Summary of Results: Audits of Medicaid and CHIP MCO Special Investigative Units

Selected Texas Managed Care Organizations

Results in Brief

Audits Summarized in this Report

Between 2018 and 2022, the Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted five audits of special investigative unit (SIU) activities at five managed care organizations (MCOs):

- Aetna Better Health of Texas, Inc.
- Blue Cross and Blue Shield of Texas
- Community First Health Plans, Inc.
- Driscoll Health Plan
- Molina Healthcare of Texas, Inc.

In 2021, 17 MCOs administered, on behalf of the state of Texas, nearly $32 billion in Medicaid and Children's Health Insurance Program (CHIP) services. The five audited MCOs served 16 percent of all Texas Medicaid and CHIP members in 2021.

Summary of Review

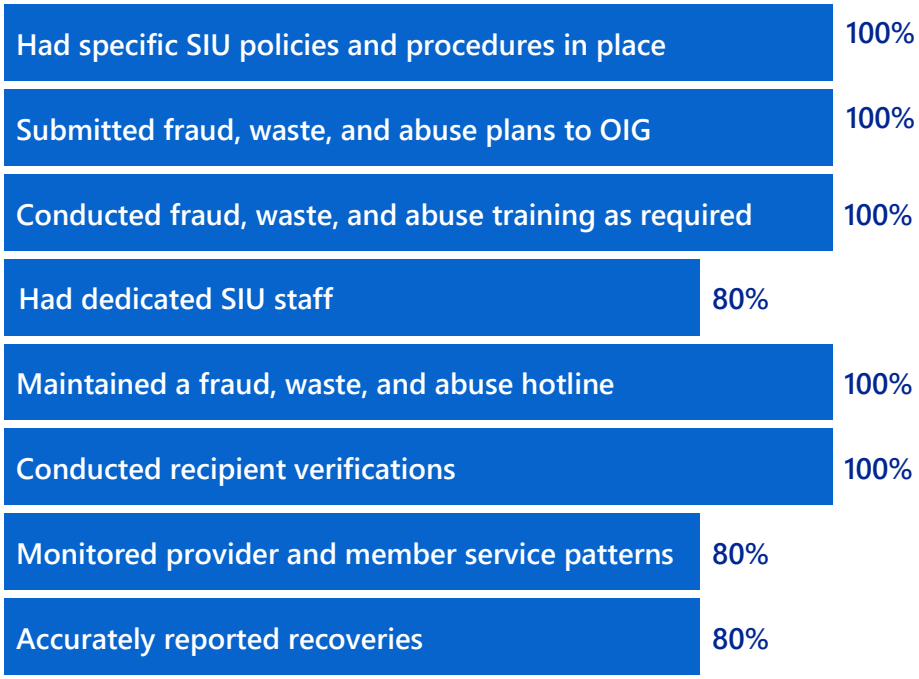
The audits evaluated each MCO's compliance with requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse in Texas Medicaid and CHIP and (b) reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services Commission. The audit scopes included some or all of the two state fiscal years prior to each report's publication and spanned the period from September 2015 through August 2020.

Conclusion

The five audited managed care organizations (MCOs) met requirements for (a) conducting recipient verifications and monitoring provider and member service patterns; (b) having specific special investigative unit (SIU) policies and procedures in place; (c) submitting fraud, waste, and abuse plans to the Texas Health and Human Services (HHS) Office of Inspector General (OIG); (d) conducting fraud, waste, and abuse training; and (e) maintaining a fraud, waste, and abuse hotline.

Four of the five MCOs had dedicated SIU staff to handle Texas volume. Four of the five MCOs also accurately reported recoveries, although some MCOs did not always complete investigative activities in an appropriate time frame. Figure 1 reflects the positive results across the five audits.

Figure 1: SIU Areas of Compliance



Source: OIG Audit

Background

HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, or abuse by Texas Medicaid and CHIP members and health care service providers. Fraud, waste, and abuse monitoring and prevention activities MCOs must conduct include (a) maintaining an SIU, (b) claims analysis, (c) hotlines, and (d) training.

As defined in Texas Administrative Code, requirements of the SIU function are prevention, detection, investigation, and reporting.

Prevention requirements include assigning responsibility for the fraud, waste, and abuse plan to someone at an appropriately high level in the MCO and providing training to prevent, detect, and report fraud, waste, and abuse.

Detection includes monitoring service patterns, conducting random payment reviews, and implementing procedures to receive and work on referrals by hotline.

Investigations must meet required timelines for completing preliminary and extensive investigations, include required elements for each type of investigation, and meet minimum sample sizes.

Reporting requirements include monthly and quarterly submissions to OIG detailing investigations conducted and monies recovered.

Corrective Actions

OIG Audit made recommendations to the MCOs to address the audit findings. All implemented corrective action plans timely.

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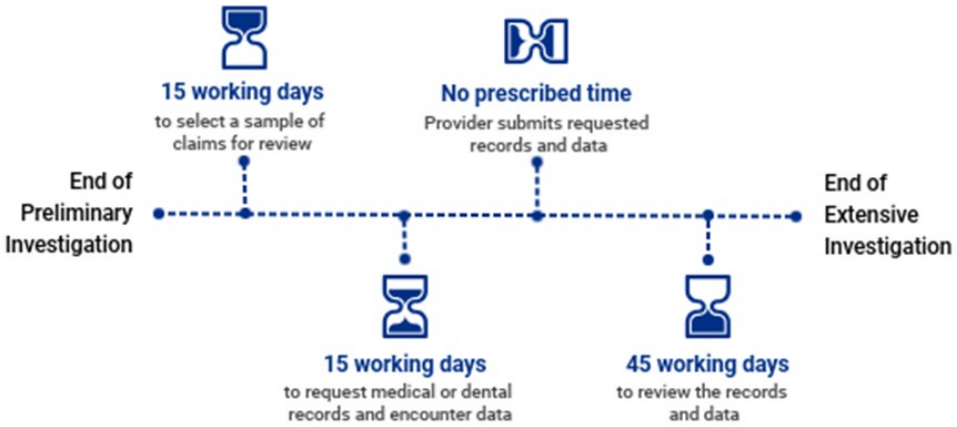
Four of the five audited MCOs had findings for not reporting all open investigations to OIG, which indicates that OIG is not consistently receiving reports of potential fraud, waste, and abuse as required. The Texas Health and Human Services Commission (HHSC) Uniform Managed Care Manual requires each MCO to submit a monthly report to OIG outlining all Medicaid fraud, waste, and abuse investigations opened by its SIU and the status of each investigation. OIG relies on MCOs to perform required reporting on their SIU activities and refer possible instances of fraud, waste, and abuse. Inconsistent reporting by MCOs impairs OIG's ability to effectively analyze, detect, and pursue fraud, waste, and abuse statewide.

Two of the five audited MCOs did not consistently comply with preliminary investigation timelines. MCOs are responsible for investigating possible acts of fraud, waste, and abuse for all Medicaid and CHIP services, starting with a preliminary investigation. SIUs must complete each preliminary investigation within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse.

Two of the five audited MCOs did not consistently comply with extensive investigation timelines. An extensive investigation involves additional required elements, including (a) selecting a sample of claims for review, (b) requesting the records, and (c) reviewing the records. Figure 2 details the timeline for each task in an extensive investigation.

Figure 2: Timeline of Tasks in an Extensive Investigation



Source: OIG Audit

Three of the five audited MCOs had findings about preliminary investigation elements, including not identifying previous allegations or provider education, not reviewing the provider's billing pattern, or not reviewing the past three years of payment history. Not reviewing all the required elements during a preliminary investigation limits the effectiveness of the preliminary investigation and may impede detection of potential fraud, waste, and abuse committed by the provider.

Two of the five audited MCOs had findings about insufficient sample sizes for extensive investigations. Limiting sample sizes can prevent SIUs from identifying claim patterns and may impede detection of potential fraud, waste, and abuse committed by the provider.