Texas Health and Human Services
Inspector General

Quarterly Report
March 2017

Office of Inspector General
Health and Human Services Commission
Texas

PROFESSIONALISM

PRODUCTIVITY

PERSEVERANCE

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OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH & HUMAN SERVICES COMMISSION

SYLVIA HERNANDEZ KAUFFMAN
PRINCIPAL DEPUTY INSPECTOR GENERAL

I am pleased to submit this latest quarterly report from the Office of Inspector General to Governor Greg Abbott, Texas Health and Human Services Executive Commissioner Charles Smith, members of the Texas Legislature, and the citizens of Texas.

This report captures the progress our office has made during the second quarter of FY 2017, including the recovery of over $20 million in state and federal overpayments. Our office completed the final in a series of SIU audit reports that have prompted significant increases to managed care investments to combat fraud, waste and abuse throughout the state. Also in the second quarter, we continued to extend our use of data to focus our efforts, inform our decisions, and drive our investigations; and have made efficiency improvements to provider enrollments and fraud referral call handling.

The IG's office appreciates the magnitude of our responsibility to lead the oversight of nearly $40 billion of state funds that may be subject to fraud, waste or abuse, and will continue its transformation towards becoming the best state-level IG in the country..

The IG team will continue its work to strengthen our efforts in this important mission, and will continue to report on our progress and results in the coming months.

Respectfully yours,
Sylvia Hernandez Kauffman

Dollars recovered

Audit and Inspections

Provider collections (Medicaid and WIC)	$5,858,051

Investigations

Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$3,964,762
Provider collections (Medicaid)	$1,478,302

Medical Services

Acute care provider collections	$1,006,303
Hospital collections	$7,330,919
Nursing facility collections	$1,071,674
Voluntary repayments and Self-reports	$49,917
Total	**$20,759,928**

Questioned costs

Audit

Provider overpayments (Medicaid)	$4,262,601

Investigations

Beneficiary overpayments (SNAP, TANF, Medicaid, WIC)	$9,185,977

Medical Services

Hospital overpayments	$7,593,957
Total	**$21,042,535**

Funds put to better use

Audit and Inspections

WIC vendor disqualifications	$5,321,457

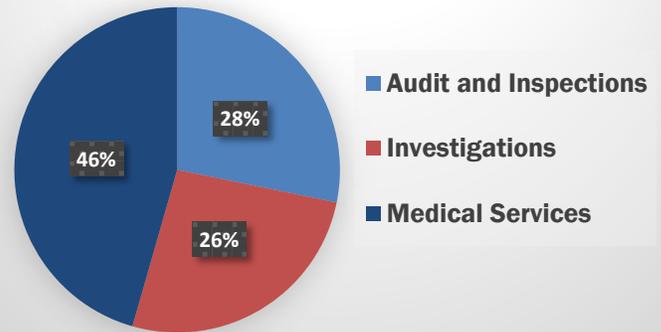**Investigations**

Beneficiary disqualifications and income eligibility matches	$1,155,960
Other beneficiary data matches	$1,676,567
Medicaid providers ordered to pay restitution	$12,166,627

Medical Services

Pharmacy Lock-In	$3,841
Total	**$20,324,452**

Dollars recovered second quarter FY17

- Audit and Inspections — 28%
- Investigations — 26%
- Medical Services — 46%

How we measure results

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

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

Questioned costs (formerly listed as dollars identified for recovery): Questioned costs include overpayments identified for recovery during an IG investigation, audit, inspection or review due to: an alleged violation of a statute, law, regulation, rule, policy, or other authority governing the expenditure of funds or the provision of services; a finding that a cost is not supported by adequate documentation; or a finding that funds were not used for their intended purpose or were unnecessary, unreasonably spent, or wasteful.

Funds put to better use (formerly listed as dollars identified as cost avoidance): Putting funds to better use 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.

These measures align with those used by the federal Government Accountability Office.

Overview

Overview

Contract-Related Audits Yield Significant Monetary Impact

Since early 2015, the IG has issued 22 contract-related audit and informational reports. These reports included 63 findings and 77 recommendations, and have had an estimated positive monetary impact of about $5.7 million to the State. The monetary impact includes a $5.3 million increase in MCO special investigative unit (SIU) financial commitments, questioned costs of $278,441 in contractor overpayments, and dollars recovered totaling $117,473.

The final capstone informational report on MCO SIUs was issued in the second quarter. In addition to increased SIU financial commitments, the series of SIU audits resulted in initiatives to improve collaboration between MCOs, HHS system, and the IG. Key activities intended to improve fraud, waste, and abuse efforts include expanding the content of quarterly meetings between SIUs and the IG, increasing IG responsiveness to SIU referrals, and collaborative efforts through the Texas Fraud Prevention Partnership.

The IG initiated an audit of a residential services contractor in February, and is completing a series of MCO utilization management audits. In the third quarter, the IG will initiate audits of managed care Pharmacy Benefit Manager compliance and third party recovery contractor performance.

Executive Dashboards Track Key Performance Indicators

To strengthen data-driven oversight, this quarter the Data and Technology Division launched two new interactive executive dashboards that provide near real-time read-outs on division performance. The new dashboards, launched in April, support the Inspections and Audit divisions. IG staff designed, developed, and implemented these dashboards from inception. The Data and Technology team will continue to develop dashboards for each mission-critical area of the IG.

Data Drives Fraud Detection Operations

IG continues to conduct monthly fraud detection operations that it began in August 2015. These

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Key quarterly results

- Recovered more than $20.8 million in state and federal funds.

- Opened five full-scale investigations as a result of the pediatric dental sedation inspection.

- Answered approximately 7,500 Integrity Line calls reporting fraud, waste, and abuse.

- Screened nearly 18,500 individuals seeking to enroll or validate their enrollment in Texas Medicaid.

- Completed a series of SIU audits, which resulted in a significant expansion of investment across most Texas SIUs.

- Completed three fraud detection operations in the field related to speech therapy, pharmacy, and durable medical equipment.

- Developed data-driven methodology to identify possible fraudulent trafficking in WIC benefits.

- Hired first Chief Pharmacy Officer as part of Medical Services staff.

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monthly operations are cross-divisional efforts and include staff from the Investigations, Data and Technology, Inspections, Chief Counsel, and Medical Services divisions. During the second quarter, IG completed three fraud detection operations focusing on different areas of potential vulnerability affecting Medicaid expenditures.

In December 2016, the fraud detection operation focused on speech and occupational therapy providers in Houston and the Rio Grande Valley. The investigators focused on suspicious indicators such as billing unreasonable hours, billing for services outside the scope of practice, and billing for claims rendered by another provider. As a result, four investigations were opened.

In January 2017, the operation focused on pharmacy providers in Houston. The investigators focused on suspicious indicators such as whether

The Rio Grande Valley Symposium drew a full house at the University of Texas Rio Grande Valley.

IG Hosts Rio Grande Valley Symposium for Regional Stakeholders

The IG hosted the first Rio Grande Valley Medicaid Integrity Symposium at the University of Texas Rio Grande Valley in Edinburg on February 17th.

The forum provided an opportunity to create and strengthen relationships between the IG; Medicaid providers; managed care organizations; and clinical practitioners, including doctors, pharmacists, dentists, and nurses.

The one-day event featured topics and discussions including trends in fraud, waste, and abuse in the Texas HHS System; a history: past, present, and future of Medicaid in the Rio Grande Valley; the IG provider audit process; and a primer on IG investigations.

A legislative panel included discussions on health and human services goals for the 85th legislature with Representative Sergio Muñoz, Jr. of District 36, and Senator Juan "Chuy" Hinojosa of District 20, with former State Representative Veronica Gonzalez of District 41 serving as moderator. The panel

State Senator Juan "Chuy" Hinojosa addresses participants at the Rio Grande Valley Symposium.

discussed priorities and concerns for each of their districts.

Additionally, a managed care panel provided an overview of managed care, and a discussion with executives from three of the largest managed care organizations: Don Langer, CEO of United Healthcare Texas Health Plan; Mark Sanders, CEO of Superior HealthPlan Texas Office; and Steve Pollock, CEO of DentaQuest. The panel discussed their roles in the Texas Fraud Prevention Partnership, which was developed by the IG to promote collaboration between the IG and the state's managed care organizations.

Other key speakers included Dr. Guy Bailey, UTRGV President; Roland Luna, Deputy IG for Investigations; Olga Rodriguez, IG Director of Policy and Publications; K.J. Scheib, Deputy Associate Commissioner for Medicaid and CHIP Services; Brian Klozik, Assistant Deputy IG for MPI; and Steve Sizemore, IG Audit Director.

Overview

specific pharmacies have a valid prescription for the drugs dispensed to Medicaid recipients, and whether recipients actually received the drugs billed by the pharmacy. This operation led to the opening of six investigations.

In February 2017, the operation focused on durable medical equipment providers in the Rio Grande Valley. The investigators focused on suspicious indicators such as billing for diabetic supplies for clients who have no history or diagnosis of diabetes, and billing for high dollar durable medical equipment (DME) products without an accompanying visit to an authorizing entity. Two investigations were opened.

Joint SNAP Integrity Initiative Continues Progress

The IG continues to work with HHS Access and Eligibility Services (AES) to identify, deter, and eliminate fraud, waste, and abuse in programs administered by the HHS System. AES and IG meet on a monthly basis to coordinate fraud prevention activities, and to develop an HHS Annual Anti-Fraud Plan, which is in its final stages of development. The Anti-Fraud Plan has been drafted and will highlight the activities of both IG and the HHS System in combating fraud, waste, and abuse.

Fraud, waste, and abuse referrals

Home health agencies / personal attendants	46.1%
Physicians (group or individual)	14.8%
Pharmacy	9.8%
Dental	8.5%
Therapy	6.3%
Nursing home	3.8%
Durable medical equipment	3.5%
Hospital	2.1%
Other	6.5%

These are the top fraud, waste, and abuse allegations by provider type that were received by the IG for the second quarter of fiscal year 2017.

Improved Process Focuses on Identifying WIC Benefits Trafficking

The IG developed a data-driven methodology focused on WIC trafficking. WIC benefits trafficking involves selling or exchanging WIC benefits for cash or any other unauthorized items. This data-driven model is based on WIC-specific data queries designed to identify vendor transaction anomalies that may indicate trafficking.

This new methodology is the result of a collaboration with the USDA Food and Nutrition Service and the USDA Office of the Inspector General. It will be implemented in the third quarter of this year with new WIC inspections to further improve the integrity of the WIC program.

IG Provider Enrollment Efficiency Improvements

Throughout this quarter, IG continued to collaborate with the HHSC Medicaid & CHIP Services Department (MCS) to streamline the provider enrollment process. The IG is tasked with conducting background checks for high-risk Medicaid and CHIP providers. Eleven IG staff members screened nearly 18,500 individual providers across approximately 5,400 enrollment applications, and conducted nearly 80 informal desk reviews for providers disputing the denial of their enrollment application. The IG met the statutorily mandated 10-day timeframe for completing screenings.

Starting January 1, 2017, the IG began receiving and processing Federal Bureau of Investigation fingerprint checks for newly enrolling high-risk providers and revalidating existing providers, in accordance with Affordable Care Act requirements. The IG has also implemented efficiency improvements to increase application processing speed, including utilizing SharePoint to record data and move toward electronic document transmission and storage.

Integrity Line Streamlines Call Handling

The IG hired and trained two new bilingual staff members for the Integrity Line, doubling its capacity to respond to reports of fraud, waste,

and abuse from Spanish-speaking callers. Also during the quarter, the IG Integrity Line answered approximately 7,500 calls, processed more than 3,700 referrals, and maintained an average answer time of 2.5 minutes.

IG Welcomes Chief Pharmacy Officer

The IG hired Catherine Coney as its first Chief Pharmacy Officer to round out the IG's Clinical Subject Matter Expert Team. Coney earned her pharmacy degree from the University of Texas at Austin and has over 30 years of experience in the practice of pharmacy, including retail and clinical delivery settings. Before coming to the IG, Coney was responsible for overseeing a major nursing facility pharmacy provider serving Medicare, Veterans Affairs, and dual-eligible clients. She is currently providing education and professional support to IG teams focused on opioid abuse, the prescription monitoring program, and e-prescribing.

IG Continues to Build Relationships with Key Officials

The IG continued outreach efforts, meeting with officials from:
- Superior HealthPlan;
- MCNA Dental:
- DentaQuest;
- United Healthcare.

The IG also met with representatives of:
- Texas Dentists for Medicaid Reform;
- South Texas Physician Alliance;
- Hidalgo County Medical Society;
- Texas Medical Association Medicaid Committee;
- The University of Texas-Rio Grande Valley.

The IG hosted the Rio Grande Valley Symposium for providers and managed care organizations in February (see details on page 7). With the Legislature in session, IG staff met with key lawmakers, including Senator Charles Schwertner, Chair of the Senate Health and Human Services

IG tools for combating fraud, waste, and abuse

Inspections
- Focus is on systemic issues.
- Scope is narrow.
- Provides practical recommendations.
- Goal is to identify areas that need to be audited, reviewed, or investigated to improve HHS System effectiveness and efficiency.

Audits
- Focus is on compliance.
- Scope is generally broad and retrospective, and supports audit objectives.
- Performance, provider, and IT audits are conducted in accordance with generally accepted government auditing standards.
- Goal is to identify overpayments made to providers and contractors, and to improve efficiency and performance across the HHS System.

Investigations
- Focus is on abusive or fraudulent practices.
- Scope varies depending on the nature and type of the investigation.
- Addresses allegations of recipient and provider fraud, and issues with employees at state supported living centers and state hospitals.

Reviews
- Focus is on waste and abuse specific to documentation, billing, and payments.
- Scope is wide to review a broad spectrum of providers.
- Educates providers on correct billing documentation, recovers overpayments, and returns underpayments.
- Goal is to ensure accurate payments for appropriate services provided.

Committee; and Representative Richard Raymond, Chair of the House Human Services Committee.

Overview

Q&A with Jami Snyder, State Medicaid Director and Associate Commissioner, Medicaid & CHIP Services Department

Please tell us about your background.

I have over 18 years of public and private sector health care industry experience. Prior to joining HHSC, I served as the Chief Operating Officer for The University of Arizona Health Plans, a managed care organization responsible for over 120,000 Medicaid and Medicare enrollees across southern Arizona.

Before that, I spent over 13 years in public service, as the Executive Director for the Arizona Governor's Council on Developmental Disabilities for the Arizona Department of Health Services, and as a Bureau Chief and Operations Administrator for the Arizona Health Care Cost Containment System, Arizona's Medicaid program. In those roles, I was responsible for coordinating oversight of the state's Medicaid-contracted health plans, including compliance with established federal and state managed care regulations and performance in a variety of areas such as network sufficiency, payment modernization, customer service, service coordination/case management, and the provision of self-directed care.

Jami Snyder

I hold a Bachelor of Arts in political science from Gustavus Adolphus College and a Master of Arts in political science from Arizona State University. In my free time, I enjoy hiking, listening to live music, and cheering on the Arizona Wildcats (don't tell the alumni association!).

What is your vision for your division over the next year?

The next year presents an opportunity for the Medicaid and CHIP Services Division to stabilize the program's infrastructure in a manner that is fully responsive to the managed care framework that now serves over 90 percent of the state's Medicaid population. Over the next year, I look forward to working with my team and our system partners, including the Inspector General, in modernizing our organizational structure, our approach to oversight, and our operational foundation to properly reflect MCS' role in ensuring that contracted managed care organizations meet established expectations related to the provision of services and supports offered to Medicaid enrollees.

Can you describe the success you had during your tenure in Arizona and how you might bring some of these approaches to Texas managed care?

While at Arizona Health Care Cost Containment System, I was fortunate to work with a team of individuals who shared my commitment to ensuring that data drive decision making, and in particular, decisions related to MCO oversight and compliance. As such, over my tenure with that agency, we developed a comprehensive set of monitoring tools to:

- Track MCO performance on a range of indicators reported routinely to the agency (e.g. claims payment timeliness, call center statistics, grievance and appeals handling).
- Assess MCO administration of various product lines as evidenced through established policies and procedures, standard operating practices, and staff aptitude.

The tools served as a centralized repository for the collection of data on health plan performance, and informed the agency's application of remedies, when appropriate. In Texas, we are actively engaged in the development of similar instruments, which will enhance our oversight of MCOs, and ensure the consistent pursuit of compliance action in instances where the MCO has failed to meet established expectations.

Additionally, while serving as the COO for the University of Arizona Health Plans, I was charged with spearheading the MCO's value-based purchasing work. This opportunity provided me with incredible insight into the complexity underlying the transformation currently taking place within the U.S. health care delivery system, particularly as we transition from a system that has historically paid for volume to one that rewards value. Over the last nine months, I have worked closely with the MCS team to develop expectations

for contracted MCOs in regard to value-based purchasing. It is my hope that this work, paired with efforts already underway in Texas through endeavors such as the Delivery System Reform Incentive Payment program, will accelerate our progress in enhancing health outcomes, while also driving down the cost of care by incentivizing appropriate utilization of services and supports.

How does your division collaborate with the Inspector General to identify fraud, waste, and abuse?

MCS actively partners with the Inspector General in identifying fraud, waste and abuse. Efforts include:

- Oversight of MCO Special Investigative Units, including issuance of liquidated damages when an MCO is found to be deficient in the administration of its SIU function.
- Coordination in the deployment of audits aimed at identifying potential fraud, waste, and abuse as well as performance deficiencies.
- Evaluation of Medicaid program administrative functions in order to ensure maximization of efforts to detect fraud, waste, and abuse.
- Participation in the Texas Fraud Prevention Partnership.

Program Insight: Texas Medicaid Vendor Drug Program

Program Insight: Texas Medicaid Vendor Drug Program

The Texas Medicaid Vendor Drug Program (VDP) provides pharmaceutical care for recipients in Medicaid, the Children's Health Insurance Program (CHIP), Children with Special Health Care Needs Services Program (CSHCN), and the Kidney Health Care Program (KHC). It also manages drug manufacturer rebate programs to maximize rebate revenue to the state.

VDP services are provided through more than 4,800 pharmacies statewide. The open formulary covers over-the-counter medication, vitamins, and limited home health supplies.

VDP is organized in the following units:

Pharmacy Rebate & Business Analysis
- Main point of contact for all system-related operational interaction between VDP and contracted vendors.
- Includes interfaces with managed care and non-managed care trading partners.
- Oversees and monitors the pharmacy claims and rebate administration contractor.
- Provides business analysis support for VDP projects.

Drug Utilization Review & Formulary Management
- Maintains an open formulary of pharmaceutical products approved for dispensing to clients enrolled in CHIP, CSHCN, KHC, fee-for-service (FFS) and managed care programs.
- Develops clinical coverage criteria and the Preferred Drug List for safe, appropriate, cost-effective drug use.
- Manages the Drug Utilization Review Board advisory committee.

Contractor Performance Management
- Oversees and monitors contractor performance to ensure vendor compliance with outpatient drug benefit requirements using performance data and communication with MCOs, vendors, and stakeholders.

Program & Project Management
- Develops, evaluates, and implements policies, rules, legislation, and contract requirements regarding the outpatient drug benefit in FFS and managed care.

- Serves as project management office for VDP projects.
- Develops and distributes stakeholder communications (including TXvendordrug. com).
- Conducts pharmacy-related cost containment initiatives.
- Coordinates federal, state, and internal audits of VDP-administered functions and services.

Pharmacy Benefits Access
- Primary point of contact for pharmacy providers and other stakeholders to address issues with clients' timely access to pharmacy benefits through the daily operations of a Pharmacy Call Center and an Issues Escalation Team.

Pharmacy Operations & Contract Oversight
- Provides oversight and monitoring as it relates to the pharmacy portions of the managed care and non-managed care contracts.
- Includes reviews of the clinical aspects of MCO pharmacy benefit programs.
- Manages clinical pharmacists, Performance Management unit, and the Program and Project Management Unit.

The interview below with Katherine Scheib highlights the role of pharmacy benefit managers (PBMs) and how HHS is managing the pharmacy benefit in a managed care environment.

Q&A with Katherine Scheib, Deputy Associate Commissioner, HHS Medicaid & CHIP Services Department

Please briefly explain how a Pharmacy Benefit Manager works.

A Pharmacy Benefit Manager, or PBM, is a third party administrator of prescription drug benefits for a health plan. A PBM's primary responsibilities are developing prescription drug benefit policies, providing access to medications, and minimizing costs. PBMs are employed in commercial health plans, self-insured employer plans, Medicare Part D plans, Medicaid/CHIP plans, and various state and federal government employee plans. PBM services include but are not limited to:

- Administrative services in adjudicating and paying for prescription claims
- Customer service to members and providers via call centers
- Clinical services such as prior authorizations, step therapy, and utilization controls
- Contracting with a network of pharmacies including mail-order and specialty
- Maintaining programs to ensure patient compliance
- Implementing therapy or disease management programs

What strategies do PBMs use to achieve savings?

PBMs use various tools to manage prescription drug benefit programs that can make access to medications more efficient and affordable. Due to state and federal regulations, PBMs are somewhat limited in their ability to implement savings strategies in Medicaid and CHIP compared to other lines of business. Below is a high-level description of some tools PBMs use to produce savings and how they are applicable in Texas:

Katherine Scheib

- Managing drug utilization through formulary development and step therapies: PBMs must follow the HHSC Formulary and Preferred Drug List.
- Negotiating rebates from drug manufacturers: Program PBMs are prohibited from independently negotiating supplemental rebate contracts for Medicaid. The state contracts with one vendor to negotiate supplemental rebates for the entire Medicaid program. However, individual PBMs may negotiate rebates for the CHIP program and any limited home health supplies offered through a pharmacy.
- Negotiating reimbursement rates and co-pay amounts: PBMs can establish a variety of reimbursement methodologies to offer contracted pharmacies. PBMs are prohibited from charging Medicaid clients any out of

Texas Medicaid spending on VDP for Fiscal Year 2016

Managed Care Organizations	$2,673,133,083
Fee-for-service	$715,675,304
Total	**$3,388,808,387**

pocket expenses.
- Encouraging the use of generic and affordable brand drugs: PBMs may encourage the use of generic drugs except for those brand drugs that have preferred status as set by the state vendor drug program.
- Managing high-cost specialty medications: PBMs can only refer drugs listed on the official Texas Medicaid FFS specialty drug list to their contracted specialty pharmacy for dispensing. This allows community pharmacies to participate in the dispensing of any drug not on the specialty drug list. PBMs cannot require beneficiaries to use mail-order pharmacy services.
- Reducing waste and improving adherence: PBMs are somewhat limited by federal rules that prohibit the delivery of a drug in a manner that is more restrictive than the state's FFS model, but many do have medication therapy management programs that serve to improve medication adherence.

How do these strategies complement the prevention and detection of fraud, waste, and abuse in Medicaid managed care?

PBMs utilize sophisticated algorithms and audit procedures to monitor potential fraud, waste, and abuse which complement the oversight provided by HHSC and the IG.

What data is tracked and used to calculate savings that PBMs achieve for the state?

Various data are used to calculate PBM savings and performance:
- Pharmacy FFS claims and MCO reported encounters are used to compile rebate amounts due, both supplemental and federal, from manufacturers. Rebates from the

manufactures are collected by the state.

- Brand/generic drug reports are designed to give the percentage breakdown of brand versus generic utilization. The report allows HHSC to monitor adherence to the preferred drug list to maximize usage of lowest cost drugs.
- Specific actuarial reports monitor reimbursement differences between managed care and FFS, including dispensing fee and ingredient cost differences.
- Actuarial reports are used to compare whether FFS or MCO/PBMs should control the formulary and preferred drug list in order to minimize costs. These studies can help determine the net cost of drugs (net of rebates) per therapeutic categories in FFS and managed care.

Investigations

Investigations

The Investigations Division detects and deters fraud, waste, and abuse through timely, high-quality investigations. It is comprised of five directorates:

- General Investigations investigates allegations of overpayments to recipients of state benefit programs.
- Medicaid Provider Integrity investigates allegations of fraud, waste, and abuse by Medicaid providers.
- State Centers Investigative Team/Electronic Benefits Transfer investigates violations involving State Supported Living Centers staff, State Hospitals staff, and EBT trafficking.
- Internal Affairs investigates employee misconduct and contract fraud within the HHS System.

General Investigations

The General Investigations (GI) directorate pursues allegations of overpayments made to applicants in the Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), Medicaid, Children's Health Insurance Program (CHIP), and Women, Infants, and Children (WIC) program, as well as other health and human services programs.

During this quarter, GI referred 53 cases for prosecution, received 38 court dispositions, identified $8,169,707 in questioned costs, and recovered $3,959,783 in overpayments.

GI continues to work with HHSC Access and Eligibility Services (AES) to identify fraud, waste and abuse. AES provides information and referral assistance to HHS programs and services, and determines eligibility for medical and disability services, and cash, food, and other assistance programs for individuals and families who qualify for these programs. GI staff participates in AES staff meetings and conferences to answer questions and provide examples of what constitutes fraud. The GI staff is also available to AES staff to provide guidance when a case worker is interviewing an applicant and suspects that they are providing false information.

GI investigations into fraud, waste, and abuse

Top accomplishments this quarter

- Recovered approximately $4 million in overpayments through General Investigations.
- Opened 598 cases and completed 533 cases through Medicaid Provider Integrity.
- Opened 293 cases and completed 290 cases through State Centers Investigation Team.
- Opened 113 cases and completed 137 cases through Internal Affairs.

during the second quarter included:

- SNAP and Medicaid fraudulent overpayments of $75,493 due to an applicant not reporting that her spouse was living in the residence, and not reporting her spouse's earned income from employment. The case was filed for criminal prosecution.
- SNAP and Medicaid fraudulent overpayments of $59,124 due to an applicant failing to report her employment and her spouse's income. The case was filed for criminal prosecution.
- SNAP fraudulent overpayment of $22,020 due to an applicant falsely claiming residence in Texas when she and her family lived in Mexico. The case was filed for criminal prosecution.

GI implemented Theory of Constraints, an innovative organizational method for process improvement, during fall 2016. Initial results include improvement in the overall timeliness of cases being worked by investigators, and an increase in the average number of investigations completed per investigator. During the second quarter, GI released improvements to streamline how it screens incoming referrals for fraud, waste, and abuse.

Medicaid Provider Integrity

MPI participates in the FBI Rio Grande Valley Healthcare Fraud Task Force. This federal task force uncovered evidence that a physician was submitting fraudulent billing for Medicaid services for patients who were deceased. The physician was indicted and subsequently pled guilty to conspiracy to commit healthcare fraud. Physician sentencing

is currently pending.

MPI opened 598 cases and completed 533 cases this quarter. The MPI Intake unit maintained an average case processing time of 25.4 days. At the end of the quarter there were 211 cases in full-scale investigation.

The following are some examples of investigations completed during the second quarter:

- An MPI investigation of an emergency services provider in south Texas identified $4,344,318.58 potentially at risk due to fraudulent billing and repeated safety and regulatory violations. Based on MPI's recommendations, Litigation has begun the process to exclude both the provider and its owner from the Medicaid program.
- An MPI Investigation identified a potential Medicaid overpayment of $337,266.87 due to a Division of Medical Services referral that suspected the behavioral health provider was overbilling Medicaid. The case was referred to the Chief Counsel Division for recoupment.

State Centers Investigation Team and Electronic Benefit Transfer Trafficking Unit

This directorate consists of commissioned and non-commissioned investigators who conduct criminal investigations involving allegations of abuse, neglect, and exploitation at state supported living centers and state hospitals; Electronic Benefits Transfer (EBT) trafficking involving authorized Supplemental Nutrition Assistance Program (SNAP) retailers and beneficiaries receiving SNAP benefits; and beneficiary Medicaid fraud.

The two units within this directorate are the State Centers Investigation Team (SCIT), and the Electronic Benefit Transfer Trafficking Unit. SCIT completed investigations of 69 state hospital cases and 200 cases related to state supported living centers.
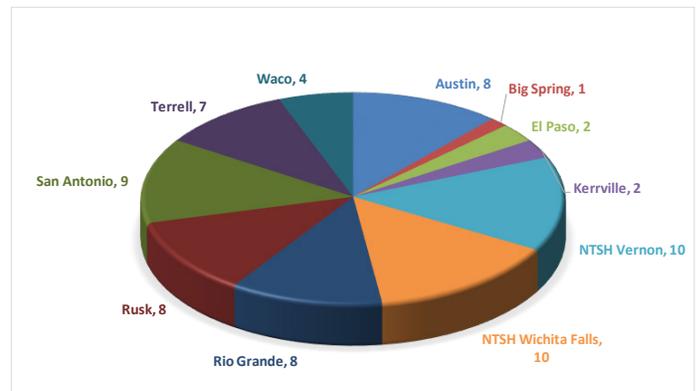
During this quarter, the directorate opened 293 investigations, completed 290 investigations, presented 21 cases for prosecution, identified

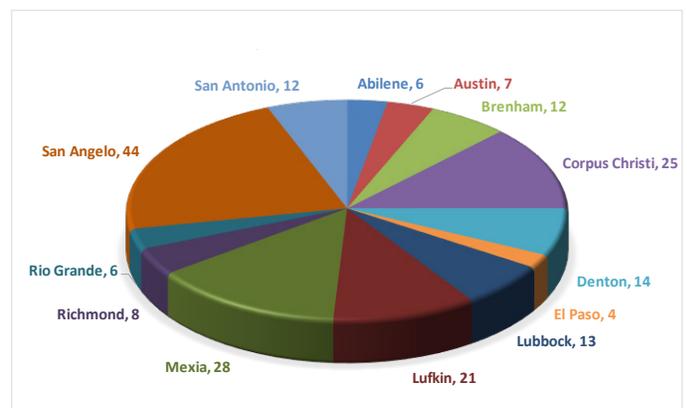$83,046 in questioned costs, and recovered $4,979.

The following are some examples of investigations completed during the second quarter:

- A joint investigation of an authorized SNAP retailer in north Texas involving USDA OIG and the IG EBT Trafficking Unit resulted in felony indictments of seven suspects by a Johnson County grand jury on February 23, 2017. A total of $22,931 in SNAP benefits were criminally trafficked through undercover transactions. Additionally, $40,275 in SNAP benefits were identified as fraudulently redeemed by 21 beneficiaries. The total identified SNAP fraud at this retailer was $63,206.
- In an ongoing investigation of direct support professionals at the Mexia State Supported

SCIT investigations completed this quarter for state hospitals

SCIT investigations completed this quarter for state supported living centers

Investigations

Living Center regarding abuse and beating of a client, one of the direct support professionals was found guilty and sentenced to seven years deferred adjudication. Trials are pending on other subjects identified in this investigation.

Internal Affairs

During this quarter, Internal Affairs opened 113 new investigations and completed 137 investigations. Of the 137 completed investigations, 46 cases were substantiated. Case completion took an average of 56 days. The cases investigated included vital statistics fraud, employee misconduct, computer misuse, and theft.

Below are examples of investigations conducted by Internal Affairs during the second quarter:

- An investigation found that a therapist was billing Child Protective Services (CPS) and Department of Family and Protective Services (DFPS) for no-show visits and billing prior to the date of scheduled visits. In March 2017, a plea agreement was reached on a 2nd degree felony of fraud with $186,993 to be paid in restitution.
- Texas Works Advisor falsified documents to certify an individual for benefits for which the individual was not eligible. The individual was sentenced by a Dallas County District Court Judge in February 2017 to three years of probation. The Texas Works Advisor is scheduled for trial at a later date.

Audit

Audit

The Audit Division conducts risk-based audits of contractors, providers, and HHS programs to reduce fraud, waste, and abuse throughout the HHS system. These audits include examining the performance of medical service providers and HHS agency contractors, and providing independent assessments of HHS programs and operations among other things.

Additionally, the Audit Division coordinates all federal government audits, manages the Recovery Audit Contractor (RAC) contract, and serves as the single point of contact with the Centers for Medicare and Medicaid Services (CMS) for Medicaid Integrity Contractor (MIC) audits and Payment Error Rate Measurement (PERM) activities.

RAC Transfer Approved

Following a successful six-month pilot period, HHS approved the permanent transfer of responsibility for contract management of RAC audits to the IG Audit Division. This transfer recognizes the IG's effective performance in managing the contract, and will serve to continually strengthen relationships and communication between the IG and HHS system management and staff.

With Audit Division oversight, the RAC contractor has been conducting two types of complex reviews for the first two quarters of fiscal year 2017. The RAC contractor initiated short-stay utilization medical record reviews of 1,604 claims to confirm that services provided in hospitals were correctly coded as outpatient. The RAC contractor also initiated newborn medical record reviews of 115 claims to identify potential upcoding, which occurs when providers inappropriately report higher, and thus more costly, levels of care than what was medically necessary or performed.

RAC results

Period	Questioned costs	Dollars recovered
FY17 Q1	$7,707,193	$8,194,389
FY17 Q2	$3,133,105	$5,211,795
FY17 YTD Total	**$10,840,298**	**$13,406,184**

Top accomplishments this quarter

- Permanent transfer of responsibility for contract management of RAC audits to the IG Audit Division from HHSC.
- Completed its series of SIU audits, which resulted in a significant increase in SIU investment across most Texas MCOs.
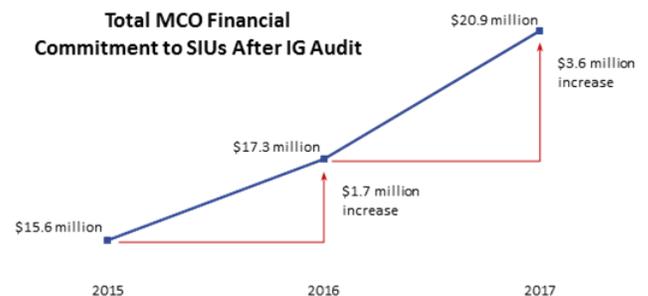
During the first two quarters of fiscal year 2017, the RAC contractor identified $10.8 million in questioned costs and collected a total of $13.4 million in recoveries that were previously identified overpayments from Medicaid providers.

MCO Special Investigative Units Audits

The Audit Division completed its audit of MCO special investigative unit (SIU) performance in the second quarter. MCOs are required to establish an SIU to investigate fraudulent claims and other program fraud, waste and abuse by members and service providers.

The Audit Division conducted audits of six SIUs as well as a third-party contractor providing SIU services to six more MCOs, and issued nine reports as a result of this audit work. These audits have had a significant impact on Texas MCOs, resulting in the substantial expansion of SIU investment across most Texas MCOs, and increased collaboration between MCOs, the IG, and the HHS system in addressing fraud, waste, and abuse.

In response to a survey sent to the MCOs after the series of SIU audits was completed, MCOs reported that 15 of 22 had increased their SIU financial commitment in state fiscal year 2016, and 20 of 22 MCOs planned to increase their commitment in state fiscal year 2017. The collective

Total MCO Financial Commitment to SIUs After IG Audit

$15.6 million (2015)
$17.3 million (2016) — $1.7 million increase
$20.9 million (2017) — $3.6 million increase

increases, totaling $1.7 million in fiscal year 2016 and $3.6 million in fiscal year 2017, respectively represent an increase in SIU spending of 10.8 and 21 percent. Financial commitments consisted primarily of increasing SIU staff and data analytic capabilities, and MCOs are also actively pursuing corrective actions to improve their SIU functions and address audit findings included in the series of reports.

Additionally, HHSC, MCOs, and the IG are engaged in new collaborative approaches to address fraud, waste, and abuse. Key activities include: expanding the content of quarterly meetings between SIUs and the IG, increasing IG responsiveness to SIU referrals, and collaborative efforts through the Texas Fraud Prevention Partnership.

Audit Reports Issued this Quarter

The Audit Division issued eight reports this quarter. These reports detail audits that resulted in a collective $5.3 million in funds put to better use, and include recommendations expected to improve HHS agency operations and contractor oversight.

1. Acute Care Utilization Management in MCOs: Community Health Choice
2. Acute Care Utilization Management in MCOs: FirstCare Health Plans
3. Claims Management System IT Interfaces
4. Deep East Texas Council of Governments
5. MCO Special Investigative Units Capstone Informational Report
6. Noncompetitive Contractor Procurements Over $10 Million: Easter Seals
7. Recovery of Overpayments Identified in Federal Audits
8. Speech Therapy Informational Report

Final audit and informational reports can be accessed on the IG website at https://oig.hhsc.texas.gov/.

New Audit Projects Underway

Residential child care facility

Objective: Determine whether state funds were used as intended by a selected residential childcare facility to provide services in accordance with contract requirements.

Employee Excellence

Front row, from left: Angelica Villafuerte, Hilary Evbayiro, and Emery Hizon. Back row, from left: Babatunde Sobanjo, Jude Ugwu, Sarah Warfel, JoNell Abrams, and Jeff Jones. Not pictured: Collette Antoine, Lorraine Chavana, Maria Johnson, Scott Miller, and Steve Sizemore.

MCO Special Investigative Unit Audit Team

The MCO SIU audit team wrapped up a series of SIU audits this quarter. From February through October 2016, the team traveled throughout Texas, Wisconsin, and California to conduct audits of six MCO SIUs as well as a third party contractor that provided SIU services to six other MCOs. The team's professionalism, productivity, and perseverance during the course of the project resulted in the significant expansion of SIU investment across most Texas MCOs, as well as increased collaboration between MCOs and the HHS system.

Background: The facility selected for review provides residential child care to children in the Department of Family and Protective Services managing conservatorship. The audit will focus on expense transactions incurred by the facility to determine whether contractually required services were provided to the children.

Hospital cost reports

Objective: Determine whether selected cost centers of the hospital cost report are correct and

accurate according to applicable CMS and state regulations.

Background: Hospital cost report data is required to confirm the eligibility of a provider to participate in Texas Medicaid or other HHS programs, and is used by HHSC to determine Medicaid reimbursement rates. There are currently no other Medicaid audits being conducted of Texas hospital cost reports aside from this IG audit and Texas Medicaid and Healthcare Partnership audits of children's hospitals.

STAR+PLUS enrollment

Objective: Evaluate processes and controls related to STAR+PLUS enrollment, and review trends in costs and utilization before and after the March 2015 expansion of the STAR+PLUS program into nursing facilities.

Background: The Medicaid STAR+PLUS program provides acute care services and long-term services and supports (LTSS) for clients with a disability and/or are age 65 or older. As of March 2015, eligible STAR+PLUS clients began receiving basic health and LTSS through one of five MCOs. STAR+PLUS enrollment increased from 410,994 clients in fiscal year 2014 to 538,385 clients in 2015. This represents an enrollment increase of over 30 percent.

HHSC processes for analyzing and preventing eligibility determination errors

Objective: Evaluate activities designed to analyze and mitigate eligibility determination errors for SNAP, TANF, Medicaid and CHIP, including practices for identifying the root causes of incorrect eligibility determinations resulting from agency errors, and developing and implementing corrective actions to prevent or reduce the recurrence of future errors.

Background: HHSC uses an automated system for eligibility determination for cash assistance (TANF), medical assistance (Medicaid and CHIP), and food assistance (SNAP). When Texas residents apply for these programs, state eligibility workers also perform non-automated tasks that are necessary for eligibility determination. Errors associated with performing these non-automated tasks could result in incorrect eligibility determinations. Various review processes have been established to identify and address these agency errors. The audit will evaluate whether HHS has processes and controls in place to identify root causes of agency errors, and whether actions are taken to prevent or reduce future incidents.

IT security controls

Objective: Assess the design and effectiveness of selected security controls over confidential information stored and processed by a selected MCO.

Background: MCOs process and store protected health information for Medicaid recipients throughout Texas. The Audit Division will examine the IT security controls and relevant information supporting security activities for a selected MCO. Audit work may include detailed tests of activities, supporting technologies and data, and site visits to locations where key activities are performed or data is stored.

Audit Projects Planned and in Progress

The following audits are currently in progress:
- Acute care utilization management in MCOs
- Assessment and evaluation practices at a long-term care nursing facility
- IT security assessment of a self-service portal
- Selected speech therapy providers
- Pharmacy audits
- Durable medical equipment claims

Other contractor-related audits the IG plans to conduct over the next two years include topics related to fee-for-service payments for retroactively enrolled MCO members, electronic visit verification contractor performance, and a dental maintenance organization comprehensive review.

A list of audits in progress, as well as audit topics the Audit Division plans to initiate, can be found in the two-year rolling audit plan located on the IG website at https://oig.hhsc.texas.gov/.

Inspections

Section

5

Inspections

The Inspections Division conducts inspections of health and human services programs, systems, and functions with a focus on systemic issues and providing practical recommendations that will improve effectiveness and efficiency, prevent fraud, waste, and abuse, and ensure the greatest benefit to the citizens of Texas.

The Inspections Division is comprised of two units:

- Women, Infants, and Children (WIC) Fraud Prevention Unit
- Inspections Unit

WIC Fraud Prevention Unit

This unit conducts in-store evaluations, covert compliance buys, and invoice audits to monitor vendors participating in the WIC program. During this quarter, the unit conducted 26 compliance buys and 71 in-store evaluations. The WIC Fraud Prevention Unit closed 106 cases during the quarter with $7,711 identified as funds put to better use. It also assessed civil monetary penalties (CMP) totaling $2,278 for three vendors with first-time violations. The maximum CMP established by the state for first-time violations is capped at $1,000. Subsequent violations are enhanced on a graduated scale.

Inspection Results

Reports for the first two inspections were recently drafted, and address Medicaid pediatric dental sedation, and opioid prescription utilization.

Pediatric dental sedation

The pediatric dental sedation inspection was prompted by adverse events that occurred during anesthesia administered to Texas Medicaid patients in late 2015 and early 2016. During the inspection, patient dental records were reviewed, and onsite visits and interviews were conducted.

The inspection indicated that the form and affiliated scoring system currently used to assess medical necessity is not adequate to justify general anesthesia without prior authorization.

Review of selected x-rays and medical notes indicated that there was not sufficient evidence to justify the level of sedation that was administered. Twenty-eight percent of the dental records reviewed did not contain documentation to

Top accomplishments this quarter

- Launched inspections related to community attendant services, the IG Medicaid recovery process, and the Treasury Offset Program.
- WIC identified $7,711 in funds put to better use.
- Made 33 dental and 6 speech therapy referrals for either TMHP provider education, IG investigation, or review by the Texas State Board of Dental Examiners.

support medical necessity and/or standard of care. Onsite visits revealed that 2 of the 12 dental offices inspected did not have the required positive-pressure oxygen delivery system used to resuscitate a patient who is unable to breathe on their own.

In addition to the observations noted above, the inspection resulted in 19 referrals to TMHP for provider education, and 7 providers were referred to the Texas State Board of Dental Examiners. Also, seven providers were referred to the IG Investigations Division. Of those seven referrals, five have resulted in full-scale IG investigations, one was referred to the Texas Attorney General Medicaid Fraud Control Unit (AG MFCU), and one was referred to the IG Division of Medical Services for additional review.
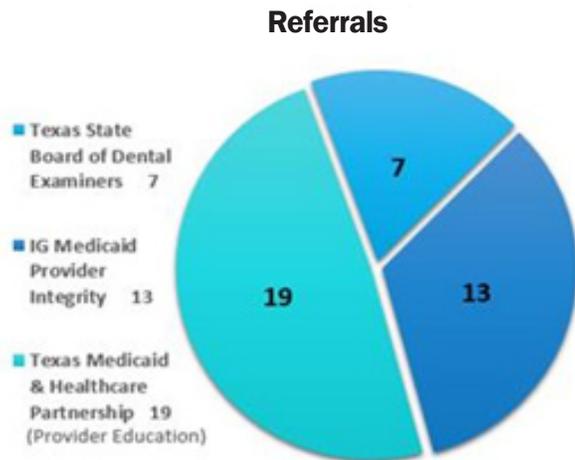
Opioid drug utilization

In 2015, the Texas Medicaid program paid over $33.3 million to fill opioid prescriptions for more than 426,000 Medicaid patients. The use of opioids, while often necessary, also comes with significant risk. The Inspections Division conducted an opioid drug utilization inspection to assess this risk in Texas Medicaid. The inspection showed that Texas could implement additional point-of-sale edits recommended by the Centers for Disease Control, including edits related to:
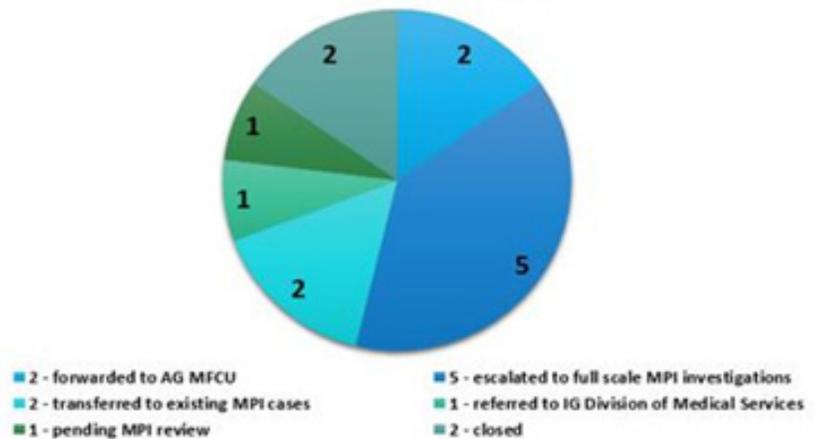
- Daily dosages and morphine milligram equivalents
- Use of extended release/long-acting opioids
- Numbers of days for which initial opioid prescriptions are dispensed
- Opioid prescriptions written with more than three months of refills

Patients can purchase medications with cash

Inspection referrals

Referrals

- Texas State Board of Dental Examiners 7
- IG Medicaid Provider Integrity 13
- Texas Medicaid & Healthcare Partnership 19 (Provider Education)

Status of referrals to IG Medicaid Provider Integrity

- 2 - forwarded to AG MFCU
- 2 - transferred to existing MPI cases
- 1 - pending MPI review
- 5 - escalated to full scale MPI investigations
- 1 - referred to IG Division of Medical Services
- 2 - closed

without detection by the Medicaid program. However, cash payment information is available through the prescription monitoring program (PMP) which is accessible by physicians.

The HHS IG Lock-In Program and HHS Vendor Drug Program point-of-sale edits do not have information available regarding cash payments for controlled substances. Over 50 percent of the sampled patients who received opioids paid for by Medicaid also purchased additional controlled substances with cash.

The PMP database, administered through the Texas State Board of Pharmacy, captures all controlled substances dispensed, including cash purchases. It collects prescription data for controlled substances dispensed by a pharmacy, and has been proven to be valuable in curtailing opioid abuse and overutilization.

However, Texas Medicaid opioid prescribers do not consistently utilize the PMP. Fifty-five out of the 100 reviewed did not access the database in 2015. Prescriber review of the PMP data could assist in reducing prescription opioid abuse and in making clinically sound decisions for their patients.

Newly Launched Inspections

The division formally initiated three new inspections this quarter related to community attendant services, the IG Medicaid recovery process (suspense account), and the Treasury Offset Program.

Community attendant services

Purpose: Determine if community attendant services (CAS) billed to Medicaid are rendered to consumers in accordance with program requirements. Community attendant services are delivered as part of Medicaid long-term services and supports.

Objectives: Determine how the Community Support Section of Access and Eligibility Services oversight of the CAS program ensures services are being rendered and properly billed; and determine whether home health agencies are effectively monitoring whether personal attendant services billed are actually provided to consumers.

IG Medicaid recovery process

Purpose: Determine how funds from settlements and judgments remitted to the IG Chief Counsel Division should be allocated between the Medicaid program and the contracted Medicaid and CHIP managed care organizations (MCO).

Objectives: Identify legal requirements governing how to allocate funds for recoveries associated with fee-for-service and managed care models of service delivery; and determine an allocation methodology, consistent with legal requirements, to distribute recoveries between Texas Medicaid and MCOs.

Treasury Offset Program

Purpose: Determine if HHSC maximizes Supplemental Nutrition Assistance Program overpayment recoveries through the Treasury

Inspections

Offset Program (TOP).

Objectives: Assess the effectiveness of procedures used to maximize accuracy of data submissions to the TOP; and determine if errors in data submissions to the TOP are effectively resolved and resubmitted.

Inspections Planned

Inspections related to electronic visit verification, Medicaid capitation payments for deceased recipients, and antipsychotics are currently being researched.

A list of inspections in progress, as well as inspection topics the Inspections Division plans to initiate, can be found in the one-year rolling inspection plan located on the IG website at https://oig.hhsc.texas.gov/.

Reviews

Reviews

The Division of 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, research and detection, and pharmacy lock-in. The division also provides clinical consultation to the Investigations, Audit, and Inspections divisions on dental, medical, nursing, and pharmacy services.

Medical Services is comprised of three units:

- Clinical Subject Matter Expert
- Record Review, Resolution, and Recovery
- Quality Review

The Clinical Subject Matter Expert (CSME) team includes a physician, dentist, dental hygienist, and pharmacist who provide clinical expertise to IG investigations, audits, inspections, special collaborative initiatives, and IG legal staff. The CSME team also communicates with MCO and DMO compliance departments to educate and to clarify questions regarding clinical documentation and medical/dental policy interpretation.

The Record Review, Resolution, and Recovery team (RRRT) identifies patterns of aberrant billing, performs Surveillance Utilization Reviews required by CMS, and collects Medicaid overpayments. RRRT nurse analysts research provider billing and review medical records to determine whether claims and services are appropriate. RRRT includes the Research Analysis and Detection (RAD) recovery team, RAD support, and the Targeted Query team which develops and runs targeted data queries to identify acute care billing outliers.

The Quality Review team conducts retrospective utilization review of hospitals and nursing facilities, and administers the pharmacy Lock-In Program. The Utilization Review team performs onsite and desk reviews of hospital claims and nursing facility Minimum Data Set forms for appropriate billing. Lock-In Program staff work with managed care organizations to monitor recipient use of prescription medications and acute care services. Specific indicators will trigger Lock-In Program intervention, locking a recipient into one pharmacy location, and locking a fee-for-service recipient into

Top accomplishments this quarter

- Recovered $7,330,919 from hospital utilization reviews.
- Recovered $884,407 from nursing facility utilization reviews.
- Recovered $931,995 in overpayments through the RAD team.
- Identified $23,167 as underpayments to nursing facilities.
- Identified $180,942 in questioned costs through the RAD team.
- Opened 279 RRRT cases.
- Closed 477 RRRT cases.

a single primary care provider.

Analysis Nets $211,872

During a statistical profile analysis of general acute care hospital outpatient claims, RRRT nurse analyst Kim Costello found one hospital's outpatient claim dollars increased 150 percent over the previous quarter. She performed a medical record review to explore the spike and identified $211,872 of scheduled outpatient day surgery facility charges were inappropriately billed as unbundled charges. Those funds have been recovered. The

Kim Costello

unbundled charges included ancillary services that are part of the all-inclusive day surgery performed.

Targeted Query Team Identifies Suspicious Billing Patterns

The Targeted Query (TQ) team is staffed by research specialists who develop and use targeted queries (a scheduled query of data from the Medicaid Fraud and Abuse Detection System) to identify patterns of incorrect billing, such as therapy provided after the date of death and multiple "once-in-a-lifetime" events for the same recipient.

During the second quarter of FY 2017, the two current TQ team members recovered $328,747,

and identified $195,947 in questioned costs.

Through one targeted query alone, the team recovered $265,939 in February. This query identifies clients who were dead or not eligible for Medicaid on the date of service.

Nursing Facility Utilization Review in Managed Care

In March 2015, the Department of Aging and Disability Services transitioned nearly 47,000 nursing facility residents from fee-for-service to the STAR+PLUS managed care delivery model. The Utilization Review (UR) team is responsible for performing retrospective utilization reviews of nursing facilities to validate the appropriateness and accuracy of Minimum Data Set (MDS) assessments and coding.

The MDS assessment is required by the federal government and provides a comprehensive assessment of each nursing facility resident's functional capabilities. Based on the results of the MDS assessment, a resource utilization group (RUG) level is calculated. The RUG level is the payment made to the nursing facility to care for the resident, and reflects the resources, services, and staffing level necessary to deliver care to the resident.

The UR team conducted a review to determine whether existing utilization review processes and procedures are compatible with the managed care model. The review was limited in scope, including only ten nursing facilities, and involved observation of services provided to residents, clinical record reviews, and interviews with staff.

The review identified the need for further study using a statistically valid random sample of STAR+PLUS members in nursing facilities to assess:

- Coordination and access to services;
- Preventable hospitalizations;
- Least restrictive environments for members;
- Accurate and complete documentation of provided services.

The review indicated that a trend in documentation errors seen in fee-for-service continues in the managed care model. The review also indicated a need for IG to revise its utilization review rules to remove reference to obsolete MDS requirements, and to actively refer to MCO contract noncompliance.

Support Services

Section

7

Chief Counsel

The Chief Counsel Division provides dedicated attorneys for the Investigations, Audit, Inspections and Medical Services divisions, and advises the IG on a wide array of complex topics centered on our mission to pursue and take enforcement actions against fraud, waste and abuse in the state's health and human services system.

Chief Counsel provides close coordination with HHS System legal on a regular basis, including regularly scheduled meetings to foster communication between the attorneys at the IG and the attorneys at the HHS System, and between IG executive leadership and legal experts at the HHS System.

The Chief Counsel Division is comprised of three units:

- General Law
- Litigation
- Special Counsel

The General Law unit is responsible for providing legal support on topics such as Medicaid provider enrollment and other legal questions that impact the mission of the IG. The unit also assists with the process of checking various federal databases to ensure integrity in the Medicaid system, and taking action against providers who are not eligible to provide services in the Medicaid system.

The Litigation unit is responsible for determining and imposing administrative actions and sanctions based on the enforcement activities of the Investigation and Audit divisions. Following the imposition of certain sanctions, the provider has a right to an informal resolution meeting or an appeal. In those cases, Litigation will conduct the informal meeting and will litigate any appeal before the HHSC Appeals Division or the State Office of Administrative Hearings.

The Special Counsel unit provides support to the main functional areas of the IG: Investigations, Audit, and Inspections.

Provider Settlements and Communication

Attorneys with Litigation engage in settlement meetings which focus on resolving outstanding enforcement actions, while also emphasizing enhanced provider understanding of Medicaid rules and investigative and audit processes. Through these meetings, the IG has actively sought input and transparency in provider relationships. The IG is working through Litigation in tandem with Audit, Medical Services, and Investigations to educate the provider community and to insure that Texas taxpayers get the best value for their dollars, and that Medicaid recipients receive high-caliber care.

Legislative Support

Attorneys in the division have been called on by the IG to craft draft language, draft bill analysis, and to be resource witnesses at various legislative hearings and briefings during the 85th Texas Legislative Session.

Data and Technology

The Data and Technology Division is charged with actively seeking and identifying suspicious patterns of fraud, waste, and abuse within Texas health and human services programs using data research, and analytics. The Data and Technology Division supports the Audit, Investigations, Inspections, Medical Services, and Operations divisions by implementing tools, solutions, and innovative data analytic techniques to streamline operations and increase the identification of fraud, waste, and abuse.

The Data and Technology Division provides support services such as identifying outliers to help focus investigative actions; identifying areas of interest that may warrant further review; clarifying details pertaining to data, processes, and regulations within the Medicaid program; assisting in the development of a statistically valid random sample; and supporting the applications that provide timely information to both executive and program areas of the IG.

The division has made significant strides in improving support through targeted selection of areas most at risk for fraud, waste, and abuse.

Some Data and Technology Division accomplishments over the past quarter include developing IG executive dashboards for the Audit and Inspections Divisions; supporting the Medicaid Provider Integrity Fraud Detection Operations for speech therapy, pharmacy, and durable medical equipment services; providing sampling and extrapolation functions to support investigations and audits; continuing to review and analyze managed care encounters; and ongoing efforts to evaluate new data sources and methods for improving analytical outcomes.
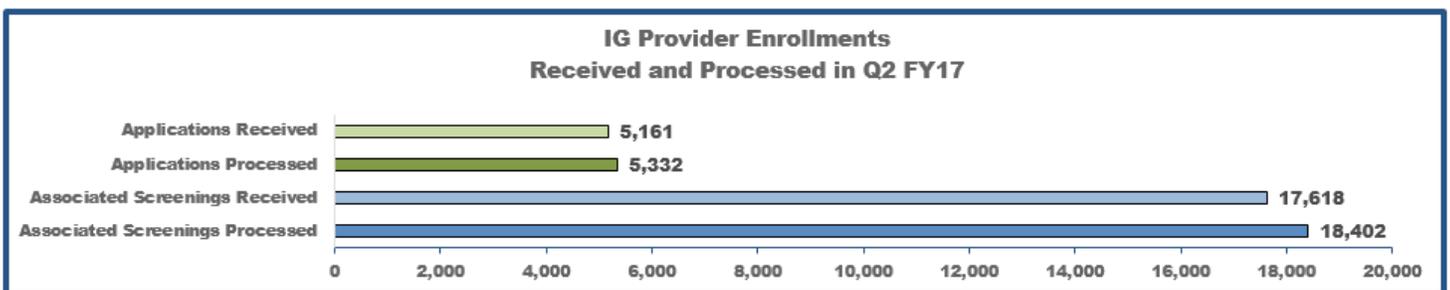
Operations

The Operations Division works to build an infrastructure for the IG that supports enhanced efficiency and effectiveness for investigations, audits, reviews, and inspections; promotes responsibility and accountability; and provides increased communication and transparency both within the organization and to external stakeholders. Operations supports IG policy and procedure development and publication, staff training, contract management, organizational development, budget and fiscal management, business operations and facilities coordination, office administration, and the coordination of strategic planning. Additionally, the Integrity Line (responsible for receiving and processing reports alleging fraud, waste, and abuse within HHS programs) and the Program Integrity Research team (responsible for conducting screenings for providers enrolling in Medicaid, CHIP, and other HHS programs) are housed within Operations.

Integrity Line and PIR

In this quarter, the Integrity Line answered approximately 7,500 calls reporting fraud, waste and abuse. In addition, the Provider Enrollment Integrity Screening team conducted screenings for approximately 18,400 individuals (representing over 5,300 provider applications) seeking to enroll or validate their Texas Medicaid enrollment.

IG Training Catalog

The Professional Development team began building a robust catalog of IG staff trainings. The courses were developed for IG staff to sharpen their skills through training on HHS programs, leadership, strategic planning, and communication. The Professional Development team provided multiple program trainings during the second quarter including an Overview of Early Childhood Intervention; and training on Statutes, Code of Federal Regulations, and Texas Administrative Code.

IG Provider Enrollments
Received and Processed in Q2 FY17

Applications Received	5,161
Applications Processed	5,332
Associated Screenings Received	17,618
Associated Screenings Processed	18,402

Note: Applications and associated screenings processed exceed those received this quarter because they include some applications that were received but not yet processed before the end of the previous quarter.

Policy and Publications

The Policy and Publications Division provides policy support for IG divisions and coordinates external communication with a variety of stakeholders. The division is comprised of three areas: Policy, Publications, and Government Relations.

The Policy team assists other IG divisions with researching Medicaid policy and facilitating communications with HHSC for policy guidance. The Policy team also researches and writes issue briefs on health policy topics relevant to the IG. The Publications team supports the IG by facilitating the publication of IG reports and handling all media inquiries. The Government Relations team provides outreach and communication with legislators, the public, managed care organizations, and other agencies within the HHS System.

In the second quarter, the Policy and Publications division was focused on the legislative session, which included analyzing legislation and committee and budget hearings. Policy staff worked with HHSC on managed care organization contract revisions, as well as developing processes for written IG policy papers and issue briefs.

PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

If you suspect a provider or recipient of state benefits
is committing fraud, waste, or abuse
call the HHS Inspector General Integrity Line

800-436-6184