OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

Initiatives Underway to Improve Collaboration and Performance

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HHSC IG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL

MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

Initiatives Underway to Improve Collaboration and Performance

WHY THE IG CONDUCTED THIS SERIES OF AUDITS

At approximately $30 billion a year, the Medicaid program and Children's Health Insurance Program constitute over 29 percent of the total Texas budget. Approximately 88 percent of individuals enrolled in Medicaid or CHIP are members of a managed care organization (MCO).

MCOs are required to establish a special investigative unit (SIU) to investigate fraudulent claims and other program waste and abuse by members and service providers. Effective SIUs are essential to ensuring that state and federal funds spent on managed care are used appropriately.

The Texas Health and Human Services Commission (HHSC) is responsible for oversight of MCO contracts. The IG is responsible for approving SIU annual plans and evaluating and sometimes investigating SIU referrals.

The IG Audit Division has completed a series of performance audits to determine how effective MCO SIUs are at (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries.

THIS INFORMATIONAL REPORT

This informational report, which is not an audit report under generally accepted government auditing standards, contains the IG Audit Division's compilation and analysis of information it reported in a series of MCO SIU audit reports, but also contains non-audited information submitted by MCOs and non-audited information from other federal and state sources.

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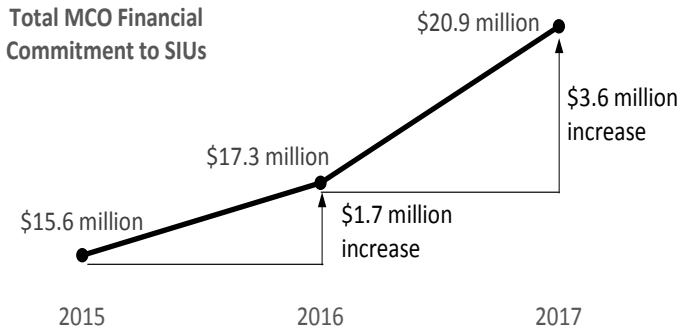
WHAT RESULTED FROM THE IG AUDITS OF MCO SIUs

The IG conducted six audits of MCO SIUs, and an audit of a third party contractor providing SIU services to six more MCOs. The impact of those audits is resulting in significant expansion of SIU functions across most Texas MCOs. MCOs are increasing the level of financial commitment to their SIU functions; HHSC, MCOs, and the IG are engaged in new collaborative approaches to address fraud, waste, and abuse; and for issues identified in the SIU audits, MCOs are implementing corrective actions.

Increased MCO Investment in SIUs

After completing its series of SIU audits, the IG Audit Division conducted a survey of MCO actions in response to this series of audits. MCO responses indicated that 15 of 22 MCOs increased their SIU financial commitment in state fiscal year 2016, and 20 of 22 MCOs plan to increase their commitment in state fiscal year 2017. The collective increases, totaling $1.7 million in fiscal year 2016 and $3.6 million in fiscal year 2017, represent increased SIU spending of 10.8 percent and 21 percent, respectively. Actual and planned increases in MCO spending are focused on actions to increase the number of staff dedicated to SIU activities and to enhance SIU data analytics capabilities.



Improved Collaboration between HHSC, MCOs, and the IG

Throughout the course of this series of audits, the IG Audit Division observed improved communication and collaboration between HHSC, MCOs, and the IG. Key activities intended to improve fraud, waste, and abuse outcomes included creation of the Texas Fraud Prevention Partnership, expanding the content of quarterly meetings between the SIUs and IG staff, and improved responsiveness by the IG after receiving SIU referrals.

Corrective Actions in Place to Address Audit Issues

The MCOs for which the IG made recommendations for improvement have all submitted, and are actively pursuing, corrective actions to improve their SIU functions. Actions are designed to address opportunities to increase SIU staffing; expand the use of data analytics and the scope of investigations; improve the accuracy of reporting to the IG; provide more effective fraud, waste, and abuse training; and expand cost containment efforts.

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INTRODUCTION

This informational report, which is not an audit report under generally accepted government auditing standards, summarizes special investigative units (SIU) program effectiveness based on the results of seven audits performed by the IG Audit Division, and additional information provided by managed care organizations (MCOs) in response to an IG survey.

The Texas Health and Human Services Commission (HHSC) Inspector General (IG) Audit Division conducted six audits of MCO[1] SIUs, and an audit of a third party contractor providing SIU services to six additional MCOs. The objective of the audits was to evaluate the effectiveness of MCO SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC. The audits included state fiscal years 2014 and 2015, which covered the period from September 2013 through August 2015.[2] Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

This informational report is the last in a series of reports on MCO SIUs. The first report was an informational report that provided background, context, and a compilation of information provided by the 22 Texas Medicaid and Children's Health Insurance Program (CHIP) MCOs. Seven subsequent audit reports detailed the IG Audit Division's conclusions regarding the compliance and effectiveness of the SIU function for twelve MCOs. During the course of these audits, the total number of Texas MCOs was reduced from 22 to 21 as a result of policy changes in the delivery of behavioral health services.

Background

Contracted MCOs are responsible for administering, on behalf of the State of Texas, billions of dollars of Medicaid and CHIP health care services each year through their health plans. By contract and state law, MCOs are required to establish and maintain SIUs to investigate

[1] Throughout this report, managed care organizations, dental maintenance organizations, and behavioral health organizations are collectively referred to as managed care organizations (MCOs). An MCO is an organization that delivers and manages health services under a risk-based arrangement. The MCO receives a monthly premium or capitation payment for each managed care member enrolled, based on a projection of what health care for the typical individual would cost. If members' health care costs more, the MCO may suffer losses. If members' health care costs less, the MCO may profit. This gives the MCO an incentive to control costs. In this report, health plans, dental maintenance organizations, and behavioral health organizations are collectively referred to as MCOs.

[2] The audit of Christus Health Plan's SIU includes state fiscal years 2014, 2015, and 2016, which covers the period from September 2013 through August 2016.

potential fraud, waste, and abuse by members[3] and health care service providers.[4] An MCO may contract with an outside organization to perform all or part of the activities associated with the SIU. The IG is responsible for approving each MCO's annual fraud, waste, and abuse plan, and evaluating and sometimes investigating any fraud referrals it receives from MCOs.[5]

SIUs are required to refer suspected fraud, waste, and abuse to the IG.[6] If the IG determines it will not pursue an SIU referral, the MCO is responsible for recovery of any Medicaid and CHIP overpayments associated with the referral.[7]

The IG Audit Division assessed the SIU function at the following six MCOs, and published reports as part of this series of SIU performance audits:

- Seton Health Plan, Inc.
  IG Report number IG-16-011, issued June 9, 2016
- Cigna-HealthSpring
  IG Report number IG-16-012, issued August 24, 2016
- DentaQuest USA
  IG Report number IG-16-013, issued August 24, 2016
- Texas Children's Health Plan, Inc.
  IG Report number IG-16-016, issued August 24, 2016
- Superior HealthPlan, Inc.
  IG Report number IG-16-014, issued August 26, 2016
- Christus Health Plan
  IG Report number IG-16-017, issued November 22, 2016

The IG also audited the SIU services delivered by Health Management Systems, Inc. (HMS), a third party contractor providing SIU services to six Texas MCOs.[8] HMS offers a variety of

[3] MCOs refer to enrollees as "members." An "enrollee" is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

[4] Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015); 4 Texas Government Code § 531.113 (September 1, 2015). *See also* 1 Texas Administrative Code § 353.502 and § 370.502 (March 1, 2012).

[5] 4 Texas Government Code § 531.113 (September 1, 2003).

[6] 1 Texas Administrative Code § 353.502 and § 370.502 (March 1, 2012).

[7] 4 Texas Government Code § 531.1131 (September 1, 2011); 1 Texas Administrative Code § 353.505 (March 1, 2012).

[8] Audit of Medicaid and CHIP MCO SIUs: Health Management Systems, Inc.: Third Party SIU, IG Report No. IG-16-015 (August 29, 2016).

services, including detection and investigation of potential fraud, waste, and abuse. The IG Audit Division reviewed SIU services related to the following six MCOs contracted with HMS:

- Community Health Choice
- Cook Children's Health Plan
- El Paso First Health Plans, Inc.
- Scott and White Health Plan
- Sendero Health Plans, Inc.
- UnitedHealthcare Community Plan of Texas, L.L.C.

The IG Audit Division evaluated MCO SIU efforts, and relevant HMS activities performed on behalf of MCOs, related to:

- Prevention processes, such as the organizational code of ethics, credentialing and re-credentialing, exclusion verification, and fraud, waste, and abuse training.
- Detection activities, such as complex data analysis, periodic provider audits, intake of fraud referrals from hotlines and other sources, and verification that recipients received billed services.
- Investigation efforts, such as conducting preliminary investigations, full-scale investigations, and SIU case management.
- Disposition of fraud, waste, and abuse investigations, including referrals to the IG, corrective action plans, and monetary recovery.
- Reporting of SIU activities to the IG, including a monthly report of ongoing investigations and annual reporting of SIU recoveries.

Texas Health and Human Services (HHS) agencies administer public health programs for the State of Texas. Within HHS, the HHSC Medicaid and CHIP Services Department oversees Medicaid and CHIP, which are jointly funded state-federal programs that provide medical coverage to eligible individuals. In 2015, there were approximately 4.4 million individuals enrolled in Medicaid and CHIP.[9]

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. CHIP provides health coverage to low-income, uninsured children in families with incomes

[9] Texas Medicaid and CHIP in Perspective, Eleventh Edition, Texas Health and Human Services Commission (February 2017).

too high to qualify for Medicaid. In federal fiscal year 2015, Texas spent $30 billion on Medicaid and CHIP. This represented 29 percent of the entire 2015 Texas state budget.[10]

Medicaid and CHIP programs deliver health care services (including medical, dental, prescription drug, disability, behavioral health, and long-term support services) to eligible individuals. CHIP provides services to individuals in Texas through a managed care model. Texas Medicaid provides services to some individuals through a traditional fee-for-service model,[11] but most are enrolled through a managed care model.[12] For providing these services, MCOs receive capitation payments, which are monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to MCOs at fixed, per member, per month, rates based on members' associated risk groups.[13] These payments include federal and state funds.

In 2015, 100 percent of CHIP enrollees were in managed care. Collectively, approximately 88 percent of the combined Medicaid and CHIP populations (3.9 million individuals) were enrolled in managed care.[14] The managed care model reinforces MCOs need to contain costs, manage utilization, and ensure quality care for its members.

[10] Texas Medicaid and CHIP expenditures in 2015 are "all funds" (which include state and federal dollars), but excludes Medicaid funding for Disproportionate Share Hospital, Upper Payment Limit, Uncompensated Care, and Delivery System Reform Incentive Payment funds. Medicaid and CHIP amounts are for the federal fiscal year, and the state budget reflects the state fiscal year which begins one month prior to the federal fiscal year.

[11] Medicaid fee-for-service was the original service delivery model for Texas Medicaid introduced in 1967. In this model, enrolled Medicaid providers are reimbursed retrospectively for a Medicaid eligible health care service or services provided to a Medicaid eligible patient.

[12] Medicaid managed care was first introduced in pilot programs in Texas in 1993. In this model, the state contracts with MCOs who contract with Medicaid providers for the delivery of health care services to Medicaid enrollees. MCOs must provide the same services under managed care as provided under the traditional fee-for-service model.

[13] A "risk group" is a group of MCO members that have a similar health status and are expected to have a similar Medicaid or CHIP spending pattern. HHSC applies an acuity risk adjustment to capitation rates to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. Final capitation payments are based on this acuity risk-adjusted premium for each combination of service area and risk group.

[14] Texas Medicaid and CHIP in Perspective, Eleventh Edition, Texas Health and Human Services Commission (February 2017).

OBSERVATIONS AND RESULTS

The IG Audit Division reviewed the audit reports in this series and evaluated MCO survey responses communicating actions taken to improve fraud, waste, and abuse prevention, detection, investigation, and reporting since September 2015. This information is categorized into four primary observations:

- MCOs overall have increased their investment in SIUs.
- Initiatives are underway to improve communication and collaboration between HHSC, MCOs, and the IG.
- Audited MCOs are taking action to address audit issues, and most MCOs, including those not audited as part of this series, are taking actions to strengthen their SIU functions.
- Outcomes associated with successful SIU investigations may discourage MCOs from investing in their SIU function.

Details related to the above observations are presented in the sections that follow.

SECTION 1: INCREASED COLLABORATION BETWEEN MCOs, HHSC, AND THE IG

Through the course of this series of audits, the IG Audit Division observed communication and reporting practices between MCOs, HHSC, and the IG. Audit reports for each MCO SIU contain specific recommendations to improve practices where needed.

To evaluate MCO SIU activities undertaken since the start of this series of audits, the IG Audit Division conducted a survey of MCOs. The results of the survey are detailed in this report, and indicate that most MCOs have taken steps to address issues identified in their audits, including MCOs that were not part of this series of audits.

Key ongoing activities intended to improve fraud, waste, and abuse outcomes include the creation of the Texas Fraud Prevention Partnership, quarterly SIU meetings with MCO SIU and IG staff, one on one meetings between MCO SIU and IG staff, improvements to the IG process for responding to SIU referrals, and quarterly meetings between the HHSC Medicaid and CHIP Services Department and IG to share fraud, waste, and abuse information. Information on each of these collaborative efforts are detailed in the sections that follow.

Texas Fraud Prevention Partnership

In the fall of 2016, the IG initiated the Texas Fraud Prevention Partnership (TFPP). The TFPP's purpose is to facilitate the exchange of information between the IG and Texas MCOs resulting in better detection, deterrence, and reduction in health care fraud, waste, and abuse. To achieve the TFPP's purpose, the TFPP will focus on enhancing and streamlining the detection, prevention, and investigation of possible fraud, waste, and abuse in Texas Medicaid and CHIP. TFPP participation is voluntary and will enable the IG and participating MCOs to individually share successful practices, effective methodologies, and strategies for detecting, preventing, and investigating health care fraud, waste, and abuse in Texas Medicaid and CHIP.

TFPP's activities will focus on the following:

- Sharing data and analytics with the IG.
- Sharing information and analysis in accordance with state and federal confidentiality and HIPAA laws, rules and regulations, and any other applicable laws.
- Identifying potential areas of fraud, waste, or abuse in Texas Medicaid and CHIP.
- Facilitating best practices in the detection, prevention and investigation of potential fraud, waste, and abuse in Texas Medicaid programs and CHIP.

MCOs participating in the initial phase are Superior HealthPlan, UnitedHealthcare Community Plan of Texas, Amerigroup Texas, Texas Children's Health Plan, Community

Health Choice, Driscoll Children's Health Plan, MCNA Insurance Company, and DentaQuest USA. As the TFPP matures additional MCOs are expected to become participants.

Periodic Meetings with MCO SIU Staff

The IG Investigations Division conducts quarterly SIU meetings, with all Medicaid and CHIP MCOs, to provide training and to discuss fraud, waste, and abuse trends and schemes. Meeting agendas include speakers from MCOs, the Medicaid Fraud Control Unit (MFCU) of the Texas Attorney General's Office, and the IG. These parties discuss program integrity initiatives and contract deliverables, present key changes or clarifications, and provide training on investigations. There is also a break-out session for the two Dental Maintenance Organizations conducted by the IG Medical Services Division to discuss specific issues related to dental fraud, waste, and abuse schemes or cases.

The IG Investigations Division organizes quarterly one on one meetings with five of the largest MCOs which includes Superior, United Health Care, Amerigroup, Texas Children's Health Plan, and Community Health Choice individually to discuss issues related to fraud, waste, and abuse detection, investigation, and reporting. During these meetings, the IG Investigations Division addresses pending cases listed on the MCO SIU monthly open case list (reported to the IG by the MCOs) and full-scale cases referred by the MCOs. The IG and MCO representatives also discuss recent fraud, waste, and abuse schemes and trends. The IG Audit Division also organizes ad hoc meetings with specific MCO SIU staff as needed and requested.

In addition to the quarterly meetings, HHSC conducts annual fraud, waste, and abuse training for MCOs and any other entities that process Medicaid claims. Staff from the IG Investigations Division participates in this training as subject matter experts.

Improvements in SIU Referral Process

The IG Investigations Division, in collaboration with MCOs, has cleared a backlog of cases and established timelines for responding to MCOs after receiving an SIU referral. In October 2016, the IG Investigations Division began a 3 phase review of approximately 900 cases, initiated in response to SIU referrals that the IG had investigated and closed. Phases 1 and 2 involved approximately 134 cases. Of the cases reviewed in phases 1 and 2, the IG reopened 38 cases for additional investigation. The phase 3 review of 745 closed cases was completed on January 6, 2017. Of the 745 cases, 61 were identified for re-opening. The 61 cases are currently being opened and assigned to full-scale investigation.

The IG Investigations Division now works collaboratively with MCO SIUs to help ensure accurate and reliable information is provided to the IG. In cases where there is incomplete information received from MCOs, the IG Investigations Division communicates with the MCO and requests more information rather than simply rejecting the cases. Additionally, the

IG Investigations Division has revised its intake and full scale investigation processes and dedicated a position to act as an MCO SIU liaison. This dedicated position communicates and facilitates referrals and coordinates investigative activities with referring MCOs.

Collaboration between MCO SIUs and the IG is imperative to ensure quality referrals or comprehensive investigations. The IG Investigations Division has recently assigned an investigator to communicate monthly with each referring MCO. This renewed emphasis on communication should increase the effectiveness of the MCO SIU and IG partnership by enabling more timely feedback and improving coordination between parties.

Collaboration on MCO Readiness Reviews, Monitoring, and Re-procurements

The IG and Medicaid and CHIP Services Department are prepared to work collaboratively in the assessment of an SIU function during MCO readiness reviews. HHSC conducts readiness reviews in order to ensure MCOs are prepared to meet contractual obligations. Readiness reviews are conducted (a) before enrollment of recipients and (b) before health care services are provided. Readiness reviews include, but are not limited to, on-site inspections and tests of service authorizations, claims payment systems, and complaint processing systems.[15]

In addition, the Medicaid and CHIP Services Department conducts site visits at MCOs to monitor and evaluate compliance with requirements of the Uniform Managed Care Contract. The IG is prepared to participate with the Medicaid and CHIP Services Department on future site visits for the purpose of assessing and reporting on SIU performance.

As part of the re-procurement process, the IG and the HHSC Medicaid and CHIP Services Department are prepared to work collaboratively to incorporate MCO SIU performance as an evaluation factor during the procurement of new managed care contracts. The objective of incorporating MCO SIU performance as an evaluation factor during the procurement process is to assist HHSC in selecting MCOs that meet state and federal requirements for identifying fraud, waste, and abuse of Medicaid funds.

Quarterly Meetings between the HHSC Medicaid and CHIP Services Department and the IG to Share Fraud, Waste, and Abuse Information

Quarterly meetings with responsible Medicaid and CHIP Services Department and the IG have been initiated. The objective of the meetings is to facilitate the sharing of program integrity information. Agenda topics include (a) provider and provider types at risk for fraud, (b) complaints against network providers, and (c) investigation coordination.

[15] 4 Texas Government Code § 533.007(e) (September 1, 2015).

SECTION 2: EVALUATING SIU PERFORMANCE

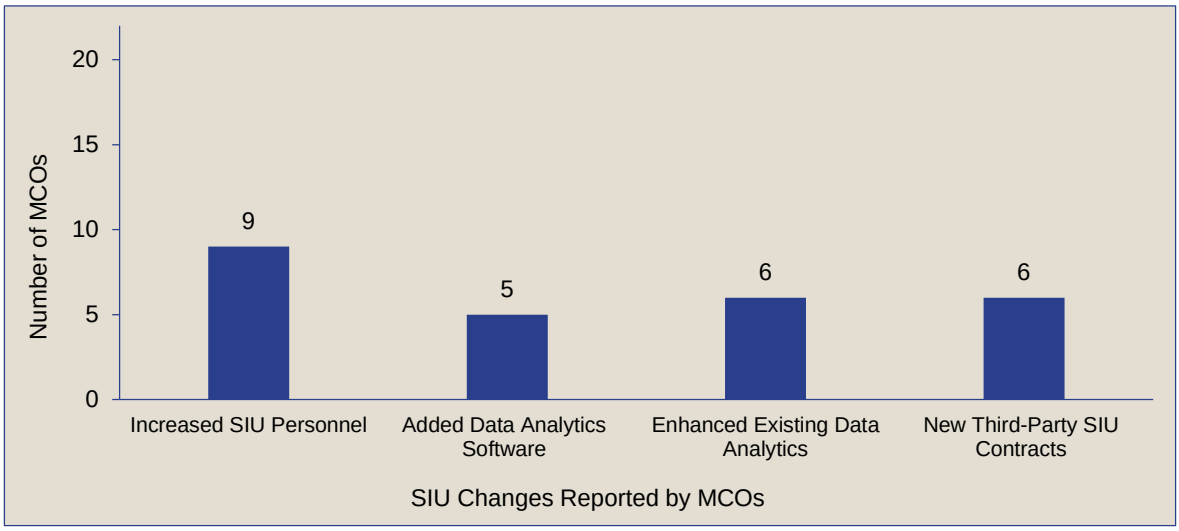
The IG Audit Division conducted a series of audits of MCO SIUs and observed numerous indicators of MCO SIU performance. Recommendations were made to individual MCOs in separate audit reports published by the IG. For audited MCOs, recommendations for improvement in SIU performance involved SIU staffing, use of data analytics, scope of investigations, reporting to the IG, and MCO fraud, waste, and abuse training. MCOs, including many MCOs not audited as part of this series, are expanding their SIU capacities, primarily through increases in funding, improving data analytics capabilities, and personnel commitments, in response to these recommendations.

Expanded SIU Capacities

In September 2016, the IG Audit Division sent a survey to the 21 Texas MCOs to gather information on changes made to SIU programs since the end of the audit period, August 31, 2015 except for the Christus audit, which extended through August 31, 2016, as well as plans for future changes.

Survey responses indicated that 18 of the 21 MCOs[16] had taken at least one action to expand their SIU commitment since August 31, 2015. Figure 1 shows specific changes to SIU programs reported by MCOs in 2016.

Figure 1: MCO Changes to SIU Programs since August 31, 2015

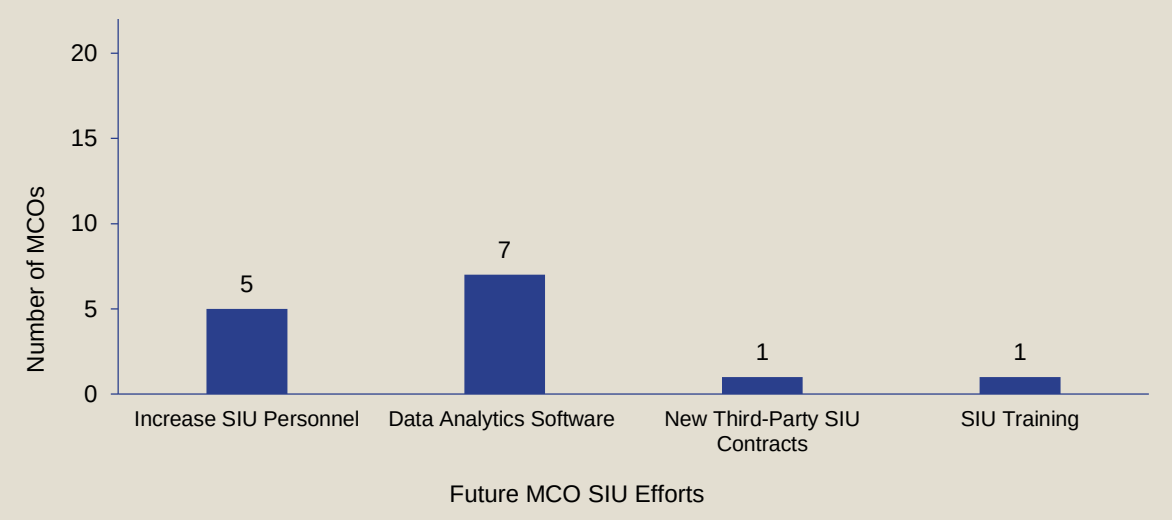


Source: IG Audit Division Survey 2016

[16] Some MCOs reported implementing improvement in more than one area.

Fourteen MCOs have plans to strengthen at least one area of their SIU in the future. Five MCOs plan to hire additional SIU personnel, seven plan to purchase data analytics software, and one intends to provide additional training for their SIU personnel. One MCO reported a plan to execute a new third-party contract to enhance its SIU capability. Figure 2 shows the MCOs' reported plans for changes to their SIU efforts.

Figure 2: MCO Reported Plans for Future SIU Investments



Source: IG Audit Division Survey 2016

In addition to SIU expanded capabilities, the total MCO financial commitment to SIUs increased. Table 1 shows the reported total dollars committed to SIUs by all MCOs from 2015 through 2017. MCOs reported an overall financial commitment of $15.6 million in 2015 and $17.3 million in 2016. These amounts represent a 10.8 percent increase in SIU investment from 2015 to 2016. Collectively, MCOs reported plans to increase SIU investment by an additional 21 percent in 2017.

Table 1: MCOs Dollar Commitment from 2015 to 2017

Year	Total Dollars Committed	Dollar Change from Previous Year	% Change from Previous Year
2015	$ 15,599,283	-	-
2016	$ 17,277,654	$ 1,678,371	10.8%
2017	$ 20,913,029	$ 3,635,375	21%

Source: Information Reported by MCOs in November 2016

Financial commitments to SIUs varied among the MCOs. The following changes in SIU investment were reported by the 22 MCOs active between 2015 and 2016:

- Fifteen MCOs reported increases in SIU commitment between 2015 and 2016. Those increases ranged from 3.6 percent to 112.9 percent.
- Five MCOs reported decreases in SIU commitment between 2015 and 2016. Those decreases ranged from 2.9 percent to 70.5 percent.
- Two MCOs did not provide 2015 data for comparison.

From 2016 to 2017, 17 of the 21 active MCOs[17] reported projected increases to their SIU financial commitments. The remaining four MCOs reported either no projected increase or a decrease in SIU financial commitment.

Areas for Improvement

MCO SIUs have experienced systemic issues in their efforts to combat fraud, waste, and abuse. The IG Audit Division has determined that these systemic issues contributed to results seen throughout the managed care system. During the series of SIU audits, the IG Audit Division assessed a variety of SIU functions performed by 12 MCOs, including prevention, detection, and reporting, and identified the following areas that consistently represented opportunities for improvement:

- SIU staffing
- Use of data analytics
- Scope and number of investigations
- MCO reporting
- Fraud, Waste, and Abuse Training

SIU Staffing

The Texas Uniform Managed Care Contract does not establish specific requirements for SIU staff or resource commitment.[18] With no specific requirement, MCOs vary widely in their staffing and resource commitments.

The New Jersey Department of Human Services employs very specific language in its managed care contract. Not only does New Jersey require a minimum of one full time equivalent employee per 60,000 enrollees, but the state has also defined education and

[17] One MCO active in 2016 was no longer contracted with HHSC to provide managed care services in 2017, reducing the number of MCOs from 22 to 21 in 2017.

[18] Texas Health & Human Services Commission, Uniform Managed Care Terms & Conditions, Attachment B-1, Section 8.1.19.1 (v 2.16).

experience requirements for investigators.[19] Implementation of such a standard in Texas would require most MCOs to increase SIU staffing levels, some by over 400 percent from current staffing levels.

Although staffing levels and requirements are not specifically established by contract for MCO SIUs, adequate staffing is required to enable SIUs to perform the activities and functions expected of an effective SIU. Many of the SIU staff that MCOs reported as participating in an MCO's SIU included directors and executives who may not be directly involved in the daily operations of an SIU. SIUs should be staffed with sufficient numbers of qualified individuals to effectively carry out fraud, waste, and abuse detection, investigation, and reporting activities.

Use of Data Analytics

Of the twelve SIUs audited, seven utilized post-payment data analytics, and one MCO had limited application of automated post-payment analysis of claims data. Texas Administrative Code requires that an MCO's annual fraud, waste, and abuse plan submitted to the IG must address the following: (1) "use of audits to monitor compliance and assist in detecting and identifying Medicaid program violations and possible waste, abuse, and fraud overpayments through data matching, analysis, trending, and statistical activities;" (2) "monitoring of service patterns for providers, subcontractors, and recipients;" and (3) "use of edits or other evaluation techniques to prevent payment for fraudulent or abusive claims."[20] Post-payment claims analysis enables more complex data analysis over longer periods of time than is available at a pre-payment level.

Scope of SIU Investigations

The scope and size of investigations can impact SIU effectiveness. Texas Administrative Code requires that full-scale investigations include at least (a) 50 recipients or (b) 15 percent of a provider's claims that are related to the suspected fraud, waste, and abuse.[21] Differing interpretations of this administrative rule have allowed some MCOs to limit investigations that might otherwise be expanded to include a larger sample of recipients or claims related to the original case of suspected fraud, wasted, or abuse.

For example, an MCO that relies on data analytics focuses its investigations on outliers. These investigations concentrated on specific combinations of services and age groups. In one instance, the MCO discovered that a billed service under review by its SIU had not been provided, and the Medicaid recipient had not been seen by the provider on the day services were billed. Despite multiple additional services billed on the same day by that provider, the

[19] State of New Jersey Department of Human Services, Managed Care Contract, Section 7.36.4 (2016).

[20] 1 Texas Administrative Code § 353.502(c)(1)(A), (B), and (E) (March 1, 2012).

[21] 1 Texas Administrative Code § 353.502(c)(2)(C) (March 1, 2012).

MCO only requested reimbursement for the service originally identified through data analytics, and did not investigate or pursue recovery of the other services billed on the date in question.

MCO Reporting

During the period under review, the IG observed instances of incomplete and inaccurate information reported to the IG by some MCOs. Examples include the following:

- Not reporting all required case information of suspected fraud, waste, and abuse on the IG monthly open case list.[22]
- Bundling cases on the open case list rather than individually listing the open cases as required by the prescribed IG template.[23]
- Discrepancies between information reported to the IG and the documentation maintained by the MCOs.

The IG relies on information MCOs report to coordinate fraud prevention, detection, and investigation efforts. Reported information that is accurate and complete will result in more positive outcomes. As previously noted, the IG and the MCOs are working together, through periodic collaborative meetings, to improve the quality of their respective communications, including the accuracy and completeness of information reported by MCOs.

Fraud, Waste, and Abuse Training

Texas regulations require MCOs to provide annual training to their employees and subcontractors on fraud, waste, and abuse.[24] The training is required to be delivered within 90 days of hire and annually thereafter.[25] Developing annual fraud, waste, and abuse training that is specific and appropriate for the roles of employees and subcontractors helps individuals become more aware of the potential for fraud, waste, or abuse in their daily work. Of the 12 MCOs included in this audit series, 2 MCOs did not provide adequate training to employees, while 1 MCO did not ensure subcontractors provided fraud, waste, and abuse training to subcontractor employees.

By consistently providing fraud, waste, and abuse training, employees and subcontractors may acquire the knowledge and awareness needed to prevent, detect, and report suspected fraud, waste, and abuse to the SIU or the IG.

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[22] HHSC Uniform Managed Care Manual, Chapter 5.0, Consolidated Deliverables Matrix, Deliverable 51, Version 2.1 (May 5, 2012) through Version 2.3 (January 5, 2015).

[23] HHSC Uniform Managed Care Manual, Chapter 5.5.1, MCO Open Case List Report Template, Version 2.1 (September 6, 2012).

[24] 1 Texas Administrative Code § 353.502(c)(6)(A) (March 1, 2012).

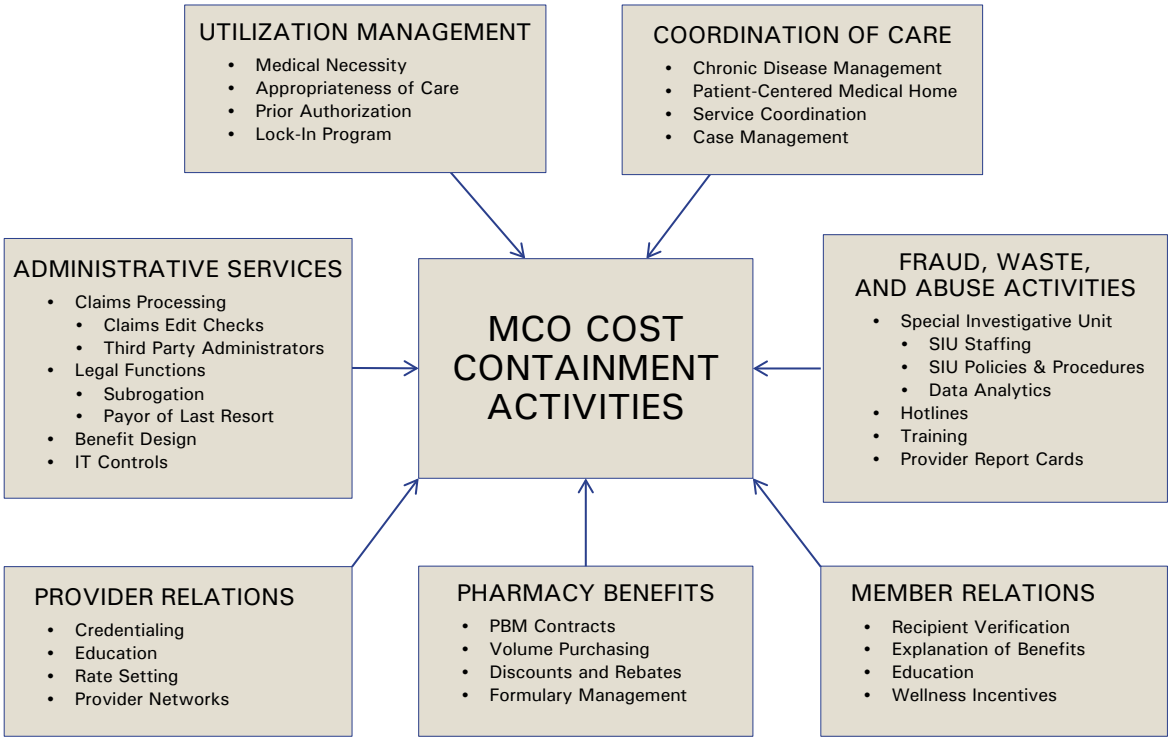
[25] An employee was considered to have been trained annually if the time between trainings was twelve months or less.

Cost Containment

A consistent theme throughout this series of audits was the role of cost containment. Several MCOs emphasized the efforts of business areas, such as utilization management and claims adjudication, to detect unauthorized or inappropriate billing and to prevent associated payments. Current SIU metrics focus on detection, investigation, and recovery of fraud, waste, and abuse on a post-payment basis.

MCO cost containment efforts cross many business areas and functions. These efforts consistently target controlling and minimizing administrative and medical expenses, but the functional and organizational structure used to pursue these efforts varies across MCOs. Figure 3 provides a partial overview of the activities MCOs employ to help contain costs. These may include activities related to (a) utilization management; (b) coordination of care; (c) fraud, waste, and abuse detection and prevention; (d) member or provider relations; (e) pharmacy benefits; and (f) administrative services. This information is not meant to represent a complete set of activities, nor does it represent the structure of the business units at any specific MCO.

Figure 3: MCO Functions and Activities Related to Cost Containment



Source: IG Audit Division

According to the Texas Association of Health Plans, Medicaid integrity initiatives should focus on cost containment strategies instead of post-payment recovery efforts,[26] and some MCOs have incorporated some type of cost containment measures. These measures have the potential to reduce the number of cases of suspected fraud, waste, and abuse by preventing overpayments that would otherwise either not be detected, or would have only a small likelihood of being detected by SIUs performing post-payment analysis.

Cost containment efforts varied among MCOs. Nine MCOs each reported over $1 million in cost containment savings, one MCO reported over $75,963, and another reported $18,247. Eleven MCOs reported no cost containment savings during the audit period.

While cost containment is an effective preventive control, it is almost always better to prevent an improper payment than it is to make one and then try to recover the overpaid amount. A comprehensive and effective fraud, waste, and abuse program should include both preventive and detective elements.

For example, information gathered in post-payment analytics and investigative activities can be used to strengthen and inform preventive efforts. According to the Medicaid Integrity Institute, "post-payment review identifies patterns and trends, and leads to recoveries, edits, and policy changes."[27] In addition, when evaluating the return on investment of cost containment activities, SIU post-payment efforts should be considered in conjunction with pre-payment efforts performed by non-SIU business areas.

By emphasizing both prevention of improper payments and recovery of overpayments, MCOs can more substantially affect fraud, waste, and abuse across the Texas Medicaid and CHIP system.

Best Practices

The IG Audit Division observed numerous MCO business practices and strategies that affect the detection, investigation, and reporting of fraud, waste, and abuse. Among these practices, the use of data analytics was noted as being particularly productive.

The Use of Post-Payment Data Analytics was Effective

Pre-payment review of claims using data analytics to detect trends and anomalies is a standard business practice for fraud, waste, and abuse detection, and is required by Texas Administrative Code. Pre-payment data analytics provide routine edit checks of claims, and detection of potential issues related to duplicate payments, incorrect coding, and rate errors.

[26] Reducing Fraud, Waste, and Abuse in Medicaid Managed Care, The Texas Association of Health Plans (2016).

[27] Data Analytic Capabilities Assessment for Medicaid Program Integrity, Centers for Medicare and Medicaid Services, Medicaid Integrity Institute. (2014).

Data analytics, when applied to post-payment data, may use algorithms and other techniques that are also effective. Data analytics include standardized queries for monthly reporting, trend analysis, automatic triggers, and application parameters that identify and report abnormal claims to the SIU for further research. Through the use of data analytics, an MCO may be able to share data related to fraud, waste, and abuse with the IG and other MCOs.

The Centers for Medicare and Medicaid Services stated that "Staff investigators can use information from these tools [data analytics and predictive modeling] to focus their efforts and resources to areas of the greatest risk and return, thereby more efficiently managing the Medicaid program, leading to greater recoveries, and discouraging future abuse."[28] The IG Audit Division found that when data analytics was used by an SIU, more investigations were conducted and the average recovery was significantly higher. Table 2 shows how the average number of investigations and average recoveries varied based on the use of data analytics.

Table 2: Results of Post Payment Data Analytics

Utilization of Post-Payment Data	Number of MCOs Reporting	Average #r of Investigations per MCO	Average Recoveries Per MCO
Data Analytics Utilized	6	149	$ 364,081
Data Analytics Not Utilized	6	33	$ 20,670

Source: Audit of Medicaid and CHIP MCO Special Investigative Units

Throughout the series of audits, some MCOs used pre-payment data analytics to support the claims adjudication process. Just as MCO use of pre-payment data analytics is an effective tool in preventing fraud, waste, and abuse, post-payment data-analytics has proven to be effective at detecting fraud, waste, and abuse.

[28] Data Analytic Capabilities Assessment for Medicaid Program Integrity, Medicaid Integrity Institute (2014).

SECTION 3: ROLES AND RESPONSIBILITIES FOR SIU OVERSIGHT

Some MCOs expressed concern over what they perceived as a lack of clarity in the respective roles of the Medicaid and CHIP Services Department and the IG, as described in the following paragraphs, with regard to oversight of SIUs. MCOs indicated the lack of clarity of roles may have contributed to miscommunication or inconsistent expectations regarding administration of SIUs and other MCO program integrity efforts. MCOs also had concerns related to the SIU referral process.

SIU Oversight Roles and Responsibilities

The HHSC Medicaid and CHIP Services Department and the IG share responsibility for oversight of MCOs and their SIUs. Coordinated oversight efforts should help ensure that MCOs effectively perform required program integrity responsibilities.

The Role of the HHSC Medicaid and CHIP Services Department

The HHSC Medicaid and CHIP Services Department is responsible for overall management and monitoring of MCO contracts. This includes updating contract requirements, providing policy interpretation and program guidance, receiving and evaluating contract deliverables, monitoring contractor performance, and addressing MCO performance issues through a series of progressive remedies, including assessment of liquidated damages.

The Role of the IG

Texas Government Code requires HHSC to adopt rules that specify the IG's role in coordinating with MCO SIUs[29]. Accordingly, HHSC has promulgated rules in the Texas Administrative Code to address the following IG responsibilities:[30]

- Review the findings of MCO SIUs.
- Investigate MCO referred cases in which the overpayment amount sought to be recovered exceeds $100,000.
- Investigate alleged fraud, waste, and abuse associated with MCO-referred providers who are enrolled in more than one MCO.

The IG is responsible for oversight of MCO SIUs. Texas Government Code states, "The commission's office of inspector general, in consultation with the commission, shall […] establish requirements for the provision of training to and regular oversight of special investigative units established by managed care organizations […]"[31]

[29] 4 Texas Government Code § 531.113(e) (September 1, 2015).
[30] 1 Texas Administrative Code § 353.501 (March 1, 2012).
[31] 4 Texas Government Code § 531.113(d-1)(2) (September 1, 2015).

Texas Government Code also requires the IG to (a) establish requirements for approving annual fraud, waste, and abuse plans, (b) evaluate and communicate statewide fraud, waste, and abuse trends to MCOs, and (c) assist MCOs in detecting and investigating fraud, waste, and abuse as needed.[32] The IG may review MCO records to determine compliance with SIU requirements.[33]

The IG Investigations Division maintains a staff position that coordinates between the IG and MCO SIUs. This coordination function supports the SIUs by:

- Reviewing and approving annual fraud, waste, and abuse plans submitted by each MCO.
- Collecting monthly MCO Open Case List reports submitted by each MCO.
- Scheduling and conducting quarterly meetings with MCOs to discuss trends in fraud, waste, and abuse.
- Providing updates to MCOs on the status of referrals retained by the IG.
- Compiling and submitting an annual report on certain fraud and abuse recoveries by the MCOs for the state legislature.[34]

SIU Investigations and Referrals

MCOs investigate claims and medical records associated with their members, and are required to collaborate with the IG in their efforts to combat fraud, waste, and abuse. Texas Administrative Code instructs MCOs to utilize the HHSC-OIG fraud referral form to report and refer all possible acts of waste, abuse, or fraud to the IG.[35] Generally, MCOs referred high dollar cases to the IG, and often retained cases with estimated overpayments less than $100,000 for investigation on their own.

MCOs refer cases to the IG through the online IG Waste, Abuse and Fraud Referral System. This online system provides a form for input of detailed information about each case such as the complainant, allegation, witness, estimated overpayment, and sampling information.

[32] 4 Texas Government Code §531.113(d-1) (September 1, 2015).

[33] 4 Texas Government Code §531.113(d) (September 1, 2015).

[34] While 4 Texas Government Code §531.1132 attaches this responsibility to the Health and Human Services Commission, in 2012 the Health and Human Services Commission assigned implementation of this report to the IG.

[35] 1 Texas Administrative Code § 353.502(c)(5)(D) (March 1, 2012).

The IG Process for Responding to MCO Referrals

After initial evaluation by the IG Investigations Intake Unit, referrals may be returned to the MCO, forwarded to another organization, or kept by the IG for further investigation. A referral is returned to the MCO if the referral is incomplete, if there is minimal or no estimated overpayment, or for various other reasons.

The IG Investigations Division conducts investigations of MCO SIU referrals it does not return to the MCO. The IG Investigations Division has access to encounter data[36] for all Medicaid and CHIP enrollees, allowing for comprehensive investigation of suspected incidences of fraud, waste, and abuse among MCOs, providers, and enrollees.

Of the 275 referrals received in 2014 and 2015, the IG Investigations Division retained 146 for further investigation, and returned 129 referrals to the MCOs. When the IG Investigations Division retains a referral from an MCO and completes its investigation, it may return the case to the MCO for recovery of the overpayment, or recommend further action by IG Litigations.

Of the 129 referrals returned to the MCOs in 2014 and 2015, the IG Investigations Division returned 26 because the referrals involved minimal overpayments. These referrals totaled approximately $1.8 million in overpayments with an average estimated value of approximately $68,000 per referral.

When a referred investigation is closed, the IG Investigations Division notifies the referring MCO, and instructs the MCO to move forward with whatever action the MCO deems necessary. When a case is returned to an MCO by the IG without opening a full-scale investigation, the MCO may need to perform further investigation or pursue recovery of overpayments.

MCO Concerns with the Referral Process

While MCOs are required to refer suspected cases of fraud, waste, and abuse to the IG, there are inherent risks and limitations associated with the referred cases. For example, when the IG accepts a referral and investigates a provider, the MCO may be required to continue paying medical claims expenses to the provider while the IG conducts its investigation. In addition, MCOs are unable to report any recoveries associated with accepted referrals as their own efforts.

Finally, if the IG is not timely in making a determination about whether to investigate the referral, and the referral is returned to the MCO many months later, it may be too late for the

[36] Encounter data are the paid claims records that state Medicaid agencies create when they pay providers on a Fee-for-Service basis. Encounter data also include records of the health care services MCOs pay to providers of Medicaid and CHIP services

MCOs SIU to conduct an effective investigation. To help address timeliness concerns, the IG now has a policy in place that it will respond to SIU referrals within 10 days after receiving the referral.

SECTION 4: OUTCOMES OF SUCCESSFUL SIU INVESTIGATIONS MAY DISCOURAGE MCOs FROM INVESTING IN SIU FUNCTIONS

Adjustments to capitation, a potential increased experience rebate to HHSC, and the desire to avoid provider abrasion may deter MCOs from investing resources into their SIU functions.

Financial Impact on MCOs

MCO SIU recoveries may, over time, decrease future capitation payments. For each applicable MCO program, HHSC will pay the MCO a fixed monthly capitation payment based on the number of eligible enrolled members. "The fixed monthly Capitation Rate consists of the following components: an amount for Health Care Services performed during the month; an amount for administering the MCO Program, and an amount for the MCO's Risk margin."[37] Overpayments, including improper coding and instances of fraud, waste, or abuse, must be adjusted or removed from the MCO's medical claims history, encounter data, and financial records, and could negatively impact future capitation payments.

In addition, an increase in income from recovered overpayments may result in the MCO paying a contract required experience rebate to HHSC, or in the MCO paying a higher experience rebate percentage to HHSC. Experience rebates are payments MCOs make back to HHSC when an MCO's profits exceed a contractual threshold. As the ratio of pre-tax income to revenue increases, the MCO must share increasingly large portions of its net income before taxes with HHSC. [38] Since MCO SIU recoveries increase pre-tax income, the MCO may face an experience rebate for substantial SIU recoveries. HHSC assessed an experience rebate for 13 MCOs in 2014, and for 11 MCOs in 2015.

Negative Impact on Provider Relations

MCOs are motivated to maintain provider networks that contain sufficient providers, geographically dispersed across a service area, to adequately serve their members. By insinuating that a provider has committed fraud, waste, or abuse or by recovering claim overpayments, an MCO can negatively affect provider relations. Provider participation in an MCO network can be particularly crucial in underserved areas. In such instances an MCO may decide not to take action against a provider found to have committed fraud, waste, or abuse, in order to preserve the availability of heath care services in that area. For example, in order to avoid ostracizing providers, MCOs may call a fraud, waste, or abuse issue a billing error or an unintentional oversight. As a result, MCOs may resort to the use of education and

[37] Attachment A - Medicaid and CHIP managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions, Section 10.01, Version 2.9 (February 1, 2014) through Version 2.16 (September 1, 2015).

[38] Attachment A - Medicaid and CHIP managed Care Services RFP, Uniform Managed Care Contract Terms and Conditions, Section 10.10, Version 2 (September 1, 2011) through Version 2.16 (September 1, 2015).

training rather than collection of overpayments in an effort to maintain strong provider relationships and network adequacy.

While this response may preserve an MCO's relationship with a valued provider, by taking such action the MCO is foregoing its obligation to recover overpayments and deter future fraud, waste, and abuse. If Medicaid and CHIP funds remain uncollected, not only have state and federal funds been improperly used but providers may take advantage of the situation believing that the repercussions are minimal.

For MCOs that directly employ providers, a lack of independence may lead to a hesitancy to report potential fraud, waste, and abuse within its system. Similar concerns may arise when providers and the MCO belong to the same parent company.

Adjustments to capitation, a potential experience rebate, the possibility of provider abrasion, and potential conflicts of interest may reduce the MCO's incentive to invest in and maintain an effective SIU.

CONCLUSION

This report is the last in a series of reports on MCO SIUs. It provides an overview of SIU program effectiveness based on the results of the MCO SIU audits.

MCOs received over $17 billion in Medicaid and CHIP capitation payments in 2015, and their health care providers submitted approximately $12.5 billion in medical claims for services provided in 2015. National studies indicate that fraud may represent at least 3 percent of medical costs in the United States, while fraud, waste, and abuse may collectively represent at least 20 percent of medical costs.[39]

HHSC, the IG, and the contracted MCOs share accountability for ensuring that state and federal dollars are used to deliver cost-effective health care services to eligible Medicaid and CHIP enrollees. To ensure that Texas Medicaid and CHIP is safeguarded against fraud, waste, and abuse, state law and contractual provisions require MCOs that have Medicaid and CHIP contracts establish an SIU to investigate potential fraud, waste, and abuse. An effective SIU function is essential to ensure that:

- State and federal funds spent on managed care are used appropriately.
- Suspected fraud is detected, investigated, and when substantiated, reported to the IG or the Office of Attorney General Medicaid Fraud Control Unit.
- Funds lost to fraud, waste, and abuse are recovered and reported to HHSC.
- Capitation rates established for Medicaid accurately reflect the cost of providing health care services to eligible beneficiaries.

MCOs may (a) have an SIU comprised entirely of internal resources, (b) engage a third party contractor to perform it's SIU function, or (c) maintain an SIU comprised of both internal and third party contracted resources. Six MCOs audited in this series maintained a subcontracted third party SIU.

As a result of this series of audits, the IG and MCOs have begun to engage in collaborative efforts to improve SIU effectiveness. To improve performance of SIUs, measures have been taken to increase the use of data analytics, enhance information sharing, and expand the impact of SIU and IG Medicaid program integrity efforts. Additionally, the IG is proactively meeting with MCOs and the HHSC Medicaid and CHIP Services Department routinely in order to maintain continued dialogue and to ensure that best practices are shared for the benefit of all MCOs.

[39] The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary. Washington, DC: The National Academies Press, Institute of Medicine (2010); Berwick, D. M., & Hackbarth, A. D., Eliminating Waste in US Health Care. *JAMA*, *307*(14), 1513-1516 (2012).

In addition, since this series of SIU audits was initiated, the IG and the Medicaid and CHIP Services Department have increased their collaborative and cooperative efforts to ensure there are clearly defined roles and responsibilities for oversight of SIUs and other Medicaid program integrity requirements, and to increase information sharing of fraud, waste, and abuse information.

Finally, the MCO community is collectively increasing its resource commitment to combating fraud, waste, and abuse by increasing SIU staffing levels, investing in data analytics tools, and providing fraud, waste, and abuse training.

The IG Audit Division thanks management and staff at the HHSC Medicaid and CHIP Services Department, the IG Investigations Division, and the MCOs for their cooperation and assistance.

APPENDIX A: Scope and Methodology

Scope

The scope of this informational report includes (a) seven audits covering the performance of 12 MCO SIUs for the period of September 2013 through August 2015, (b) MCO self-reported information on activities occurring subsequent to August 2015, and (c) information obtained from the IG Investigations Division on initiatives underway as of December 2016.

Methodology

The IG Audit Division reviewed the results, issues, and recommendations reported for this series of audits. This included audited information for the SIU function at six MCOs as well as a third party contractor providing SIU services to an additional six MCOs.

In addition to audited information, the IG Audit Division reviewed survey information reported by the 21 MCOs in response to a request for information sent at the close of the series of audits. The IG Audit Division also compiled information based on interviews with responsible management in the IG Investigations Division.

Professional judgment was exercised in planning, executing, and reporting results for this report.

The IG Audit Division conducted the series of performance audits discussed in this report in accordance with generally accepted government auditing standards (GAGAS) issued by the Comptroller General of the United States. The IG Audit Division did not produce this report in accordance with GAGAS. This report is not an audit report. This report consists of audited and non-audited information compiled by the IG Audit Division. Some of the information reported by the MCOs and by the IG Investigations Division has not been validated, but in combination with audited information is sufficient to satisfy the objective of this report.

APPENDIX B: Report Team and Report Distribution

Report Team

The IG staff members who contributed to this informational report include:

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- Laura Ketterman, Director of Compliance

Community Health Choice

- Kenneth W. Janda, President and Chief Executive Officer
- Nike Otuyelu, Corporate Compliance and Risk Management

Cook Children's Health Plan

- Robert Watkins, President and Chief Operating Officer
- Kathleen Roman, Director of Regulatory Compliance

DentaQuest USA

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- Nicholas Messuri, Chief Compliance Officer

Driscoll Children's Health Plan

- Mary Peterson, President
- Lauren Parsons, SIU Compliance Officer
- Cecilio Trevino, SIU Manager

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FirstCare Health Plans

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- Holly Munin, Plan Chief Performance Officer
- Daniel Kreitman, Director of SIU

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- Randall Wright, President
- Sharon McWhorter, Director, Controls and Compliance

UnitedHealthcare Community Plan of Texas, L.L.C.

- Don Langer, President and Chief Executive Officer
- Stephen Lobo, Fraud, Waste and Abuse Manager

ValueOptions of Texas, Inc.

- Timothy Murphy, President and Chief Executive Officer
- McKenzie Frazier, Director of Compliance/Program Integrity

APPENDIX C: IG Mission and Contact Information

Inspector General Mission

The mission of the IG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of IG's mission and statutory responsibility includes

- Stuart W. Bowen, Jr. — Inspector General
- Sylvia Hernandez Kauffman — Principal Deputy IG
- Christine Maldonado — Chief of Staff and Deputy IG for Operations
- Olga Rodriguez — Senior Advisor and Director of Policy and Publications
- Roland Luna — Deputy IG for Investigations
- David Griffith — Deputy IG for Audit
- Quinton Arnold — Deputy IG for Inspections and Evaluations
- Debbie Weems — Deputy IG for Medical Services
- Alan Scantlen — Deputy IG for Data and Technology
- Anita D'Souza — Chief Counsel

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- Phone: 1-800-436-6184

To Contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
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