- A health care worker selling a patient's medication, keeping it for him/herself or throwing it away.
- A doctor selling prescriptions.
- A nurse ordering medication for patients without a doctor's approval, and a nurse intercepting delivery of the medication for the nurse's use.

The Medicaid Fraud Control Unit

The Medicaid Fraud Control Unit (MFCU) was created in 1979 as a division of the Office. MFCU has four principal responsibilities:

- Investigating criminal and civil fraud by Medicaid providers.
- Investigating physical abuse and criminal neglect of patients in health care facilities licensed by the Medicaid program, including nursing homes and Department of Aging and Disability Services homes.
- Prosecuting criminal fraud by Medicaid providers or assisting local and federal authorities with such prosecution.
- Investigating fraud within the administration of the Medicaid program.

MFCU does not look into fraud committed by Medicaid recipients. The Commission's Office of Inspector General is responsible for investigating Medicaid recipient fraud.

MFCU has grown from 43 employees at the end of fiscal year 2003 to 193 employees at the end of fiscal year 2007.

The Civil Medicaid Fraud Division

The Office's Civil Medicaid Fraud Division (CMF) enforces the Texas Medicaid Fraud Prevention Act (Texas Human Resources Code, Chapter 36). The Texas Medicaid Fraud Prevention Act permits private citizens to file lawsuits on behalf of the State against those who violate the Act. These private citizens are referred to as "relators" and they assist the State in identifying and pursuing fraudulent activity committed against the Medicaid program. Relators in successful matters receive a portion of recovered funds. CMF may also pursue cases on its own on behalf of the Medicaid program.

In addition to actively litigating in state and federal courts, CMF works with relators, MFCU, the federal government, other state governments, and law enforcement to conduct nationwide fraud recovery efforts. Through these efforts, the Office has recovered more than \$250 million on behalf of the Texas Medicaid system.

In August 1999, the CMF was created within the Elder Law and Public Health Division of the Office. In February 2003, CMF was merged into the Office's Antitrust Division, and the resulting division was renamed the Antitrust and Civil Medicaid Fraud Division. In April 2008, CMF was split from this division into a separate, stand-alone division.

The Commission's Office of Inspector General

The Commission's Office of Inspector General (HHSC-OIG) investigates waste, abuse, and fraud in all health and human services programs in Texas. The HHSC-OIG refers criminal Medicaid provider fraud cases to MFCU. Waste, abuse, and fraud may fall into one or more categories. Examples include, but are not limited to:

- Third-party resources waste, abuse, and fraud. This includes investigations of suspicion or evidence that a third-party is liable for costs incurred by Medicaid. Examples of third parties are employer health insurance, auto insurance, and worker's compensation plans.
- Provider waste, abuse, and fraud. This includes:
 - ♦ Investigations of waste, abuse, and fraud in Medicaid or the Children's Health Insurance Program (CHIP), including billing for services not provided or not medically necessary.
 - ♦ Audit reviews of contracts and grants for potential waste, abuse, or fraud (for example, services not provided, unallowable expenditures, and other abuse or fraud).

- ♦ Investigations of waste, abuse, and fraud related to participation or administration of the Women, Infants and Children (WIC) program by contractors, local agencies, and vendors.
- Recipient waste, abuse, and fraud. This includes:
 - ♦ General investigations of waste, abuse, and fraud in the Food Stamp Program, Medicaid, and Temporary Assistance for Needy Families cash assistance programs (for example, knowingly misstating or concealing information to receive more benefits).
 - ♦ Investigations of abuse and overuse of Medicaid health benefits.
 - ♦ Investigations of false reporting of income, household number, residency and/or abuse and trafficking of WIC benefits.
- Employees, contractors, or vendors waste, abuse, and fraud. This includes suspected cases of:
 - ♦ Abuse, neglect, and exploitation at Texas Youth Camps.
 - ♦ Retaliation against employees under the Whistleblower Act.
 - ♦ Fraud or abuse involving vital records at the Bureau of Vital Statistics.

Medicaid Fraud Control Unit Funding, Staffing, and Expenditures

The 78th Legislature appropriated additional funds and full-time equivalent positions to the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) starting in fiscal year 2004. However, the federal government, which provides 75 percent of the funding for MFCU, required a phased-in approach to the staffing expansion. As a result, actual expenditures and filled positions were significantly less than the amounts appropriated for the 2004 – 2005 biennium. Table 4 shows the increase in MFCU's employees, funding, and expenditures from fiscal year 2003 (prior to the expansion) through fiscal year 2007.

Table 4

MFCU's Funding and Expenditures State Fiscal Years 2003 through 2007					
Type of Funding or Expenditure	Fiscal Year 2003	Fiscal Year 2004	Fiscal Year 2005	Fiscal Year 2006	Fiscal Year 2007
Appropriations					
Original Funding in the General Appropriations Act	\$2,202,832	\$2,179,216	\$2,179,216	\$10,891,555	\$10,891,555
Additional Funding in the General Appropriations Act	447,107	12,020,228	10,111,368	2,982,099	3,436,037
Total Funding in General Appropriations Act	\$2,649,939	\$14,199,444	\$12,290,584	\$13,873,654	\$14,327,592
Employees					
Authorized Full-time Equivalents	39	208	208	208	208
Number of filled positions at End of Federal Fiscal Year ^a	43	105	171	198	193
Expenditures					
Federal Share of Expenditures	\$1,435,967	\$3,491,213	\$7,541,766	\$9,061,812	\$9,632,282
State Share of Expenditures	1,198,681	1,500,736	2,956,259	3,547,189	3,895,957
Total Expenditures^b	\$2,634,648	\$4,991,949	\$10,498,025	\$12,609,001	\$13,528,239
^a The federal fiscal year is October 1 through September 30.					
^b Total expenditures are based on a state appropriation year.					

Source: Unaudited information from the Office of the Attorney General and the General Appropriations Act.

Medicaid Fraud Control Unit Case Statistics

As Table 5 shows, the total number of cases opened, referred for prosecution, and closed by the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU) increased from fiscal year 2003 to fiscal year 2007. The number of cases opened reflects the number of new cases opened during that fiscal year. The status of cases referred for prosecution is as of August 31, 2007.

Table 5

Summary of Cases Opened, Closed, and Referred by MFCU for Prosecution ^a					
Disposition of Case	Fiscal Year 2003	Fiscal Year 2004	Fiscal Year 2005 ^b	Fiscal Year 2006	Fiscal Year 2007
Total Number of Cases Opened	155	329	715	802	734
Total Number of Cases Referred for Prosecution	64	124	119	274	413
Case Is Still Open	1	10	7	24	138
Defendant Acquitted	1	0	1	1	0
Defendant Convicted or agrees to pre-trial diversion	31	68	68	83	66
Case Declined or Dismissed	27	43	39	142	196
Closed Administratively	3	3	3	24	2
Civil Settlements	1	0	1	0	11
Total Number of Cases Closed	150	145	366	522	518
Closed After Preliminary Investigation	0	2	60	108	108
Closed During Full Investigation	76	55	189	154	73
Closed Because a Prosecuting Authority Declined the Case	16	32	26	120	187
Closed After Presented to a Prosecuting Authority	58	56	91	140	150

^a Based on data as reported in MFCU's Case Management System. Auditors' analysis did not include cases that were under federal seal. Therefore, these totals may not match the numbers reported by the Office into the Automated Budget and Evaluation System of Texas, or ABEST, and the *Joint Semi-Annual Interagency Coordination Report by the Office of the Attorney General and the Texas Health and Human Services Commission, Office of the Inspector General (HHSC-OIG)*.

^b Preliminary investigations were not entered into the Case Management System until fiscal year 2005.

Copies of this report have been distributed to the following:

Legislative Audit Committee

The Honorable David Dewhurst, Lieutenant Governor, Joint Chair
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 Warren Chisum, House Appropriations Committee
The Honorable Jim Keffer, House Ways and Means Committee

Office of the Governor

The Honorable Rick Perry, Governor

Office of the Attorney General

The Honorable Greg Abbott, Attorney General



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