Inspector General

Texas Health and Human Services

20D0695

OIG Quarterly Report

Quarter 4, Fiscal Year 2020

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I. Executive Summary

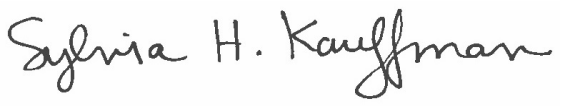
I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the fourth quarterly report for fiscal year 2020, summarizing the excellent work this office has performed during this period.

The Office of Inspector General recovered nearly $121 million this quarter, capping off a record year for the OIG. For the fiscal year, recoveries were more than $503 million, the most ever collected in a single year. In addition, we identified nearly $626 million in potential future recoveries and achieved $106 million in cost avoidance.

That a record-breaking year in terms of productivity occurred during the serious disruption caused by the COVID-19 global pandemic speaks to the outstanding work performed by the OIG team. When Governor Abbott declared a state of emergency in March, we quickly shifted to teleworking to protect the health and safety of our staff. Our dedicated staff quickly adapted and continued to be productive despite some of the initial challenges of working from home. This office also took steps to help providers by adjusting reporting requirements and deadlines to allow them to focus on patient needs and kept them informed and updated through a dedicated page on our website, ReportTexasFraud.com. We continue to be flexible as the pandemic situation changes, ensuring safety is first and foremost in our actions.

The outstanding work performed by the OIG team during the fiscal year, in particular during the pandemic, reflects our commitment to our core values — Accountability, Integrity, Collaboration and Excellence. As we begin a new fiscal year, we remain steadfast in our dedication to our mission: ensuring that funds dedicated to providing services to those who need them are spent only for their intended purpose. While some uncertainty remains regarding the pandemic, there is no doubt that the OIG team will continue to serve the citizens of Texas with professionalism and vigor. I am honored to work with this outstanding team.

Respectfully,



Sylvia Hernandez Kauffman
Inspector General

II. Fiscal year 2020 Results

Dollars recovered

Audit and Inspections	
Audit collections	$1,620,027
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$33,027,439
Voluntary repayments by beneficiaries	$179,794
Total	**$33,207,233**
Investigations and Reviews	
Provider overpayments	$21,178,289
Acute care provider overpayments	$5,430,479
Hospital overpayments	$16,590,430
Nursing facility overpayments	$1,233,121
Recovery Audit Contractor recoveries	$59,765,824
WIC collections	$30,846
Total	**$104,228,989**
Third Party Recoveries	
TPR recoveries	$364,172,816
Peace Officers	
EBT trafficking retailer overpayments	$297,624
Total dollars recovered	**$503,526,689**

Dollars identified for recovery

Audit and Inspections	
Provider overpayments	$1,211,243
Inspections	$1,004,119
Total	**$2,215,362**
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$56,046,082
Investigations and Reviews	
MCO identified overpayments	$34,136,454
Acute care provider overpayments	$5,690,950
Hospital overpayments	$21,011,438
Nursing facility overpayments	$800,097
Recovery Audit Contractor identified	$68,092,167
WIC vendor monitoring	$11,074
Total	**$129,742,180**
Third Party Recoveries	
TPR identified recoveries	$434,014,427
Peace Officers	
EBT trafficking	$4,945,993
Total dollars identified for recovery	**$626,964,044**

Cost avoidance

Benefits Program Integrity	
Client disqualifications	$6,733,940
Investigations and Reviews	
Medicaid provider exclusions	$8,864,558
WIC vendor monitoring	$868,341
Pharmacy Lock-In	$2,866,774
Third Party Recoveries	
Front-end claims denials	$86,782,097
Peace Officers	
Disability determination services	$537,768
Total cost avoidance	**$106,653,479**

Liquidated damages

LDs collected	$4,961,825

How we measure results

An investigation, audit, inspection or review that is performed, managed or coordinated by the OIG can result in:

Dollars recovered: Dollars recovered are overpayments that have been collected based on the results of an investigation, audit, inspection or review.

Dollars identified for recovery: This is a measure of the total potential overpayments resulting from activities of the Office of Inspector General. These potential overpayments have not actually been collected at this point (and notice not necessarily sent to providers, contractors and/or managed care organizations). These potential overpayments are estimates prior to further analysis or additional information submitted by the subject of the potential recovery.

Cost avoidance: Cost avoidance results in resources being used more efficiently; an increase in available resources from reductions in inefficient expenditures; or avoidance of unnecessary expenditure of funds for operational, medical, contract or grant costs.

Liquidated damages: The OIG recommends that HHS assess liquidated damages when managed care organizations (MCOs) and dental maintenance organizations are found to be non-compliant with program integrity requirements in their contracts. Liquidated damages are not intended to be a penalty but are intended to be reasonable estimates of HHS's projected financial loss and damage resulting from an MCO's nonperformance.

III. Fiscal year 2020 Highlights

OIG responds to COVID-19 pandemic

When Governor Abbott issued a state of disaster declaration on March 13, the OIG took a number of steps to maintain operations and ensure employee safety.

To help providers maintain their focus on patients, the OIG changed a variety of processes and extended timeframes for data requests and management responses. The Audit and Inspections Division temporarily paused new audits and inspections, while Medical Services halted onsite nursing facility reviews and notified providers that deadline extensions were granted for medical records requests, reconsiderations and identified recoupment payments. A COVID-19 focused page for providers was added to the OIG website that updated deadline information and provided links to other relevant pandemic-related information.

Provider Investigations teamed with OIG's Communications Team to launch a public COVID-19 fraud alert section on the OIG website and social media posts to inform the public about COVID-19 fraud, waste or abuse schemes. With the effect on the economy leading to an increase in benefit applications, the OIG Communications Team produced guides to educate applicants and benefit recipients on the appropriate use of SNAP, Medicaid and Temporary Assistance to Needy Families benefits. Another guide helps Supplemental Nutrition Assistance Program (SNAP) retailers prevent trafficking and promote an understanding of ways to appropriately use SNAP benefits to purchase eligible food items.

With the help of the HHS Information Technology team, existing technology was employed to allow staff to telework and keep the office functioning. The OIG Operations Division also deployed new software and training to allow Fraud Hotline staff to answer calls while teleworking. The WIC Vendor Monitoring Unit adjusted its mission to increase the number of remote store inventory audits in lieu of performing the audits in-store.

Fiscal year 2020 performance

Audit reports issued	34
Audits in progress	10
Inspections reports issued	1
Inspections in progress	7
Total investigations opened	21,282
Total investigations completed	20,085
Client investigations completed	16,582
EBT retailer investigations completed	418
Internal Affairs investigations completed	197
State center investigations of abuse, neglect and exploitation completed	710
Medicaid provider investigations completed	
Preliminary	1,918
Full-scale	260
PI cases transferred to full-scale investigation	235
PI cases referred to Medicaid Fraud Control Unit	520
Hospital claims reviewed	23,964
Nursing facility reviews completed	157
Medicaid and CHIP provider enrollment screenings performed	93,623
Medicaid providers excluded	224
Fraud hotline calls answered	26,603

Preventing FWA from happening in the first place

Several key initiatives were implemented as part of the OIG fraud, waste and abuse (FWA) prevention strategy in fiscal year 2020. The agency's effort focused on educating clients, providers and HHS employees.

At the request of the Texas Dental Association (TDA), the OIG published an educational brochure to explain what dental providers need to know to

avoid illegally soliciting clients who have Medicaid. Dental providers are prohibited from offering cash, gifts or other items to people who have Medicaid in order to influence their health care decisions. The brochure was distributed to TDA to share with its members in October 2019 and is available on the OIG's website.

The OIG hosted the Healthcare Fraud Prevention Partnership (HFPP) Regional Information Sharing Session in Austin. The HFPP is a public-private partnership between federal government, state agencies, law enforcement, private health insurance plans and health care anti-fraud associations. Through data and information sharing, the HFPP fosters a collaborative and proactive approach to combat health care fraud. The session in January focused on how the OIG uses HFPP tools to identify possible fraud, waste or abuse.

In August OIG staff presented required annual FWA training to the 18 MCOs and two DMOs participating in Texas Medicaid. The training included the basics for identifying and reporting FWA and also focused on the different schemes the OIG has uncovered in fraudulent billing, altered documentation and kickbacks.

The OIG provides numerous FWA trainings for employees. The State Centers Investigations Team (SCIT) team provided 85 trainings for HHS employees who care for intellectually and developmentally disabled individuals at state supported living centers and state hospitals. The presentations include an overview of SCIT, the life cycle of a case, the types of investigations SCIT conducts and explanations of relevant statutes.

Additionally, the OIG collaborated with HHS Professional Development to create a new training, "Fraud, Waste and Abuse in Health and Human Services Programs," that was made available for Medicaid and CHIP staff in July. The training details the various types of FWA across health care delivery and how staff can report any suspect activity to the OIG.

Feedback loop drives policy improvements

The OIG's work includes recommending systemic changes designed to improve efficiency and prevent FWA in Texas Health and Human Services programs (HHS). Through the course of OIG work, including audits, investigations, reviews, inspections and data analytics, staff identify opportunities to increase program effectiveness and reduce opportunities for FWA.

Aiming to reduce improper spending before it happens, the OIG utilizes a feedback loop approach to share information related to policy, system or operational considerations with HHS programs to respond to emerging risks in the health care delivery system. As part of the feedback loop process, the OIG may also consider tailored education and outreach to clients, providers or other stakeholders to educate and prevent FWA on a particular issue or topic.

For example, the OIG discovered Medicaid providers billing disproportionate amounts of urine drug tests (UDTs). Data mining and outlier detection revealed that providers were using redundant procedure codes; they were billing for validity tests already included in existing UDT procedure codes and therefore should not be billed a second time. Based on data analysis of the irregular billing patterns, the OIG made policy recommendations to HHS to deny validity tests billed with UDTs on the same day by the same provider and exclude specific procedure codes related to UDTs billed on the same day by the same provider. In fiscal year 2020, Texas Medicaid implemented the changes likely to prevent future drug test overpayments.

Data analytics drives FY 2021 work plan

In fiscal year 2020, the OIG developed a process to identify key areas of risk for FWA in the programs, systems and services delivered by Texas Medicaid providers and contractors. This data-driven process identifies potential areas of focus for the topic and data strategies the OIG may consider for

future audits, inspections and investigations.

Skilled policy and data analysis staff conduct a preliminary examination of a topic. The review considers known and emerging risks on each topic based a number of factors, including other state and federal agency reports, initial data reviews and interviews with HHS staff to estimate the potential impact of a topic. Analysis focuses on compliance; health and safety; data integrity and unusual service use.

In the fourth quarter, the review of prioritized topics culminated in an audit and inspections work plan for fiscal year 2021, facilitating strategic allocation and deployment of OIG tools. The work plan is available on the OIG website.

Technology creates efficiencies

The OIG continues to refine its capabilities to make its work data-driven. This enables the OIG to pinpoint areas where FWA is happening and target cases with the highest potential for recoveries.

During fiscal year 2020, the OIG migrated its Medicaid Fraud and Abuse Detection System, a statutorily required system used to perform key analytical research and ad hoc query-reporting capabilities to assist in prevention efforts. The move allows the OIG to maintain operations, integrating data assets and advancing analytical processes.

The Fraud, Waste and Abuse Research and Analytics (FWARA) team completed phases of enhancements that significantly speed analytics processes that support data mining of Medicaid claims for potential fraud, waste or abuse. For example, a data query of 21 million dental services previously took 11.5 hours to return; it now takes slightly more than 10 minutes. These advancements improve the timeliness of monitoring billing trends, which is critical to detecting emerging concerns. The FWARA team also worked with the Nursing Facility Utilization Review (NFUR) team to revamp its risk assessment process to achieve faster and more comprehensive results. The new framework better highlights facilities that scored high on several risk factors, allowing NFUR to better prioritize its work.

The OIG is also working with the Texas Department of Licensing and Regulation to integrate license and supervisory relationship data for speech language pathologists and audiologists; integrating the data will enhance OIG analytics and detection of potential program violations.

Digital resources streamline operations

The OIG expanded its digital operations this year to reduce paperwork and improve efficiency. FWARA implemented SharePoint as a safe and secure way for stakeholders (providers, managed care and dental maintenance organizations, and others) to provide information to the OIG. The FWARA team is responsible for acquiring data from MCOs for use in investigations, audits and inspections. To increase efficiency in completing the data requests, FWARA collaborated with MCOs to implement a more streamlined data request process. The Women, Infants and Children (WIC) Vendor Monitoring Unit now uses a SharePoint case management system that consolidates all daily operations, including compliance buys, on-site store reviews and inventory audit activities.

Internal Affairs implemented a paperless process by using a shared drive for case file storage. The Electronic Benefit Transfer Trafficking Unit implemented a paperless project that reduces the need for overnight shipping of investigative reports and allows electronic storage of investigative reports and documentary evidence.

Medical Services collaborated with the Texas Medicaid & Healthcare Partnership to complete a digital scanning support project. This allows Medicaid providers to convert paper medical records into high quality, indexed, searchable and Health Insurance Portability and Accountability Act compliant electronic versions. Medical Services reviews records for accuracy and compliance with state and federal guidelines and regulations.

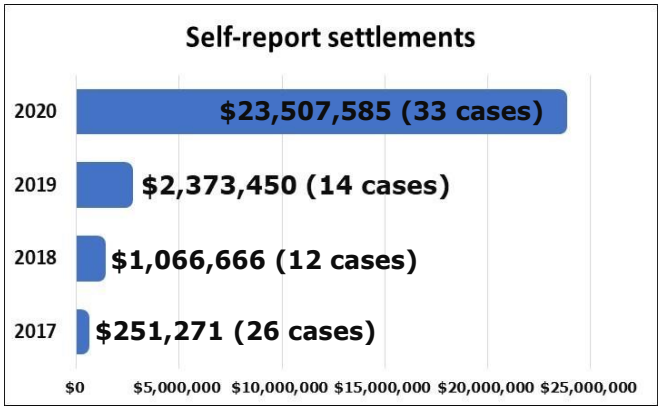
More Texas providers utilizing self-reporting

Providers are increasingly using the OIG's self-report process to resolve cases. Self-reports in fiscal year 2020 lead to the resolution of 33 cases; the OIG closed 14 self-reports in fiscal year 2019.

Providers and managed care organizations may use the OIG Fraud Hotline or website at any time to report any compliance or overpayment matters relating to themselves. The OIG considers self-reporting as a potential mitigating factor that may warrant less severe or restrictive administrative action or sanction.

The provider types that utilized the self-report process include clinics, hospitals, home health agencies and mental health rehabilitative services.

The resolved self-reports in 2020 resulted in settlements totaling $23,507,585, a significant increase over the $2,373,450 in settlements the previous year. This year's self-reports also resulted in the OIG opening 20 individual cases regarding persons who were the subjects of the self-reports.



Engaging with our stakeholders

Connecting with stakeholders expanded through a variety of traditional and digital communication. Each month the OIG shares the results of its work with more than 16,000 subscribers through the OIG Update. In fiscal year 2020, the electronic newsletter regularly provided stakeholders with the results of audits, inspections, investigations and reviews.

The OIG expanded its presence on social media through LinkedIn (hhsc-office-of-inspector-general). Social media connects the OIG with a wider audience, including people who may be affected by but not realize the impact of our work. LinkedIn provides an additional opportunity to highlight issues in health care delivery and engage with current and future employees, providers, vendors and program partners. The OIG is also active on Facebook (TxOIG) and Twitter (@TexasOIG).

In an effort to better highlight our mission, the OIG adopted a new URL for its website, ReportTexasFraud.com. This year the website was also updated with a refreshed home page, extended resources, more prominent links to the provider exclusions list and fraud reporting forms and other enhancements to improve readability.

ReportTexasFraud.com was featured on new posters and brochures designed to facilitate a simple process for reporting suspected wrongdoing. The print materials encourage readers to visit the website if they suspect a provider or recipient is misusing state benefits. The material is available for download on the OIG's website.

Enhancing professional rigor

The Legislative Budget Board (LBB) identified core skills training as a key output measure for the OIG beginning in fiscal year 2020. This new measure includes training presented by OIG staff or external entities to OIG staff and training presented by OIG staff to external stakeholders.

OIG Professional Development guided each division to create training with sound objectives, a depth of content, and applicability to inspections, investigations, audits and reviews. The LBB gave the OIG a target of 121 core trainings per fiscal year. The OIG surpassed the target by providing 147 trainings for the year. Additional training and professional development actions are highlighted throughout this report.

IV. Quarter 4 Results

Dollars recovered

Audit and Inspections	
Audit collections	$589,550
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$3,856,334
Voluntary repayments by beneficiaries	$30,941
Total	**$3,887,275**
Investigations and Reviews	
Provider overpayments	$7,125,927
Acute care provider overpayments	$822,855
Hospital overpayments	$4,676,911
Nursing facility overpayments	$347,071
Recovery Audit Contractor recoveries	$17,680,558
WIC collections	$4,843
Total	**$30,717,909**
Third Party Recoveries	
TPR recoveries	$85,660,463
Peace Officers	
EBT trafficking retailer overpayments	$59,744
Total dollars recovered	**$120,855,197**

Dollars identified for recovery

Audit and Inspections	
Provider overpayments	$220,469
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$13,605,469
Investigations and Reviews	
MCO identified overpayments	$14,270,853
Acute care provider overpayments	$741,698
Hospital overpayments	$3,911,174
Nursing facility overpayments	$0
Recovery Audit Contractor identified	$17,648,616
WIC vendor monitoring	$5,857
Total	**$36,578,198**
Third Party Recoveries	
TPR identified recoveries	$108,049,076
Peace Officers	
EBT trafficking	$1,178,635
Total dollars identified for recovery	**$159,631,847**

Cost avoidance

Benefits Program Integrity	
Client disqualifications	$1,500,984
Investigations and Reviews	
Medicaid provider exclusions	$1,129,590
WIC vendor monitoring	$0
Pharmacy Lock-In	$774,314
Third Party Recoveries	
Front-end claims denials	$20,517,174
Peace Officers	
Disability determination services	$246,768
Total cost avoidance	**$24,168,830**

Liquidated damages

LDs collected	$850,750

How we measure results

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Dollars identified for recovery: This is a measure of the total potential overpayments resulting from activities of the Office of Inspector General. These potential overpayments have not actually been collected at this point (and notice not necessarily sent to providers, contractors and/or managed care organizations). These potential overpayments are estimates prior to further analysis or additional information submitted by the subject of the potential recovery.

Cost avoidance: Cost avoidance results in resources being used more efficiently; an increase in available resources from reductions in inefficient expenditures; or avoidance of unnecessary expenditure of funds for operational, medical, contract or grant costs.

Liquidated damages: The OIG recommends that HHS assess liquidated damages when managed care organizations (MCOs) and dental maintenance organizations are found to be non-compliant with program integrity requirements in their contracts. Liquidated damages are not intended to be a penalty but are intended to be reasonable estimates of HHS's projected financial loss and damage resulting from an MCO's nonperformance.

V. Trends

Provider Investigations

Investigations & Reviews (I&R) continues to receive a high number of complaints and managed care organization (MCO) referrals related to personal care attendants. Complainants report attendants billing for services not rendered, falsifying documentation and billing for attendant care while the client is an in-patient at a hospital or nursing facility. In addition, complainants continue to report client and attendant collusion by sharing payments or falsifying documentation of visits through the electronic visit verification system. The OIG continues to investigate attendant care cases and recommend administrative action based on findings.

Pharmacy Invoice Initiative

I&R's Provider Investigations continues to pursue cases resulting from a pharmacy invoice initiative. The initiative monitors data to identify pharmacies that billed and were paid for 100 percent of all refills, filled prescriptions after an expiration date, reflected a sudden continuous claim and payment increase and exhibited billing patterns for odd quantities over a 30-day period.

A sample of case results for Provider Investigations settled by Litigation for this quarter include:

- **Settlement reached in dental fraud detection operation.** The OIG settled a case against a dental provider in Dallas. Based on information identified during a Fraud Detection Operation, the investigation found multiple instances where the provider billed for services not provided or for a more expensive service code instead of the appropriate lower-cost service code. The dental provider will repay $124,066.
- **Data-driven initiative results in settlement with DME provider.** The OIG Durable Medical Equipment (DME) Review Project used data to identify providers who significantly stand out among their peers in payment for incontinence supplies. Based on billing details, including size and quantity, investigators

Provider investigations

Types of preliminary investigations

Attendants	51%
Physician (individual/group/clinic)	14%
Home health agency	7%
Durable medical equipment	5%
Hospital	4%
Dental	4%
Nursing facility	3%
Pharmacy	2%
Assisted living	2%
Therapy (counseling)	2%
Adult day care	1%
Medical transportation	1%
Rehabilitation center	1%

8 other categories at less than 1%

Types of full investigations

Home health agency	18%
Physician (individual/group/clinic)	16%
Dental	15%
Nursing facility	9%
Hospital	9%
Durable medical equipment	7%
Attendants	5%
Rehabilitation center	5%
Independent school district	5%
Pharmacy	4%
Therapy (physical/occupational/speech)	2%
Managed care organization	2%
Intermediate care facility	2%

Referrals to I&R

MCO/DMO referrals	99
OIG Fraud Hotline referrals	77

Note: Referrals to Provider Investigations, as referenced in the top chart above, go through a preliminary investigation. Cases that meet evidentiary requirements are transferred for a full investigation, as referenced in the full investigation chart.

contacted identified provider clients to confirm receipt of the supplies, as billed. A Dallas DME provider did not have appropriate documentation to support the payments for claims with dates of service ranging between February 2015 and January 2019. The provider will repay $20,125.

- **Settlement reached over pharmacy inventory.** The OIG executed a settlement agreement in August with a pharmacy in Mission for unsupported billed services. Through a collaborative effort with the provider, a settlement for $132,457 was executed.

Benefits Program Integrity

The Benefits Program Integrity (BPI) division completed 4,203 investigations involving some form of benefit recipient overpayment or fraud allegation. Eighty-five percent of all investigations completed involved unreported income or an issue with the reported household composition. Household composition cases usually include an unreported household member who has income or could also include a reported household member who does not actually live in the same residence. Both instances cause the household to receive more benefits than they are eligible for.

BPI completed 235 investigations where fraud was determined. BPI referred 2 investigations for prosecution and 233 for an administrative disqualification hearing. Ninety-two percent of fraud investigations completed involved either unreported income or an issue with the reported household composition.

A sample of cases worked by BPI this quarter include:

- **Inaccurate income and household composition.** In July, BPI resolved a case in Taylor County where a client falsely reported her household composition and income; she did not include her husband and his income on seven SNAP and Medicaid applications between October 2016 and January 2019. The BPI investigator gathered evidence from a variety of sources to prove the client lived on a military base with her husband. The case was presented to the Taylor County District Attorney for prosecution. The client pleaded guilty, received deferred adjudication with five years' probation and was ordered to pay $19,000 in restitution.
- **Excessive benefits.** BPI investigated a client in Bexar County who submitted falsified applications for SNAP and Medicaid benefits. From December 2013 to June 2018, the client concealed his and his wife's income as business owners. As a result, the client received $94,510 in excess SNAP and Medicaid benefits. The case was presented to the Bexar County District Attorney's Office for prosecution. The client pled no contest to the charge of third-degree theft-welfare fraud. In June, the client was sentenced to ten years deferred adjudication probation, ordered to pay full restitution, complete 100 hours of community service and attend an anti-theft program facilitated by Bexar County.
- **Falsifying benefits application.** In July, BPI resolved a case in Smith County where a client failed to report her husband, the father of the client's children, as part of her household. The BPI investigator verified through a variety of sources that the client's husband lived in the household and had income. The case was submitted to the Smith County District Attorney. The client pled guilty to third-degree felony theft, received 10 years deferred adjudication probation and was ordered to pay $34,564 in restitution.

Electronic Benefits Transfer

This quarter the EBT Trafficking Unit completed 165 investigations and presented another 87 investigations for either administrative disqualification hearings (84) or prosecution (3). During the quarter the EBT Trafficking Unit identified for recovery $1,176,160 and collected $59,744.

Trends identified by the unit include:

- **Mobile vendors.** EBT Trafficking continues

to see complaints in cases involving mobile vendors in the Houston area and their acceptance of SNAP benefits. The mobile vendors will create a credit account for a recipient by acquiring the recipient's SNAP benefits information and personal information number. Possession of this information is a violation by the mobile vendor, and it is a violation for the recipient to provide the data.

- **Law enforcement collaboration.** EBT Trafficking continues to collaborate with law enforcement agencies across the state. The requests for assistance pertain to current or former SNAP recipients and involve providing information to help investigate persons involved in criminal activity and locate fugitives with arrest warrants; EBT has also been asked to provide investigative assistance with cases that include an element of SNAP trafficking.

A sample of cases worked by EBT this quarter include:

- **Retailer investigation.** The EBT Trafficking Unit completed an investigation into the allegation of a retailer setting up unauthorized credit accounts for SNAP recipients and then accepting SNAP as payment on those accounts. The program violation was referred to Hidalgo County District Attorney's Office and to U.S. Department of Agriculture (USDA) Food and Nutrition Services. The district attorney's office declined prosecution; however, the USDA charged the retailer in August with a civil penalty of $7,920 in lieu of a two-year disqualification.
- **Selling benefits.** The EBT Trafficking Unit continues to close cases resulting from an investigation that produced criminal charges of benefits trafficking against 62 defendants. The investigation identified more than $71,000 in fraudulently used SNAP benefits. One of the cases resolved in the fourth quarter involved a woman who sold her SNAP benefits to a restaurant owner who used the benefits to stock his business. In August, the defendant pleaded guilty to the charges and received a 10-year prison sentence that was probated.

Open IA cases by type

Falsifying information/documents	21%
Unprofessional conduct	18%
Conflict of interest	10%
Law enforcement assist	10%
Benefits fraud	5%
Contract procurement	5%
Time and leave abuse	5%
Other	26%

Internal Affairs

Internal Affairs (IA) worked 39 active investigations in the fourth quarter, and 33 investigations were closed during the quarter. IA processed 82 referrals this quarter and investigated 33 of those referrals. The remaining were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers, DFPS Office of Consumer Relations and HHS Complaint and Incident Intake.

Trend identified by IA include:

- **Decrease in active cases.** IA has seen a downward trend for active cases since the fourth quarter of fiscal year 2019. This could be attributed to changes to IA's program, such as the transfer of investigative responsibility for allegations of vital statistics fraud to the Department of State Health Services and IA's greater focus on serious misconduct as opposed to complaints which are appropriate for management action without IA's involvement. A greater number of criminal cases are being directly referred to local law enforcement, a change which reflects acceptance of these referrals by local prosecutors and municipal law enforcement agencies. IA is also seeing a downward trend for cases with allegations of unprofessional conduct. This could be attributed to the majority of HHS staff teleworking because of the COVID-19 pandemic.

Sample of cases concluded by IA this quarter:

- **Travel fraud.** Internal Affairs conducted a criminal investigation into the allegation that an HHS team member committed employee misconduct by violating Texas Penal Code Section 37.10 - Tampering with Governmental Record - and defrauded HHS by making a false entry into eTravel regarding mileage reimbursement for approximately $350. The evidence supported the allegation, and the case has been referred to the district attorney's office for possible action.
- **Unauthorized release of information.** IA conducted an administrative investigation into the allegation that a Texas Works Advisor (TWA) accessed and released personal information of a client without a legitimate business need. Specifically, the TWA accessed the personal information of the TWA's ex-spouse's girlfriend from the girlfriend's benefits application and shared it with the ex-spouse. IA determined that the TWA violated the HHS HR manual by accessing information without the client's informed consent and not keeping the information obtained confidential.

State Centers Investigative Team

The OIG's State Center Investigations Team (SCIT) opened 144 investigations and completed 129 investigations in the fourth quarter, with an average completion time of 20 days. This compares to 205 opened investigations and 181 completed investigations in the fourth quarter of fiscal year 2019.

A recent SCIT case involved an assault at the Abilene State Supported Living Center. An employee was accused of striking a client in the head. Subsequent interviews by the SCIT investigator confirmed the allegation. The case was referred to the Taylor County district attorney for prosecution. The court accepted a guilty plea to assault, a class A misdemeanor. The OIG received the court disposition, or notice of the decision, in the fourth quarter. As part of the plea agreement, the accused received 12 months of community supervision with court costs and fines imposed.

VI. Rule Proposals

MCO audit coordination

Proposed amendments to 1 TAC §371.37 related to MCO Audit Coordination, along with the HHS companion rule 1 TAC §353.6, were adopted on July 28, 2020 and published in the August 14, 2020 issue of the Texas Register.

The adopted rules clarify OIG and HHS Medicaid and CHIP Services Department roles and jurisdiction related to audits of MCOs. The amendment to 1 TAC §371.37 adds new detail that describes the coordination — in planning and performance — between OIG and HHS when OIG plans and conducts MCO audits. These rules became effective on August 17, 2020.

VII. Agency Highlights

OIG resolves a case against a North Texas DME provider

The OIG settled a case in July against a Grand Prairie durable medical equipment (DME) provider. The provider was found to have issues with recordkeeping and doctor authorizations that had expired or were incomplete. The provider worked collaboratively with OIG Litigation regarding the documentation issues and took the initiative to improve its billing practices and internal policies. To resolve the case, the provider agreed to a settlement of $20,135.

Settlement reached with a Pharr provider

The OIG entered into a settlement agreement in July with a Pharr physician-group regarding after-hours billing. An office-based provider may bill an after-hours charge in addition to a visit when providing medically necessary services for the care of a client after routine office hours as defined by policy. The provider worked collaboratively with the OIG in reviewing records and the initial allegations. Provider and the OIG reached a settlement agreement for $150,000.

Settlement agreement reached in an El Paso self-report case

The OIG executed settlement agreements in August with an El Paso mental health provider following the provider's self-reports of potential issues with 10 of its case managers billing for services not rendered. The provider was able to void the claims regarding one of the case managers; thus, it prevented the Medicaid system from suffering any loss for those claims. The provider agreed to pay back a total $218,861 within two years of the full execution of the settlement agreements. The OIG opened nine exclusion cases against the case managers. The OIG considers self-reporting as a potential mitigating factor that may warrant less severe or restrictive administrative action or sanction.

Quarter 4 performance

Audit reports issued	17
Audits in progress	10
Inspections reports issued	0
Inspections in progress	7
Total investigations opened	9,222
Total investigations completed	5,018
Client investigations completed	4,203
EBT retailer investigations completed	165
Internal Affairs investigations completed	33
State center investigations of abuse, neglect and exploitation completed	129
Medicaid provider investigations completed	
Preliminary	422
Full-scale	66
PI cases transferred to full-scale investigation	55
PI cases referred to Medicaid Fraud Control Unit	130
Hospital claims reviewed	5,992
Nursing facility reviews completed	3
Medicaid and CHIP provider enrollment screenings performed	21,727
Medicaid providers excluded	45
Fraud hotline calls answered	7,827

Dental fraud detection operation

OIG data analytics continues to play a proactive role in detecting potential fraud, waste, and abuse (FWA). In July, the Investigations and Reviews Division utilized data analytics during an FDO to focus on providers whose billing patterns exhibit potential indicators of FWA. The OIG's Fraud, Waste and Abuse Research and Analytics team used algorithms to identify dental providers that appeared to be outliers among their peers related to general dentistry services. Based on this methodology, the FDO focused on four providers

in the Houston area. The preliminary investigative findings are pending.

OIG audit completes PBM series

The OIG completed a series of audits of Medicaid pharmacy benefit managers (PBMs). Each Texas Medicaid State of Texas Access Reform (STAR) program and Children's Health Insurance Program (CHIP) managed care organization (MCO) is required to subcontract with a PBM to process prescription claims and perform other selected pharmacy-related services. The Vendor Drug Program (VDP) provides guidance to the MCOs, their PBMs and pharmacies in administering pharmacy benefit services, including lists of drugs available to Medicaid and CHIP members as pharmacy benefits and related authorization requirements.

The series includes three PBM audits of three different MCOs all contracted with the same PBM, Navitus. In each audit, the preferred drug lists and formularies used by Navitus matched at least 97% of those established by VDP. However, Navitus did not consistently comply with requirements related to design and performance of prior authorizations. OIG made recommendations to the MCOs to ensure Navitus a) adds all VDP-approved formulary and approved preferred drug list line items with the appropriate designated preferred or non-preferred status and b) complies with the VDP clinical criteria requirements for drug codes that require additional clinical reviews and prior authorizations. All three reports were published in August, and many recommendations have already been implemented.

Faster data analysis

OIG's Fraud, Waste and Abuse Research & Analytics (FWARA) conducted a series of technical projects to optimize analytics processes running off their new data analytics platform. Improvements to automation and other efficiencies have improved the team's management of algorithms that feed into various OIG operations, such as Fraud Detection Operations, investigations and audits. The projects have amplified the team's abilities to analyze large datasets which has been particularly relevant for managed care-focused data reviews. For example, one data review involved a focused analysis of every medical and dental Medicaid claim over a five-year period.

WIC activities across the state

In direct response to COVID-19, WIC has temporarily modified how daily operations are now conducted, which includes a central focus on inventory audits while maintaining a safe working environment. This has resulted in WIC completing 67 inventory audits for this fiscal quarter. The unit also collected $51 in civil monetary penalties associated to a disqualification prior to COVID-19, identified $1,057 for recovery, recovered $4,802, and provided 93 educational letters to vendors. An inventory audit is a comparison of a vendor's paid claims and their purchase invoices for WIC food items. The purpose of the inventory audit is to determine if the vendor had a sufficient inventory of WIC food items to justify their submitted claims.

TFPP update

Regular meetings of the Texas Fraud Prevention Partnership (TFPP) provide an opportunity for the OIG and Texas Medicaid and CHIP MCOs and DMOs to discuss their combined efforts to prevent, detect and investigate FWA in Medicaid and CHIP program delivery. TFPP MCO Leadership meetings in February and June of 2020 focused on FWA trends, MCO referrals to the OIG, updates on current OIG audits and medical service reviews, and the impact of COVID-19 on business processes. Beginning in fiscal year 2021, these meetings will be held three times per year.

TFPP SIU meetings are held three times each year with MCO Special Investigative Units (SIUs) and the Attorney General Medicaid Fraud Control Unit (MFCU). Agendas this year included information on COVID-19 FWA schemes, FWA training for MCO staff, and case presentations from UnitedHealthcare, MCNA, Amerigroup and Aetna. One-on-one meetings were held with SIU staff at the largest MCOs to discuss pending investigations and referrals; MFCU staff also attended.

BPI improving referral screenings

In May, the Arlington and San Antonio Intake Teams were realigned under one team within BPI, effectively standardizing BPI's intake referral screening and preliminary investigative processes across the state. This change enhanced productivity and the quality of investigations created by helping to better assess and prioritize referrals at the preliminary stage. Since the realignment, the amount of time for screening referrals has decreased from 60 days to fewer than five. As of August, the BPI Intake Teams screened more than 120,000 referrals, matches and hotline complaints in fiscal year 2020.

Technology improves BPI investigations

BPI collaborated with HHS Information Technology and the Texas Medicaid & Healthcare Partnership team to integrate Medicaid, CHIP and long-term care payment data into BPI's Automated System for Office of Inspector General. This new interface will allow investigators to automate Medicaid overpayment calculations, decrease time spent on manual calculations and increase accuracy of the calculations.

Third Party Recoveries collaborates with MCOs to improve efficiency

OIG Third Party Recoveries (TPR) kicked off a project with the Texas Medicaid and Healthcare Partnership (TMHP) Third Party Liability (TPL) area to increase training opportunities for MCOs that will drive improvements to both medical and pharmacy other insurance (OI) records. Medicaid expenditures are reduced when third party payers are identified and billed prior to Medicaid.

The project focused on activities related to OI identification, such as how to read and use OI files more efficiently and training that assists MCOs with coordination of benefits to ensure Medicaid is the payer of last resort. Accurate and up-to-date OI data will increase efficiencies for the MCOs TPL activities and reporting, including TPRs monitoring and data reporting processes.

OIG maximizes program integrity efforts

In August, the OIG Investigations and Reviews (I&R) division launched a hospice project with Qlarant, the Centers for Medicare & Medicaid Services (CMS) Unified Program Integrity Contractor (UPIC). CMS selected Qlarant to perform data analysis and investigative functions to detect, prevent, and deter program integrity risks in the Medicare and Medicaid programs. This collaboration allows I&R to augment current investigative activities and maximize program integrity efforts in multiple areas.

Completed Reports

Audit

Infinity Pharmacy Solutions: A Texas Vendor Drug Program Provider. OIG completed an audit of Infinity Pharmacy Solutions, LLC, a Texas Vendor Drug Program (VDP) provider. The audit objectives were to determine whether Infinity Pharmacy Solutions properly billed the VDP for Medicaid claims submitted, and whether Infinity Pharmacy Solutions complied with selected contractual and Texas Administrative Code requirements.

As permitted by Texas Administrative Code § 371.35(a), auditors used sampling and extrapolation as part of the audit. Audit results indicated that there were exceptions related to claims validity, refills and quantity. Of the 232 claims tested, there were 20 unsupported claims with 22 exceptions totaling $5,186. The unsupported claims represent overpayments to Infinity Pharmacy Solutions. By extrapolating the results to the population of claims within the scope of the audit, OIG determined that the exceptions represented an overpayment for the population of $7,569. Auditors offered recommendations to Infinity Pharmacy which, if implemented, will correct deficiencies

in compliance with contractual and Texas Administrative Code requirements.

Alamo Area Council of Governments: Local Developmental and Disability Authority Performance and Medicaid Contracts. OIG completed an audit of the Alamo Area Council of Governments (AACOG). AACOG operates as a local intellectual and developmental disability authority (LIDDA) and provides Home and Community-based Services (HCS) under contracts with the Texas Health and Human Services Commission (HHSC). The audit objectives were to determine whether controls over the contracts ensured (a) individuals enrolled in HCS were assigned services coordinators and received required service coordination activities, (b) AACOG monitored service coordination activities and reported contract funds and expenses as required and (c) documentation existed to support paid encounters.

Audit results indicated that a service coordinator was assigned to each of the 60 individuals in the sample and AACOG's general ledger supported the total amount of contract expenditures AACOG reported to HHS. However, AACOG did not always ensure that service coordination progress notes were complete or that person-directed plans were completed timely.

Auditors offered recommendation to AACOG which, if implemented, may ensure progress notes exist and contain information necessary to support service coordination paid encounters and person-directed plans are renewed timely.

Fee-for-Service Claims Submitted by Aveanna Healthcare Medical Solutions: A Texas Medicaid Durable Medical Equipment and Supplies Provider. The OIG completed an audit of Aveanna Healthcare Medical Solutions (Aveanna), a durable medical equipment (DME) and supplies provider. The objective of the audit was to determine whether there was valid support for the authorization and delivery of fee-for-service DME and supplies associated with Medicaid claims submitted by and paid to Aveanna as required by state laws, rules and guidelines.

Of 1,938 claims tested, 1,694 (87%) were completed as required by laws, rules and guidelines. Additionally, Aveanna stopped services after a beneficiary's death for all beneficiaries tested. However, Aveanna did not always meet authorization requirements for DME and supplies, and Aveanna did not always maintain the appropriate proof of delivery documentation for Medicaid fee-for-service claims. As a result, Aveanna did not meet Texas requirements for DME and supplies for a total of 244 claims, for which Texas Medicaid made payments of $50,728 in error. The total amount due to the State of Texas is $50,728.

OIG offered recommendations to Aveanna, which, if implemented, will correct deficiencies in compliance with state laws, rules and guidelines.

Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: All Star Medical Equipment and Supply, Inc. OIG completed an audit of All Star Medical Equipment and Supply, Inc.'s (All Star's) delivery of durable medical equipment (DME) and supplies to Medicaid beneficiaries after the beneficiary's date of death and its submission of fee-for-service claims to the Texas Medicaid and Healthcare Partnership (TMHP). For each of the deliveries tested, the beneficiary was eligible at the time of delivery, even though it was past the beneficiary's date of death. Both TexMedConnect, which All Star uses for verification, and Texas Integrated Eligibility Redesign System (TIERS), which the audit team used for verification, listed the beneficiary as eligible at the time of delivery. Therefore, the audit did not result in recommendations to All Star.

Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: Nextra Health, Inc. OIG has completed an audit of Nextra Health, Inc.'s (Nextra) delivery of durable medical equipment (DME) and supplies to Medicaid beneficiaries after the beneficiary's date of death and its submission of fee-for-service claims to the Texas Medicaid and Healthcare Partnership (TMHP). For each of the deliveries tested, the

beneficiary was eligible at the time of delivery, even though it was past the beneficiary's date of death. Both TexMedConnect, which Nextra uses for verification, and Texas Integrated Eligibility Redesign System (TIERS), which the audit team used for verification, listed the beneficiary as eligible at the time of delivery. Therefore, the audit did not result in recommendations to Nextra. Future OIG work will address verification.

Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: Longhorn Health Solutions. The OIG completed an audit of Longhorn Health Solutions' (Longhorn) delivery of durable medical equipment (DME) and supplies to Medicaid beneficiaries after the beneficiary's date of death and its submission of fee-for-service claims to the Texas Medicaid and Healthcare Partnership (TMHP). For 15 of the 16 deliveries tested, the beneficiary was eligible at the time of delivery, even though it was past the beneficiary's date of death. Both TexMedConnect, which Longhorn uses for verification, and Texas Integrated Eligibility Redesign System (TIERS), which the audit team used for verification, listed the beneficiary as eligible at the time of delivery. Therefore, the audit did not result in recommendations to Longhorn. Auditors communicated other, less significant, issues separately in writing to Longhorn's management.

Security Controls Over Confidential HHS Information: Aetna Better Health of Texas. OIG completed an audit of Aetna Better Health of Texas (Aetna). The objectives of the audit were to assess the design and effectiveness of selected security controls over confidential Texas Health and Human Services (HHS) System information stored and processed by Aetna, as well as business continuity and disaster recovery plans for operations relating to the processing and storage of confidential HHS System information by Aetna.

Overall, Aetna implemented controls to safeguard confidential HHS System information and developed procedures to ensure the continuation of the operations necessary to deliver services to members in the event of an emergency or disaster. Access to confidential HHS System information must be managed in accordance with HHS Information Security Controls (IS-Controls). Aetna's processes for managing certain accounts with access to confidential HHS System information in its claims management system did not meet all HHS IS-Controls requirements. OIG offered recommendations to Aetna, which, if implemented, should ensure access to confidential HHS System information in its claims management application is managed in accordance with HHS IS-Controls requirements.

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Cigna-HealthSpring Life and Health Insurance Company, Inc. OIG conducted an audit of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by Cigna-HealthSpring Life and Health Insurance Company, Inc. (Cigna-HealthSpring), a managed care organization (MCO). The audit was a follow-up to complaints of MCO payments to nursing facilities being delayed by more than 90 days and unprocessed retroactive adjustments related to nursing facility utilization review resource utilization group (RUG) rates. Cigna-HealthSpring was one of five MCOs audited to address this concern. The audit objective was to determine whether Cigna-HealthSpring accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

Cigna-HealthSpring adjudicated an average of over 99.8% of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by its Uniform Managed Care Contract. However, Cigna-HealthSpring did not always (a) process RUG rate adjustments as required or (b) process other types of adjustments timely. Specifically, Cigna-HealthSpring did not process $244,251 in net RUG rate adjustments, and for 19 (66%) of 29 other types of adjustments tested, Cigna-HealthSpring did not process the adjustments totaling $3,773 timely, which caused delays in payments to nursing facilities that ranged from 54 to 671 days.

OIG offered recommendations to Cigna-HealthSpring, which, if implemented, will result in Cigna-HealthSpring complying with its contractual requirements to automatically identify and process all retroactive adjustments within 30 days.

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: UnitedHealthcare Community Plan. The OIG conducted an audit of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by UnitedHealthcare Community Plan (UnitedHealthcare), a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO). The audit served as a follow-up to complaints of MCO payments to nursing facilities being delayed by more than 90 days and unprocessed retroactive adjustments related to nursing facility utilization review resource utilization group (RUG) rates. United was one of five MCOs audited to address this concern. The audit objective was to determine whether United accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

UnitedHealthcare adjudicated almost 97% of clean claims within 10 days in calendar year 2018. However, UnitedHealthcare did not always (a) process RUG rate adjustments as required or (b) process other types of adjustments timely. Specifically, UnitedHealthcare did not process $582,157 in net RUG rate adjustments, and for 27 (90%) of 30 other types of adjustments tested, UnitedHealthcare did not process the adjustments totaling $15,857 timely, which caused delays in payments to nursing facilities that ranged from 33 to 317 days.

OIG offered recommendations to United, which, if implemented, will result in Cigna-HealthSpring complying with its contractual requirements to automatically identify and process all retroactive adjustments within 30 days.

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Amerigroup Texas, Inc., and Amerigroup Texas Insurance Company. The OIG conducted an audit of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company (Amerigroup), a managed care organization (MCO). The audit served as a follow-up to complaints of MCO payments to nursing facilities being delayed by more than 90 days and unprocessed retroactive adjustments related to nursing facility utilization review resource utilization group (RUG) rates. Amerigroup was one of five MCOs audited to address this concern. The audit objective was to determine whether Amerigroup accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

Amerigroup adjudicated and paid most clean claims accurately and timely. Additionally, based on self-reported information, Amerigroup adjudicated an average of 99.8% of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by the Uniform Managed Care Contract. However, Amerigroup did not always (a) process RUG rate adjustments as required or (b) process other types of adjustments timely. As a result, Amerigroup did not process $758,289 in net adjustments, which includes adjustments expected to reduce prior payments by $911,735 and adjustments expected to increase prior payments by $153,445. The other adjustments not timely processed resulted in payments to nursing facilities totaling $21,225 being delayed between 39 and 314 days.

OIG offered recommendations to Amerigroup, which, if implemented, will result in Amerigroup complying with its contractual requirements to automatically identify and process all retroactive adjustments within 30 days.

Pharmacy Benefits Manager Navitus Health Solutions LLC: Community First Health Plans. The OIG conducted an audit of selected pharmacy benefits delivered by Community First Health Plans, Inc. (Community First) and its subcontracted pharmacy benefit manager (PBM), Navitus Health Solutions, LLC (Navitus). Community First works in conjunction with Navitus to provide pharmacy benefit services to Medicaid and CHIP

managed care members. The audit objective was to determine whether Community First and Navitus administered the formulary, preferred drug list and prior authorizations in accordance with the Uniform Managed Care Contract, STAR Kids contract, Uniform Managed Care Manual and selected applicable state rules and statutes.

The audit showed Navitus generally adhered to formulary and preferred drug list requirements. However, in some cases, Navitus did not consistently and correctly update its formulary listing and its preferred drug list. As a result, Community First may have incorrectly rejected claims for prescriptions that should have been accepted, caused members to experience delays in receiving prescriptions or not receive those prescriptions at all, or paid higher prices or reduced state rebates for drugs. In addition, Navitus did not consistently comply with requirements related to design and performance of non-preferred and clinical prior authorizations. Specifically, for 28 of 75 prior authorizations and rejected claims tested, Navitus did not perform required clinical and non-preferred prior authorizations as required, and, in some cases, Navitus communicated an incorrect rejection message to the member.

The OIG made recommendations to Community First, which, if implemented, will ensure Navitus (a) implements an appropriate method to add all VDP-approved formulary and approved preferred drug list line items with the appropriate designated preferred or non-preferred status, (b) implements periodic reviews to ensure all current drug codes are correctly reflected in the formularies and Medicaid preferred drug list and (c) complies with the VDP clinical criteria requirements for drug codes that require additional clinical reviews and requirements for non-preferred prior authorizations.

Pharmacy Benefits Manager Navitus Health Solutions LLC: Community Health Choice. OIG conducted an audit of selected pharmacy benefits delivered by Community Health Choice, Inc. (Community Health Choice) and its subcontracted pharmacy benefit manager (PBM), Navitus Health Solutions, LLC (Navitus). Community Health Choice works in conjunction with Navitus to provide pharmacy benefit services to Medicaid and CHIP managed care members. The audit objective was to determine whether Community Health Choice and Navitus administered the formulary, preferred drug list, and prior authorizations in accordance with the Uniform Managed Care Contract, Uniform Managed Care Manual and selected applicable state rules and statutes.

Navitus generally adhered to formulary and preferred drug list requirements. However, in some cases, Navitus did not consistently and correctly update its formulary listing and its preferred drug list. As a result, Community Health Choice may have incorrectly rejected claims for prescriptions that should have been accepted, caused members to experience delays in receiving prescriptions or not receive those prescriptions at all, or paid higher prices or reduced state rebates for drugs. In addition, Navitus did not consistently comply with requirements related to design and performance of non-preferred and clinical prior authorizations. Specifically, for 21 of 75 prior authorizations and rejected claims tested, Navitus did not perform required clinical and non-preferred prior authorizations as required, and, in some cases, Navitus incorrectly rejected claims for prior authorizations not required or communicated an incorrect rejection message to the member.

The OIG made recommendations to Community Health Choice, which, if implemented, will ensure Navitus (a) implements an appropriate method to add all VDP-approved formulary and approved preferred drug list line items with the appropriate designated preferred or non-preferred status, (b) implements periodic reviews to ensure all current drug codes are correctly reflected in the formularies and Medicaid preferred drug list and (c) complies with the VDP clinical criteria requirements for drug codes that require additional clinical reviews and requirements for non-preferred prior authorizations.

Pharmacy Benefits Manager Navitus Health Solutions LLC: Parkland Community Health Plan. The OIG conducted an audit of selected pharmacy benefits delivered by Parkland Community Health Plan, Inc. (Parkland) and its subcontracted pharmacy benefit manager (PBM), Navitus Health Solutions, LLC (Navitus). Parkland works in conjunction with Navitus to provide pharmacy benefit services to Medicaid and CHIP managed care members. The audit objective was to determine whether Parkland and Navitus administered the formulary, preferred drug list, and prior authorizations in accordance with the Uniform Managed Care Contract, Uniform Managed Care Manual, and selected applicable state rules and statutes.

Navitus generally adhered to formulary and preferred drug list requirements. However, in some cases, Navitus did not consistently and correctly update its formulary listing and its preferred drug list. As a result, Parkland may have incorrectly rejected claims for prescriptions that should have been accepted, caused members to experience delays in receiving prescriptions or not receive those prescriptions at all, or paid higher prices or reduced state rebates for drugs. In addition, Navitus did not consistently comply with requirements related to design and performance of non-preferred and clinical prior authorizations. Specifically, for 19 of 75 prior authorizations and rejected claims tested, Navitus did not perform required clinical and non-preferred prior authorizations as required, and in some cases, Navitus incorrectly rejected claims for prior authorizations not required or communicated an incorrect rejection message to the member.

The OIG made recommendations to Parkland, which, if implemented, will ensure Navitus (a) implements an appropriate method to add all VDP-approved formulary and approved preferred drug list line items with the appropriate designated preferred or non-preferred status, (b) implements periodic reviews to ensure all current drug codes are correctly reflected in the formularies and Medicaid preferred drug list and (c) complies with the VDP clinical criteria requirements for drug codes that require additional clinical reviews and requirements for non-preferred prior authorizations.

Stakeholder Outreach

OIG meets with hospital associations

During the summer, the OIG met with the Texas Hospital Association, Teaching Hospitals of Texas, Children's Hospital Association of Texas, and Texas Organization of Rural & Community Hospitals to discuss the OIG's hospital utilization reviews in managed care. The goal of hospital utilization review is to validate inpatient admissions for medical necessity, correct diagnosis and procedures, diagnosis-related group assignment and quality of care issues.

OIG trains MCOs about Lock-In program

The OIG in June delivered Lock-In Program training to new MCO staff. This training provided an overview of the program including key definitions, legal references, lock-in criteria, supporting documentation and how the OIG receives referrals. The Lock-In Program is used to restrict the potentially dangerous overuse of medications and medical services.

OIG publishes educational articles for providers

In July, OIG Chief Pharmacy Officer Catherine Coney, R. Ph. collaborated with the OIG Communications Team and Medical Services to publish an article in Texas Pharmacy, the official magazine for the Texas Pharmacy Association. The article entitled "Call the OIG Fraud Hotline if You Suspect Wrongdoing" explains the intake process and possible outcomes for calls to the hotline. The goal of the article is to encourage pharmacists and technicians to report observations of other pharmacists, suspicious corporate behavior or a Medicaid beneficiary who may be abusing benefits.

The communications team worked with OIG Chief Dental Officer Dr. Janice Reardon, DDS and Provider Investigations to produce a similar article for the Texas Dental Association's TDA Today. Geared toward dentists, hygienists and dental assistants, this piece featured a dental case that originated with a call to the hotline. The caller gave details about a dentist who was possibly billing for work that wasn't performed and engaging in illegal marketing. The case moved to a full-scale investigation and concluded in a settlement with the provider agreeing to pay $125,000 in penalties.

Medical Services meets with stakeholders

Medical Services continued to educate and inform stakeholders by holding virtual quarterly stakeholder meetings for the Nursing Facility Utilization Review (NFUR) in June and for the Hospital Utilization Review (HUR) unit in July. Both units provided an overview of the quality control process and reviewed identified trends. NFUR discussion included reviewing the fiscal year 2020 work plan, sample periods, proposed rule changes and reviewing HHS's Information Letter 19-23 Best Practices and its impact on future resource utilization groups reviews. HUR discussion included reviewing principal diagnosis coding, updating the record requests process and providing the status of managed care reviews.

OIG meets with Texas HHS

Each quarter, the OIG holds meetings with various program areas across Texas Health and Human Services (HHS). This quarter, the OIG met with the HHS chief program and services officer and executives from Medicaid CHIP Services and Health, Developmental and Independence Services. The August and May meetings provided the opportunity for programmatic updates; fraud, waste, and abuse trends; OIG policy recommendations; and contractors' program integrity performance. The OIG also met with the HHS Chief Operating Officer Maurice McCreary to coordinate operational topics such as procurement and IT projects. In July, the OIG met with staff from the Texas Medicaid Healthcare Partnership to discuss ongoing projects such as the Medicaid Fraud and Abuse Detection System transition, third party liability and COVID impacts.

Conferences and Presentations

- IG Kauffman and Chief of Investigations and Reviews Steve Johnson served on panels at the August annual conference of the National Association for Medicaid Program Integrity. Kauffman addressed how the OIG meets the top challenges to program integrity; Johnson outlined how the OIG uses data from the Healthcare Fraud Prevention Partnership. Additional OIG staff attended the virtual gathering, which focused on a variety program integrity issues, innovative efforts to undercover FWA, and the convergence of government and commercial health care. COVID-19 was also a common theme, especially determining how to assess program integrity within a constantly moving and evolving health crisis.
- In August, BPI field investigators from across the state participated in training related to interviewing subjects and witnesses during a beneficiary investigation. The training focused on implementing non-confrontational interview techniques designed to increase the quality of subject interviews and enhance investigators' ability to elicit truthful information. The training also focused on ways to conduct investigative interviews remotely to protect against the spread of COVID-19.
- In August, OIG Chief Dental Officer Dr. Janice Reardon and OIG Senior Dental Analyst Sherry Jenkins participated in the Dental Maintenance Organization Orientation

Training summary

Trainings conducted this quarter	29

webinar that provides information on the dental team's role in provider investigations. Their role includes providing dental expertise, suggestions and guidance for the fraud detection operation algorithms, test sheets and dental records collection.

- The EBT Trafficking Unit successfully developed and presented training on subpoenas and search warrants for its investigative staff and the OIG State Center Investigative Team in June. The virtual training was designed to explore the requirements of securing and executing subpoenas and search warrants and to understand the reporting requirements after their execution.
- OIG Office of Strategy staff virtually attended the 33rd National Academy for State Health Policy (NASHP) annual conference entitled "State Health Policy: Flexibility and Resiliency through COVID-19 and Beyond" in August. NASHP is a nonpartisan forum of policymakers throughout state governments, focused on learning, leading and implementing innovative solutions to health policy challenges.
- Medical Services educated staff by holding virtual trainings for the Acute Care Surveillance, Hospital Utilization Review and Nursing Facility Utilization Review units. In July, trainings included Evaluation & Management Coding and Medical Records Review, Principal Diagnosis, and Present on Admission. In August, trainings included the guidelines for medical records reviews and retrospective reviews related to Early Term Deliveries.
- Provider Integrity Development and Support (PIDS) maintains a collaboration with Provider Field Investigations to present program integrity-focused training to support the development of new and experienced Intake and Field Investigators. Drawing on the extensive knowledge and experience of PIDS staff and I&R leadership, investigators have an opportunity to attend their initial training and refresh their skills through webinars developed and presented by PIDS. Topics included this quarter were new investigator skills and the use of research tools available both within the OIG and via outside resources.
- Internal Affairs (IA) conducted virtual trainings in August with some topics that focus on the challenges of conducting investigations while teleworking. Trainings have included overview of all general features and how to conduct virtual interviews. IA also held four video conferences presented by IA investigators on case studies.

VIII. Program Integrity Spotlight

OIG initiatives drive FWA investigations

The OIG's work to uncover fraud, waste and abuse in health care delivery often begins with referrals from MCOs, providers and clients. The OIG receives more than 200 referrals each day through ReportTexasFraud.com and the OIG Fraud Hotline. The OIG also self-initiates cases based on data analytics or trends seen by its investigators. This approach involves multi-disciplinary teams across the OIG, including the Intake Resolution Unit (preliminary investigation), Policy & Strategic Initiatives (policy clarifications), Medical Services (clinical consultations), the Fraud, Waste, and Abuse Research and Analytics team (MCO encounter and paid claims data analysis), Provider Investigations (case investigation). The OIG Litigation team provides legal planning, support and guidance throughout this process. Together, these groups employ a variety of research, analytical tools and strategies to identify potential wrongdoing by Medicaid health care providers.

Self-initiated cases are based on extensive research identifying potential violations and the applicability of policy, statutes and contracts. The research includes identifying coding limitations in the Healthcare Common Procedure Coding System, Texas Medicaid & Healthcare Partnership, and the Texas Medicaid Provider Procedures Manual; reading up on what is happening in other states, specifically in the National Health Care Anti-Fraud Association's SmartBrief; analyzing referrals and complaints received by the OIG; performing internet searches; reading OIG audits and MCO provider manuals; and other activities.

Once the evidence identifies an issue for an initiative case, OIG staff analyze data to identify any providers exhibiting the behavior in the initiative. Data mining is performed to reveal the claims that do not follow policy. Finally, the case is presented to the provider for resolution of possible overpayments.

The following are active types of initiative cases:

- **Electroencephalographic (EEG) services.** Neurologists and other clinicians are billing for an EGG service which requires 24-hour monitoring by a clinician who can intervene in the monitoring and/or patient care as needed. The OIG initiative identified providers who are equipping patients with mobile EEG units and sending them home for overnight monitoring without 24-hour monitoring by a clinician. As a result, the providers inappropriately received a higher reimbursement amount.
- **Hospital ER injection/infusions cases.** The initiative monitors data to identify hospital outpatient facilities that billed and were paid separately for injections/infusions when the same services were already covered by another billing code paid on the same dates of service. Additionally, the administration of an injection is not reimbursable to outpatient hospital providers.
- **Laboratory improvement amendments (CLIA) initiative.** The CLIA initiative is designed to identify independent laboratories that received payment for specific types of testing without holding the appropriate CLIA certification to perform such testing. CLIA regulations set standards that are designed to improve quality in all laboratory testing and include specifications for quality control, quality assurance, patient test management, personnel and proficiency testing.
- **Non-covered services.** This initiative monitors data to identify providers that are billing and being reimbursed for services that, per the Texas Medicaid Provider Procedures Manual and the Healthcare Common Procedure Coding System, are not covered benefits of the Texas Medicaid Program and/or are not covered by the contracted MCO.
- **Private duty nursing cases.** In this initiative,

the investigator identified providers that were billing over the daily allowable amount of units of private duty nursing. A home health agency must bill private duty nursing in 15-minute increments, not to exceed 96 units per day. The OIG identified providers that billed and were reimbursed for more than 96 units on a single date of service for one patient.

- **Critical care cases.** These cases involve a patient receiving emergency room services at a lower level and the hospital billing for a higher level, such as for critical care. As a result, the provider inappropriately receives a higher reimbursement amount.

The OIG works with providers to resolve cases and prevent further occurrences of wrongdoing. Initiatives also may provide opportunities for fraud prevention through education.

IX. Division Performance

Strategy

The Strategy Division includes three teams: Fraud, Waste, and Abuse Research and Analytics, Policy and Strategic Initiatives, and the Results Management Team.

Fraud, Waste, and Abuse Research and Analytics (FWARA) implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of fraud, waste, and abuse. FWARA assesses trends and patterns regarding behavior of providers, clients and retailers participating in Texas Health and Human Services (HHS) programs. FWARA consists of four units:

- Fraud Analytics
- Data Research and Analysis
- Statistical Analysis
- Data Operations

Policy and Strategic Initiatives serves as the policy research team and liaison between HHS and the OIG. The unit conducts analysis of program policies and coordinates and ensures timely and effective communications with a variety of stakeholders. This unit also leads cross-functional priority projects across the OIG.

The Results Management Team collaborates with divisions across the OIG to identify opportunities for operational efficiencies and effectiveness with a focus on continuing to evolve the OIG's work in managed care.

FWARA performance

Data requests received	210
Data requests completed	188
Algorithms executed	113
New algorithms developed	3

Chief Counsel

The Office of Chief Counsel Division provides legal counsel and conducts employee FWA investigations. It is comprised of the following:

- General Law provides legal support for audits, investigations, inspections and reviews. Furthermore, General Law supports OIG operations, including researching termination/exclusion issues, reviewing federal share obligations, analyzing extrapolation processes, contracting and assisting with rule and statute changes affecting the agency.
- Litigation handles the appeal of investigations and audits that determined providers received Medicaid funds to which they were not entitled.
- Internal Affairs investigates employee misconduct in the provision of health and human services, including contract fraud within the HHS system.
- State Centers Investigations Team conducts criminal investigations of allegations of abuse, neglect and exploitation at state supported living centers and state hospitals.

Internal Affairs performance

Investigations opened	33
Investigations completed	33

State Centers Team performance

Cases opened	144
Cases completed	129

Audit and Inspections

Audit conducts risk-based audits related to the accuracy of medical provider payments; the performance of HHS agency contractors; and programs, functions, processes and systems within the HHS system. Protocols of provider audits are periodically published on the Resources page on the OIG's website.

Inspections conducts inspections of HHS programs, systems and functions.

Audits in progress

- IT Security and Business Continuity and Disaster Recovery Plans
- Managed Care Pharmacy Benefit Managers' Compliance
- Durable Medical Equipment Claims
- MCO Clean Claims for Nursing Facility Providers
- Substance Use Disorder Contracts
- Performance of Selected Contractors Supporting the Texas Integrated Eligibility Redesign System
- Selected MCO Financial Data
- Selected HHSC Grant Recipients
- Third Party Administrator
- Fee-for-Service Payments for Services Covered by MCOs
- STAR Kids Medical Necessity Determination Processes

Inspections in progress

- Child and Adolescent Needs and Strengths Assessment in Community-Based Care
- Local Mental Health Authorities
- Overlapping Long-Term Care Claims During Hospital Stays
- Mental Health Targeted Case Management and Rehabilitative Services in Managed Care
- State Supported Living Centers' Background Checks and Training Processes

Audit performance

Overpayments recovered	$589,550
Overpayments identified	$220,469
Audit reports issued by contractors	4

Audit reports issued

- Infinity Pharmacy Solutions: A Texas Vendor Drug Program Provider
- Alamo Area Council of Governments: Local Developmental and Disability Authority Performance and Medicaid Contracts
- Fee-for-Service Claims Submitted by Aveanna Healthcare Medical Solutions: A Texas Medicaid Durable Medical Equipment and Supplies Provider
- Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: All Star Medical Equipment and Supply, Inc.
- Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: Nextra Health, Inc.
- Security Controls Over Confidential HHS Information: Aetna Better Health of Texas
- Durable Medical Equipment Delivered to Deceased Medicaid Beneficiaries: Longhorn Health Solutions
- Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Cigna-HealthSpring Life and Health Insurance Company, Inc.
- Pharmacy Benefits Manager Navitus Health Solutions LLC: Community First Health Plans
- Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Amerigroup Texas, Inc., and Amerigroup Texas Insurance Company
- Pharmacy Benefits Manager Navitus Health Solutions LLC: Community Health Choice
- Pharmacy Benefits Manager Navitus Health Solutions LLC: Parkland Community Health Plan
- Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: UnitedHealthcare Community Plan

Inspections reports issued

- Member Complaints Received by Texas Medicaid Managed Care Organizations - Series III: Inspection of Member Complaint Appeals
- Molina Quality Living Program

Investigations and Reviews

The Investigations and Reviews Division includes these units:

Provider Investigations (PI) investigates and reviews allegations of fraud, waste and abuse involving Medicaid providers who may be subject to a range of administrative enforcement actions including education, prepayment review of claims, penalties, required repayment of Medicaid overpayments and/or exclusion from the Medicaid program. Some referrals come through the OIG Fraud Hotline or complaints from the OIG's online Waste, Abuse and Fraud Electronic Referral System. Referrals are also received from managed care organizations throughout the state. When criminal Medicaid fraud is suspected, PI refers the matter to the Attorney General's Medicaid Fraud Control Unit. The two work together on joint investigations by sharing resources and information that will lead to successful administrative disposition or criminal prosecution.

Benefits Program Integrity investigates allegations of overpayments to health and human services program clients enrolled in the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF) program; Medicaid; Children's Health Insurance Program (CHIP); and the Women, Infants, and Children (WIC) program.

Medical Services conducts claims and medical record reviews on a variety of health and human services, including acute care utilization, hospital utilization, nursing facility utilization, and pharmacy lock-in. Medical Services also provides clinical consultation to the Benefits Program Integrity and Provider Investigations units, as well as the Audit and Inspections Division, on dental, medical, nursing and pharmacy services.

Program Integrity Development and Support (PIDS) provides support and process improvements to other division units. Responsibilities include developing projects to improve investigative outcomes, reporting statistics, acting as the Managed Care Organization Special Investigative Unit liaison, planning and conducting Investigative Initiatives and Fraud Detection Operations and acting as the lead on open records requests.

Provider Enrollment Integrity Screenings (PEIS) unit is responsible for conducting certain federal and state required screening activities for providers seeking to

Provider Investigations performance

Preliminary investigations opened	397
Preliminary investigations completed	422
Full-scale investigations completed	66
Cases transferred to full-scale investigation	55
Cases referred to AG's Medicaid Fraud Control Unit	130
Open/active full-scale cases at end of quarter	119

Medical Services performance

Acute care provider recoveries	$822,855
Acute care services identified overpayments	$741,698
Hospital and nursing home UR recoveries	$5,023,982
Hospital UR claims reviewed	5,992
Nursing facility reviews completed	3
Average number of Lock-in Program clients	2,336

Benefits Program Integrity performance

Overpayments recovered	$3,856,334
Cases completed	4,203
Cases opened	8,940
Cases referred for prosecution	2
Cases referred for Administrative Disqualification Hearings	233

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	7,339
Individual screenings processed	21,727

EBT Trafficking Unit performance

Overpayments recovered	$59,744
Cases opened	105
Cases completed	165

Peace Officers performance

Cost avoidance	$246,768

Investigations and Reviews

enroll in Medicaid, CHIP and other state health care programs. The screenings and reviews conducted by PEIS promote compliance with federal provider enrollment program integrity requirements; increase accountability for the appropriate use of taxpayer resources by helping to prevent fraud, waste and abuse; and protect the health and safety of Texans.

The Electronic Benefits Transfer (EBT) and Women, Infants and Children (WIC) Investigation teams include commissioned peace officers and non-commissioned personnel. The Cooperative Disability Investigations team investigates statements and activities that raise suspicion of disability fraud. These teams conduct administrative and criminal investigations related to those benefit programs.

Investigations and Reviews also oversees the Recovery Audit Contractor, which is a vendor contracted with the state to identify and recover Medicaid overpayments using data analytics and clinical reviews of medical records.

Operations

The Operations Division is comprised of five core functions:

- Operations Support includes OIG purchasing, OIG contract management and the OIG Fraud Hotline. The Fraud Hotline receives allegations of fraud, waste and abuse and refers them for further investigation or action as appropriate.
- Finance and Budget oversees the OIG budget, tracks recoveries, reports Legislative Budget Board performance measures and works closely with HHSC Central Budget on the agency's LAR/ Exceptional Items.
- Workforce Operations and Professional Development promotes OIG training services and internal policy development.
- Third Party Recoveries works to ensure that Medicaid is the payor of last resort, oversees the Recovery Audit Contract and operates the Medicaid Estate Recovery Program.
- The Ombudsman provides an independent and neutral process for OIG employees to address concerns and work towards resolution.

Operations performance

Fraud hotline calls answered	7,827

Third Party Recoveries performance

Dollars recovered	$85,660,463
Identified recoveries	$108,049,076
Cost avoidance	$20,517,174

External Relations

The External Relations Division focuses on engaging and ensuring a timely response to OIG critical stakeholders:

- Communications manages press relations, maintains the OIG website and social media platforms, publishes the agency's external facing reports and work products, and facilitates communication between the Inspector General and various stakeholders.
- Government Relations serves as the primary point of contact for the executive and legislative branches of government and state policy makers. Government Relations also analyzes legislation to understand the impact to OIG operations.
- Office of Chief of Staff leads OIG-wide initiatives and special projects.

External Relations performance

Website page views	174,496
Communications materials produced	93

Texas Health and Human Services Office of Inspector General

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To report fraud, waste or abuse

OIG Fraud Hotline: 800-436-6184 **Online:** oig.hhsc.texas.gov/report-fraud

Website: ReportTexasFraud.com

OIG on LinkedIn: hhsc-office-of-inspector-general

OIG on Twitter: @TexasOIG

OIG on Facebook: TxOIG

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This report meets the requirements for information related to the expansion of managed care as required by House Bill 1, 86th Legislature, Rider 112, Office of Inspector General Report and Government Code §531.102 (t)