

Quarterly Report

Quarter 3, Fiscal Year 2018



Texas Health and Human Services
Office of Inspector General



OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH & HUMAN SERVICES COMMISSION

SYLVIA HERNANDEZ KAUFFMAN
INSPECTOR GENERAL

I am pleased to present the third quarterly report for fiscal year 2018, summarizing our significant work during this period, to Governor Greg Abbott, acting Executive Commissioner Cecile Young, the Texas Legislature, and the citizens of Texas.

Every day, our multidisciplinary team of innovative auditors, investigators, clinicians, inspectors, policy and data experts, analysts, and lawyers uses data strategically to combat fraud, waste, and abuse in the delivery of health and human services in the state of Texas. Through their hard work and dedication, the Office of Inspector General recovered \$47,542,096 this quarter, the highest recovery amount ever reported in any quarter by this office. The previous highest amount recovered was \$25 million. Our office identified another \$155,198,483 in funds to be recovered. In addition, \$2,203,787 in funds were not spent thanks to work done by our OIG team. While OIG continues to maximize recoveries, this office is also committed to increasing work to prevent potential fraud, waste, and abuse from occurring in the first place, rather than having to recoup money after it has already been spent inappropriately.

As we continue to redefine our oversight and program integrity strategy in a managed care environment, the office realigned resources and restructured to facilitate that focus. The first step was the creation of a Chief Strategy Office that combines our data and technology team with an expanded group of policy experts and staff with managed care and contract knowledge. This move will position this office to continue to be a national leader in redefining program integrity in managed care.

While our organizational structure may be different, our focus remains the same. Our charge is to detect, prevent, and deter fraud, waste, and abuse in the delivery of all health and human services across Texas. Our work helps ensure that those who depend on these services can get them, while those taxpayer funds used to provide them are spent only for their intended purpose. That mission is what drives us, and that will not change. I am proud to serve alongside my team to protect the integrity of health and human service programs and the health and safety of Texans.

Respectfully,

Sylvia Hernandez Kauffman

Quarter 3 results

Dollars recovered

Audit

Audit collections (OIG Audits, UPIC Audits, and RAC Audits) \$10,924,952

Inspections

Inspections collections \$1,913,699
WIC collections \$6,057

General Investigations

Client collections (SNAP, TANF, Medicaid, CHIP, WIC) \$21,059,406

Peace Officers

EBT trafficking \$60,115

Medicaid Program Integrity

Provider collections \$2,135,643

Medical Reviews

Acute care provider collections \$2,676,265
Hospital collections \$8,577,899
Nursing facility collections \$106,455
Voluntary repayments and self-reports \$81,605

Total \$47,542,096

Dollars identified for recovery

Audit

Provider overpayments (OIG Audits, UPIC Audits, and RAC Audits*) \$10,512,227

Inspections

Deceased recipients \$3,499,024
Electronic visit verification \$117,676,488

General Investigations

Client claims in process of recovery (SNAP, TANF, Medicaid, WIC) \$7,835,899

Peace Officers

EBT trafficking \$276,722

Medicaid Program Integrity

MCO identified overpayments \$4,434,771

Medical Reviews

Acute care \$939,035
Hospitals \$10,024,317

Total \$155,198,483

Cost avoidance

General Investigations

Client disqualifications \$1,335,388

Medicaid Program Integrity

Medicaid excluded providers \$30,529

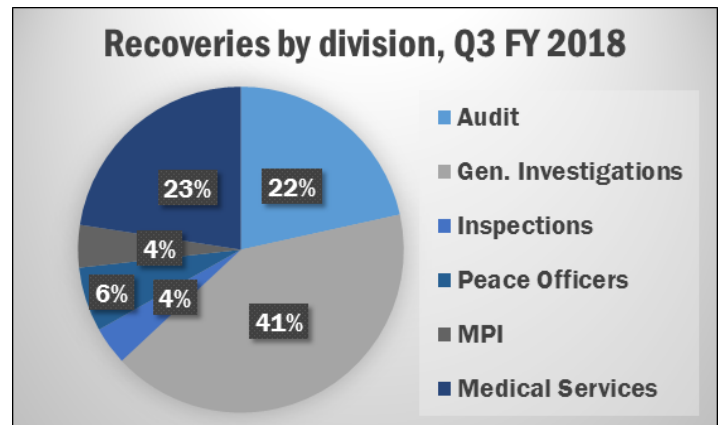
Medical Services

Pharmacy Lock-In \$837,870

Total \$2,203,787

*The RAC Audit contractor identified an error in reporting dollars identified for recovery in the previous two quarters. The amounts have been restated to reflect the correct totals:

Quarter 1: \$6,675,068 **Quarter 2:** \$8,476,096



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: Dollars identified include overpayments identified for recovery during an OIG investigation, audit, inspection or review for: 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.

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.

OIG peace officer recoveries

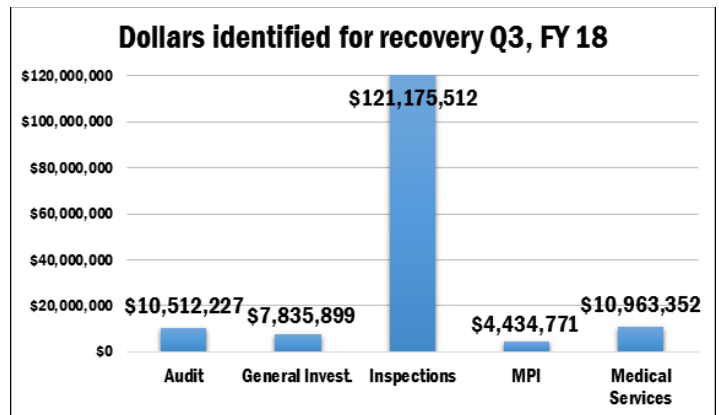
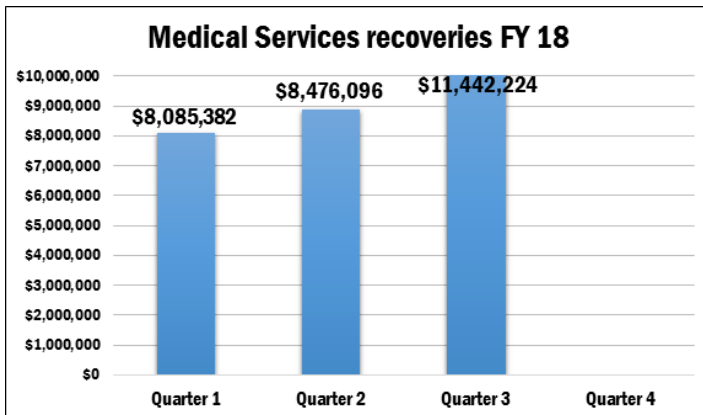
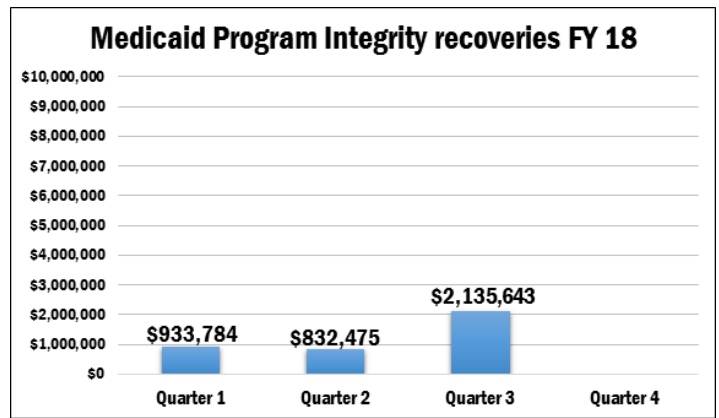
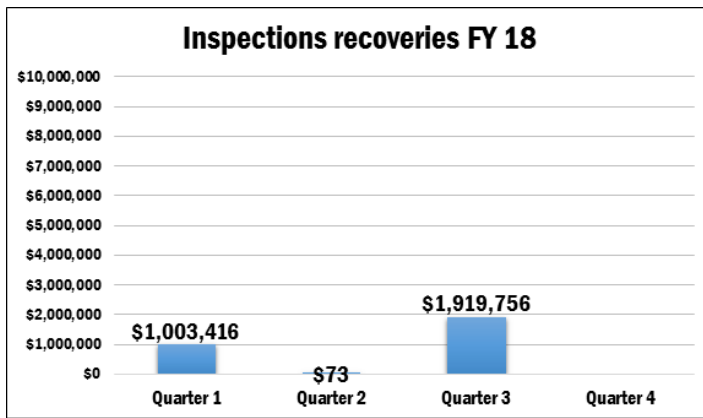
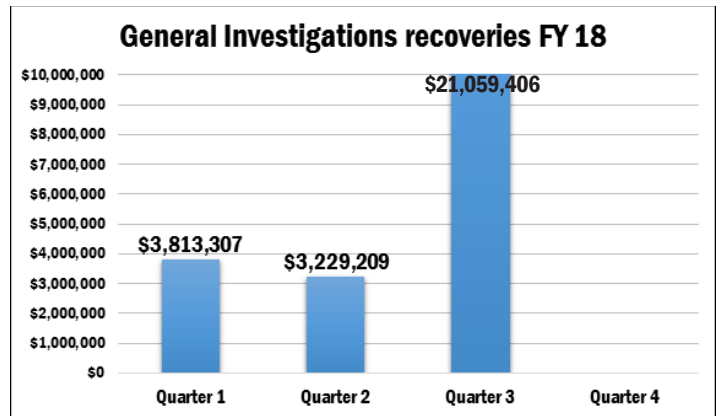
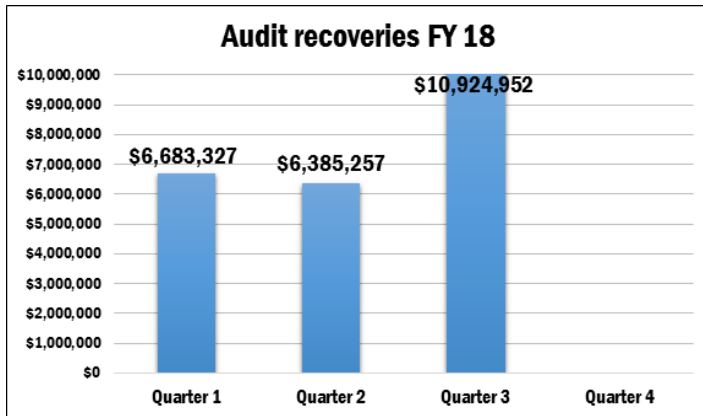
Dollars recovered \$60,115

Dollars identified for recovery \$276,722

Cases involving OIG peace officers 340

HB 2523 passed in the 85th Texas Legislature requires the OIG to report the portion of funds recovered from investigations involving OIG peace officers.

Fiscal year 2018 results to date



Quarter 3 trends

MPI full-scale cases opened

Medicaid Program Integrity (MPI) opened 31 full-scale cases involving 15 Medicaid provider types:

- Ambulance
- Behavioral Health
- Medical Clinic/
Group Practice
- Dental
- Home Health
Agency
- Massage Therapy
- Laboratory
- Physical Therapy
- Psychologist
- Psychotherapy
- Speech Therapy
- Pharmacy
- MCO
- Adult Day Care
- Neurologist

Trends: The majority of the full-scale cases opened during Q3 involve dental providers and include allegations related to solicitation; poor quality of care; and billing for services not necessary, not rendered, or not covered by Texas Medicaid. Additionally, MPI is investigating behavioral health providers for billing for more therapy units than provided; exceeding program limits on numbers of hours per day billed; and billing for individual therapy while providing group therapy. New allegations include laboratories submitting improper claims for telemonitoring services.

Case highlights

MPI investigation leads to settlement with psychologist

In a recent MPI investigation of a psychologist involving claims from 2015 and 2016, MPI examined billings, clinical records and other evidence and alleged that the provider's claims were out of compliance with Medicaid policy that prohibits billing for more than 12 hours of treatment in a given day. The provider agreed to a settlement of \$855,977.71, with an initial lump sum payment of \$250,000. Until the overpayment is fully refunded, the provider must immediately notify the OIG before selling any part of the provider's practice, and any remaining balance will be due and payable if there is a sale. In the event of a default of the settlement agreement, any requests for enrollment or re-credentialing of the provider with a Managed Care Organization may be denied.

Type of complaints received by MPI

Home health agency (long-term care services)	56.87%
Physician (individual or group practice)	9.52%
Nursing facility	7.48%
Dental	4.76%
Therapy	3.67%
MTP (non-emergency transportation)	3.54%
Pharmacies	2.59%
Hospitals	2.18%
Durable medical equipment	1.63%
Managed care organizations	1.50%

Trends

Home health agency: The majority of complaints received are for attendants not working the hours reported, or the attendant and client colluding to falsify timesheets and splitting the paycheck.

Physician: MCOs providing SIU investigations of physicians for up-coding E&M codes, or poor record keeping.

Electronic Benefits Transfer Trafficking Unit

The OIG Electronic Benefits Transfer Trafficking Unit (OIG-EBT) received a complaint regarding a seafood retailer who was abusing Supplemental Nutrition Assistance Program (SNAP) benefits.

OIG-EBT investigated and discovered a former employee of the seafood retailer was refunding benefits from client's accounts for cash. Clients paid the former employee \$20 cash to refund \$180 to \$200 in SNAP benefits to clients' accounts when no purchases or transactions were completed. The investigation showed that the former employee issued refunds to 468 clients in 1,123 transactions totaling more than \$165,000. Forty-one clients identified during this investigation received \$1,000 or more. The OIG referred these clients to the Dallas County District Attorney for prosecution. The former employee also refunded \$4,607 to her personal SNAP account. The OIG referred her case to the Dallas County District Attorney for receiving benefits illegally and for conducting the 1,123 transactions totaling more than \$165,000 in illegally obtained SNAP benefits.

Quarter 3 policy recommendations

Audit

RUG therapy levels: The OIG recommended to HHSC that it should make policy changes to prevent therapy Resource Utilization Group (RUG) levels and payments based on more therapy than what is documented in a physician's written order and, if therapy decreases, an amount of therapy that would not qualify for a therapy RUG level. The recommendation follows an audit of Mission Nursing and Rehabilitation Center (Mission), a long-term care nursing facility in Mission, Texas, to (a) assess the accuracy of therapy related payments and reimbursements, and the completeness of supporting documentation, and (b) determine whether Mission provided therapy services consistent with physician orders, according to resident assessments and evaluations, and in compliance with federal and state requirements.

The OIG found that for all 30 Mission resident files tested, Mission's practice of clustering therapy sessions during look-back periods led to assigning higher RUG levels, increasing Medicaid payments by nearly \$700,000.

Inspections

Electronic Visit Verification process changes: The OIG conducted an inspection to determine how effective the Electronic Visit Verification (EVV) system is at verifying that home service visits for Medicaid clients occurred and at confirming that home services were provided. The OIG recommended that Medicaid and CHIP Services (MCS) should comply with the Texas Administrative Code 354.1177(g)(1), which prohibits payment of a claim without a matching EVV transaction, and, where appropriate, recover dollars paid without an EVV match.

The OIG also recommended that MCS should require

a prospective matching process and ensure claims without a matching EVV are not paid; allow providers to only submit claims with a single date-of-service per detail for claims requiring EVV; that vendors be required to develop and implement EVV edits and audits to help enforce reason code policy; and that MCS establish a standard for percentage of auto-verified EVV transactions that providers must achieve.

Medicaid Payments for Deceased Clients in the Texas Medicaid System: The OIG conducted an inspection to determine how Texas Medicaid can strengthen processes used to identify and recoup capitation payments for deceased clients. It was important that the OIG establish ways for Texas Medicaid to better identify deceased clients and ensure that Texas Medicaid effectively recoups capitation payments for deceased clients.

The OIG recommended that HHSC Access and Eligibility Services (AES) should enforce existing policies and procedures to end a deceased client's eligibility in the Texas Integrated Eligibility Redesign System (TIERS) and create a timeline for processing date of death information and alerts. By creating a timeline, the Texas Works Advisor will have a specified amount of time to end the client's eligibility and avoid unnecessary capitation payments made for deceased clients.

The OIG also recommended that AES establish an agreement with the Department of State Health Services Vital Statistics Unit for Texas Works Advisors to obtain death certificates to better match deceased persons against the Texas Medicaid client database. Another recommendation included improving management oversight to prevent errors in a deceased client's eligibility that results in erroneous capitation payments.

Agency highlights

South Texas doctor indicted on fraud charges

A McAllen-based physician was indicted in May for his role in a \$240 million health care fraud and international money laundering scheme. The OIG was part of the investigative team that led to Jorge Zamora-Quezada of Mission, Texas, being charged in the Southern District of Texas with one count of conspiracy to commit health care fraud, five counts of health care fraud, and one count of conspiracy to commit money laundering.

The indictment alleges that Zamora-Quezada and his co-conspirators falsely diagnosed vulnerable patients from the Rio Grande Valley, San Antonio, and elsewhere with various degenerative diseases, including rheumatoid arthritis. He and his co-conspirators then administered chemotherapy and other toxic medications to the patients based on the false diagnoses. Zamora-Quezada and his co-conspirators also allegedly conducted fraudulent and excessive medical procedures on patients in order to increase income. He and his co-conspirators allegedly obstructed the investigation by fabricating patient records and concealing thousands of medical records from Medicare by stashing them in a barn in the Rio Grande Valley.

The indictment also alleges that Zamora-Quezada and his co-conspirators laundered the proceeds of their fraud scheme by investing them in commercial and residential real estate in the United States and Mexico.

The OIG, along with the HHS-OIG's McAllen Field Office, the FBI's San Antonio Division-McAllen Resident Agency's Rio Grande Valley Health Care Fraud Task Force, and the McAllen Complex Financial Crimes Task Force, continues to investigate, including searching for potential victims of Zamora-Quezada and his co-conspirators. Patients who believe they may be victims of the physician, from January 2000 through May 2018, can call the FBI victim's hotline at 1-833-432-4873, option 8, or email the taskforce at ZamoraPatient@fbi.gov.

Settlements resulting from provider investigations

The OIG recovered nearly \$3 million this quarter as a result of settlements arising from provider investigations of two hospitals, two durable medical equipment providers,

Quarter 3 highlights

Audit reports issued	5
Audits in progress	29
Inspections reports issued	2
Inspections in progress	7
Investigations completed	3,756
Investigations opened	4,982
Medicaid provider cases completed	
Preliminary	690
Full-scale	49
MPI cases transferred to full-scale investigation	31
MPI cases referred to Medicaid Fraud Control Unit	176
Hospital claims reviewed	10,038
Nursing facility reviews conducted	116
Medicaid and CHIP high-risk provider enrollment screenings performed	5,861
Medicaid providers excluded	91
Fraud hotline calls answered	6,476

one dental practice, two psychologists, and one laboratory. Investigations typically result from referrals from the public or managed care organizations, and can be initiated based on data analytics performed by the OIG.

Pharmacy fraud detection operation

The OIG conducted a fraud detection operation (FDO) in April that focused on pharmacy providers in Austin, Grand Prairie, Houston, San Antonio, and Weslaco.

The OIG identified pharmacy providers whose billings suggested they were outliers for specific measures compared to their peers. This included the addition of algorithms related to opioids and other controlled substances, which are not normally prescribed by family practice, general practice, and internal medicine providers.

Investigators conducted interviews with providers, staff, and clients or their caregivers, and performed records reviews to determine whether or not the outlier status was attributed to a program violation. Evidence collected on at least one of the six providers selected by

Agency highlights

the OIG confirmed potential program violations and will be recommended for a full-scale investigation. Further review is underway on additional cases which could result in recommendations for provider education, full-scale investigation, referral to the Texas State Board of Pharmacy, and/or referral to the Office of Attorney General's Medicaid Fraud Control Unit.

Treasury Offset Program recoveries

Treasury Offset Program (TOP) recoveries for March and April totaled \$13.6 million. The jump in TOP recoveries from last year is due to more delinquent SNAP recipients.

TOP is a fully-automated program that captures federal payments to collect delinquent debts owed to federal and state agencies. In Texas, when a SNAP client is more than 120 days delinquent in their reimbursement of an overpayment, the HHSC Accounts Receivable Tracking System sends the client's information to TOP, which will then stop any federal payment, such as a tax refund, to the client order to pay down the client's debt.

SNAP provides benefits to an average of 1.6 million Texas households per month, with an annual expenditure of over \$5 billion.

Productive quarter in EBT Trafficking recoveries

The OIG had one of its highest production quarters in Electronic Benefit Transfer trafficking. The EBT Trafficking Unit recovered \$58,229.89 and identified \$276,722.31 in fraudulently used SNAP benefits through undercover purchases, interviews, surveillance, and data analysis. The \$276,722.31 increase from the second quarter (\$198,529) is in large part attributed to ongoing investigator training and streamlining processes.

MCO fraud, waste, and abuse training

Nearly 100 Medicaid MCO and DMO staff and their contractors attended annual fraud, waste, and abuse training in May. OIG staff educated attendees on current trends and schemes in fraud, waste, and abuse; the importance of identifying and reporting fraud, waste, and abuse; the timeline for referrals; state and federal agencies involved in fraud, waste, and abuse prevention, detection, and investigation; applicable regulations; definitions and concepts; and MCO responsibilities that include FWA Compliance Plans and internal MCO training.

Medicaid provider investigations training

The Medicaid Program Integrity (MPI) Division held training sessions in April on Medicaid provider investigations. Staff from the Austin, San Antonio, Grand Prairie, and Fort Worth offices gathered in Austin to learn about common fraud, waste, and abuse schemes; program violations and how to build an effective case; safeguarding confidential information; and how to better use MPI data and technology resources.

Strengthening oversight of fraud, waste, and abuse activities in managed care

The OIG recommended changes to managed care contracts effective March 1, 2018. The OIG recommended a new requirement for MCOs to maintain documentation for services provided on a case-by-case basis. Case by case refers to additional benefits outside the scope of Medicaid covered services. In addition, the OIG recommended adding a new requirement for MCOs to submit documentation demonstrating how they comply with OIG Lock-In Program Policies and Procedures. Previously, MCOs were required to submit this documentation as requested.

Unified Program Integrity Contractor for the Southwest Region

To better coordinate audits, investigations, and data analyses, and to lower the burden on providers, the Centers for Medicare & Medicaid Services (CMS) created Unified Program Integrity Contractors (UPICs) to perform program integrity work in Medicare and Medicaid. UPICs work in five geographic areas, with Texas in the southwestern jurisdiction. Qlarant (formerly Health Integrity) was awarded the UPIC southwestern jurisdiction, with a "go-live" date of April 1, 2018.

CMS created UPICs to consolidate its previous network of contractors: Zone Program Integrity Contractors, Program Safeguard Contractors, Medicare-Medicaid Data Match (Medi-Medi) programs, and Medicaid Integrity Contractors.

This streamlined process allows the UPIC to perform both audits and investigations of Medicaid providers for

Agency highlights

Texas. The UPIC collaborates with the state to select the providers to audit or investigate. Provider types audited in the past include pharmacies, hospices, community mental health centers, durable medical equipment providers, and home health providers. This coordinated approach makes the program integrity work process more effective and efficient for both CMS and Texas. UPICs' primary focus is to detect and proactively prevent health care fraud, waste, and abuse.

Streamlining the provider enrollment process

Over the past year, the OIG collaborated closely with HHSC Medicaid/CHIP Services, and the Texas Medicaid & Healthcare Partnership (TMHP) staff to implement system and operational changes that increase program integrity and improve the enrollment process for providers.

The updates include:

- Publication of clear and consistent definitions of the terms “New Enrollment, Re-enrollment, Revalidation, Deactivation/Reactivation, Disenrollment, Termination, and Exclusion.”
- Creation of a message dashboard in the TMHP portal for each provider registered in the portal, where they can receive notifications from TMHP in one central location.
- A streamlined online application for providers seeking to revalidate their current participation in Texas Medicaid.
- A reminder letter to providers that is sent 90 days before their current enrollment period expires, notifying them that they need to submit a revalidation application.
- The creation of a new, interactive provider enrollment application instruction site, which replaces the instructional pages in the provider application.

OIG SSA staff working cases with federal government personnel

The OIG now has three federally funded full-time staff working with the U.S. Social Security Administration (SSA) Office of Inspector General in Dallas on the Cooperative Disability Investigations (CDI) Program Unit task force. CDI is a joint effort among the SSA, SSA OIG, and states

OIG Fraud Hotline: 800-436-6184

To help prevent and detect fraud, waste, and abuse in Texas Medicaid, the Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Women, Infants, and Children (WIC) programs, the OIG operates a Fraud Hotline that is answered live Monday–Friday from 8 a.m.–5 p.m. at 800-436-6184. The public can also submit reports online by visiting our website at <https://oig.hhsc.texas.gov/report-fraud>

The OIG received 6,476 calls to the Fraud Hotline this quarter from people reporting allegations of fraud, waste, and abuse either by clients or providers.

Please note that the OIG cannot give callers updates on the status of any open investigation, but callers are given tracking numbers to reference if they have more information to add later.

to investigate fraud in federal and state disability claims and social services programs such as SNAP, TANF, Medicaid, and WIC.

In federal fiscal year 2017, the CDI program reported \$228 million in projected savings to SSA's disability programs.

Peace officer training

Thirty-four peace officers completed in-service training this quarter. The commissioned officers investigate abuse and neglect complaints at state supported living centers and state hospitals, as well as electronic benefits transfer trafficking in the Supplemental Nutrition Assistance Program (SNAP). The training, conducted at the Bexar County Sheriff's Office, consisted of how to execute a search warrant, conduct an arrest, implement OIG policies, shoot a firearm, and follow state and federal regulations.

New cost avoidance reporting methodology

OIG staff developed new cost avoidance reporting practices to improve reporting of savings and effectiveness related to the Lock-in Program's intervention when

Agency highlights

Medicaid recipient prescription abuse is suspected by the OIG in fee-for-service and managed care. For managed care programs, this initiative will maximize savings through the Lock-in Program. The previous methodology was reporting only a portion of the actual costs avoided because it included approximately 11 percent of Lock-in Program participants, reported one year of cost avoidance for these participants, and included pharmaceutical costs avoided only. The new methodology more accurately measures the program's effectiveness by considering all participants, reporting cost avoidance for all years a client participates, and including acute care hospital costs as well as pharmaceutical costs.

Draft rule on frequency of nursing facility utilization reviews

The OIG is reviewing public comments after posting a draft rule concerning the frequency of nursing facility utilization reviews (NFUR). The proposed rule would update the requirement that the OIG conduct utilization reviews of every nursing facility at least every 15 months with a process by which the OIG selects nursing facilities to review by conducting a comprehensive annual review of all nursing facilities by considering criteria such as length of time since the last review, previous review results, complaints, and referrals. The comment period ran from May 7-18, 2018.

Hospital-related data analysis

Through hospital data analysis using the Medicaid Fraud and Abuse Detection System, the OIG collected more than \$2.5 million from hospital providers who did not meet Texas Medicaid's spell of illness policy.

A spell of illness is a 30-day annual limit on adult inpatient stays per ailment. Except for specific diagnoses or transplants, hospital admissions must be separated by at least 60 consecutive days since the previous admission's last day of discharge.

Completed reports

Audit

Audit of Medicaid and CHIP MCO Special Investigative Units: Driscoll Health Plan: The OIG conducted this audit to evaluate how effective Driscoll Health Plan's special investigative unit (SIU) is at preventing, detecting, and investigating fraud, waste, and abuse, and

reporting reliable information on SIU activities, results, and recoveries.

Driscoll is one of 18 managed care organizations (MCOs) contracted to provide Medicaid and Children's Health Insurance Program (CHIP) health care services in Texas. Approximately 87 percent of Medicaid and CHIP enrollees are members of an MCO. MCOs are required to establish an SIU to investigate fraudulent claims and other program waste and abuse by members and service providers. Effective SIUs are essential to support overall MCO cost containment efforts, and to ensure that state and federal funds spent on managed care are used appropriately. The OIG is responsible for reviewing SIU annual plans, and evaluating and sometimes investigating SIU referrals.

Identified issues included not dedicating adequate staff to the SIU; not meeting mandated timelines; not initiating any new investigations during a 13-month period; and not fully recovering overpayments.

The OIG found that while Driscoll maintains a contractually required annual SIU fraud, waste, and abuse plan, it needs to improve its SIU function in order to comply with the plan and effectively detect and investigate fraud, waste, and abuse, report reliable information on SIU activities to the OIG, and recover identified overpayments. The OIG recommended that HHSC require Driscoll to implement corrective actions to achieve full compliance and strengthen Driscoll's SIU fraud, waste, and abuse detection, investigation, recovery, and reporting activities.

Audit of R Medical Outreach and Associates, LLC: A Texas Medicaid Durable Medical Equipment and Medical Supplies Provider: The OIG conducted an audit of R Medical Outreach and Associates, LLC, a durable medical equipment (DME) and medical supplies provider in El Paso, Texas, to determine whether R Medical billed Medicaid for fee-for-service incontinence supply claims according to state rules and guidelines, including requirements for billed claims represented by Home Health Services (Title XIX) DME/Medical Supplies Physician Order forms and delivery slips.

Texas Medicaid covers medical supplies for chronic and stable conditions, including incontinence supplies. For these supplies, Medicaid requires a physician to sign a Title XIX form to authorize the Medicaid client to receive the incontinence supplies listed on the form for up to six months from the date of the physician's signature.

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The OIG found that R Medical needed to correct its processes to ensure that Title XIX forms are properly completed and renewed as required by the Texas Medicaid Provider Procedures Manual (TMPPM) and that claims are filed in accordance with TMPPM. The OIG recommended that R Medical should repay HHSC \$1,211,602.35 for claims paid in error.

Audit of Cook Children's Home Health: A Texas Vendor Drug Program Provider: The OIG conducted an audit of Cook Children's Home Health to determine whether it properly billed the Vendor Drug Program for submitted Medicaid claims and complied with contractual and Texas Administrative Code (TAC) requirements between March 2012 and February 2015. OIG staff performed limited testing of information technology general controls to determine the reliability of the data used to form audit conclusions and found it to be reliable. Audit results did not identify any exceptions to Texas Medicaid billing requirements and indicated that Cook Children's properly billed the claims tested and complied with applicable contractual and TAC requirements.

Assessment and Evaluation Practices at Mission Nursing and Rehabilitation Center: The OIG performed an audit of Mission Nursing and Rehabilitation Center, a long-term care nursing facility in Mission, Texas. OIG staff (a) assessed the accuracy of therapy related payments and reimbursements, and the completeness of supporting documentation, and (b) determined whether Mission provided therapy services consistent with physician orders, according to resident assessments and evaluations, and in compliance with federal and state requirements.

The OIG found that for all 30 Mission resident files tested, Mission's practice of clustering therapy sessions during look-back periods led to assigning higher Resource Utilization Group (RUG) levels, increasing Medicaid payments by nearly \$700,000. Those 30 files also lacked required documentation, such as signed and dated physician's orders, documentation for necessity of therapy, or the resident's certified and recertified plans of care.

The OIG recommended to HHSC that it should make policy changes to prevent therapy RUG levels and payments based on more therapy than what is documented in a physician's written order and, if therapy decreases, an amount of therapy that would not qualify for a therapy RUG level. The OIG referred the documentation issues to CMS because Medicare reimburses Mission for the cost of

therapy services supported by this documentation.

Audit of Specialty Therapeutic Care, L.P., A Texas Vendor Drug Program Provider: The OIG conducted an audit of Specialty Therapeutic Care, L.P. to determine whether it properly billed the Texas Vendor Drug Program (VDP) for Medicaid claims submitted and complied with selected contractual and Texas Administrative Code (TAC) requirements. The VDP provides statewide access to covered outpatient drugs for individuals enrolled in Medicaid, the Children's Health Insurance Program, the Children with Special Health Care Needs program, the Healthy Texas Women program, and the Kidney Health Care program.

Specialty Therapeutic Care, a community pharmacy, processed 497 Texas Medicaid claims for prescriptions through VDP during the audit period of March 1, 2012, through February 28, 2015. These claims resulted in the pharmacy receiving reimbursements of more than \$6.7 million from Texas Medicaid. The OIG found that Specialty Therapeutic Care did not bill VDP properly, or comply with other selected contractual or TAC requirements, for 6 of 211 claims tested.

Audit results indicated there were no exceptions related to NDC usage, quantity, refills, controlled substances, warehouse billing, or acquisition cost, and information technology general controls were sufficiently reliable for the purposes of the audit. There were exceptions related to claims validity. The OIG recommended that Specialty Therapeutic Care ensure claims contain the correct prescriber identification number. Based on issues identified in this audit, Specialty Therapeutic Care owes the State of Texas \$92,615.08.

Inspections

Medicaid Payments for Deceased Clients: Inspection of Capitation Payments Made for Deceased Clients in the Texas Medicaid System:

The OIG conducted an inspection to determine how Texas Medicaid can strengthen processes used to identify and recoup capitation payments for deceased clients. The OIG wanted to establish how Texas Medicaid identifies deceased clients and ascertain if Texas Medicaid effectively recoups capitation payments for deceased clients.

A federal audit report found that Texas Medicaid did not always stop making capitation payments after a client's death, despite efforts to identify and recover unallowable

Agency highlights

payments. The report said between January 1, 2013, and December 31, 2015, Texas Medicaid paid MCOs \$6.4 million for 2,224 clients with death dates reported as prior to this period. HHSC requested a follow-up inspection to the federal audit to determine why HHSC made capitation payments to MCOs for clients after their date of death, and if HHSC made capitation payments for additional deceased clients.

The OIG recommended that HHSC Access and Eligibility Services enforce existing policies and procedures to end a deceased client's eligibility in the Texas Integrated Eligibility Redesign System (TIERS) and create a timeline for processing date of death information and alerts; establish an agreement with the Department of State Health Services Vital Statistics Unit for Texas Works Advisors to obtain death certificates to better match deceased persons with Medicaid clients; improve management oversight to prevent errors in deceased client's eligibility that result in erroneous capitation payments; and properly adjust eligibility to reflect verified date of death information for the confirmed deceased clients.

Electronic Visit Verification: Inspection of Electronic Visit Verification System: The OIG looked into how effective the HHSC Electronic Visit Verification (EVV) system is at verifying home service visits for Medicaid clients and that a home health attendant was present to provide services. The OIG wanted to assess the percentage of Medicaid claim details matched with EVV data and the effectiveness of the EVV Provider Compliance Plan.

HHSC designed the EVV system to deter fraud, waste, and abuse in personal care services in Texas Medicaid. Those services, performed by home health attendants who are not required to be licensed or certified, are provided in client homes to assist medically fragile clients to continue to live in the community. When used as intended, claim details matched to an EVV transaction can provide documentation that an attendant was present to provide services. In state fiscal year 2017, EVV services totaled nearly \$2.6 billion in paid claims.

The OIG recommended that Medicaid and CHIP Services (MCS) should comply with the Texas Administrative Code 354.1177(g)(1), which prohibits payment of a claim without a matching EVV transaction, and, where appropriate, recover dollars paid without an

EVV match. Based on the data available to the OIG, in state fiscal year 2017, HHSC paid more than \$117 million for claims without a matching EVV transaction. OIG also recommended that MCS require a prospective matching process and ensure claims without a matching EVV are not paid; allow providers to only submit claims with a single date-of-service per detail for claims requiring EVV; require vendors to develop and implement EVV edits and audits to help enforce reason code policy; and establish a standard for percentage of auto-verified EVV transactions that providers must achieve.

Issue Briefs

Attendant Care Services: Attendant care services can reduce Medicaid costs by providing services to people over the age of 65 and those with disabilities in their community. While cost-effective and beneficial for clients, receiving attendant care services may pose risks to clients' health and safety because services are not delivered in a traditional medical setting and may be provided without supervision.

The OIG's Medicaid Program Integrity (MPI) Division investigates allegations of fraud, waste, and abuse by Medicaid providers and receives, tracks, and reports on provider complaints. During the second quarter of fiscal year 2018, 38 percent of MPI complaints received about all provider types were allegations of fraud, waste, and abuse committed by attendants.

Stakeholder outreach

IG legislative visits and testimony: IG Sylvia Hernandez Kauffman met with these state legislators to discuss program integrity issues:

- State Sen. Donna Campbell
- State Sen. Juan Hinojosa
- State Sen. Charles Schwertner

Ms. Kauffman appeared before the Texas House Appropriations Committee in April to present and answer questions on OIG efforts in managed care. In May, Ms. Kauffman testified before the House Human Services Committee on program integrity in managed care. IG Kauffman also attended the Texas Legislative Oversight Committee hearing.

IG stakeholder and regional visits: During her visit to the Rio Grande Valley, IG Kauffman met with area Medicaid providers to discuss fraud, waste, and abuse issues.

Agency highlights

Several regional home healthcare agencies briefed the IG on the client solicitation challenges they face as they struggle to provide quality services to their clients and maintain their businesses. She also met with the OIG team in the Pharr office, who shared their ideas on how to improve the OIG, and visited the Rio Grande State Center.

IG Kauffman visited Doctors Hospital at Renaissance in Edinburg, touring the neonatal intensive care unit and listening to concerns about providing quality health care to an area experiencing large population growth. IG Kauffman also visited the Harlingen Nursing and Rehabilitation Center operated by Regency Integrated Health Services, where staff briefed her on facility operations, client care, and regulatory oversight policies.

Ms. Kauffman and OIG's Chief Dental Officer gave a presentation on risk management, compliance programs, and dental ethics in San Antonio at the annual Texas Dental Association meeting.

Ms. Kauffman attended a meeting with the Texas Healthcare Association in May to discuss program integrity issues. In May, IG Kauffman held meetings with Texas Hospital Association and Texas Association of Health Plans representatives to discuss program integrity matters significant to the OIG and the associations.

Medical association meetings: OIG held its quarterly Nursing Facility Utilization Review Stakeholder Meeting in March to update attendees on potentially preventable events reviews and draft nursing facility review rules. OIG staff also presented on nursing facility trends, reviews, and common errors.

DMS held its Hospital Utilization Review Stakeholders Meeting in April. Participants discussed identified issues related to medical records provided by outsourced medical

records management entities and the updated Medicaid Provider Database Form, which includes updated Hospital Utilization Review contact and hospital information.

OIG's Chief Dental Officer and Chief Strategy Officer met with Texas Dental Association (TDA) representatives at the quarterly TDA stakeholder meeting to discuss priorities and issues important to the OIG and TDA, including upcoming audits and how the OIG investigates solicitation cases.

Lock-in Program bi-monthly teleconference:

The OIG continued its bi-monthly Lock-in Program teleconferences with managed care organizations (MCOs). The March call included a webinar titled "Emerging Trends in Opioids" presented by OIG's Chief Pharmacy Officer. The presentation pointed out the unintended consequences of opioid use, and that 1,375 Texans died from opioid use in 2016, the latest numbers available from the National Institute on Drug Abuse.

State Supported Living Centers and State Hospital meetings: OIG staff met with program managers and superintendents at the Lubbock State Supported Living Center and Austin State Hospital this quarter to discuss changing client demographics and staffing ratios at the facilities. Living-center and hospital staff told the OIG they were pleased with the thoroughness and timeliness of OIG investigations.

Alliance of Independent Pharmacists: OIG staff met with Alliance of Independent Pharmacists representatives in April to discuss their concerns and share information they think the OIG would find useful. The OIG uses these meetings as opportunities to gain a better understanding of the issues and concerns of medical providers specific to program integrity.

Program Integrity Spotlight

Texas Medicaid and CHIP Managed Care Organizations' Special Investigative Units Review and Recommendations

The OIG submitted the Texas Medicaid and CHIP Managed Care Organizations' Special Investigative Units Review and Recommendations report in compliance with the 2018-2019 General Appropriations Act, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission [HHSC], Rider 152).

HHSC Rider 152 required the OIG to conduct a review of Medicaid and Children's Health Insurance Program (CHIP) managed care organizations (MCOs) Special Investigative Units (SIUs). It also required the OIG to develop recommendations with Medicaid and CHIP MCOs for the composition and activities of SIUs.

The OIG studied information in this area in addition to distributing a 32-question SIU Composition and Activities Survey to the 22 Texas Medicaid and CHIP MCOs and DMOs (collectively referred to as MCOs). In addition to the OIG SIU Composition and Activity Survey, the OIG reviewed findings from the OIG Cost Avoidance Waste Prevention Survey, the OIG's Audit report on MCOs' SIU performance, the MCOs' fraud, waste, and abuse (FWA) Compliance Plans, and managed care contracts from other states.

Currently, MCOs are required to develop a FWA Compliance Plan that outlines the MCOs processes to prevent, detect, investigate, report, and refer potential fraud, waste, and abuse to the OIG and Attorney General's Medicaid Fraud Control Unit (MFCU). The FWA Compliance Plan's critical elements can be carried out by many of the MCO's business areas, including SIUs, Claims Adjudication, Legal, and Provider Relations. MCO efforts to prevent fraud, waste, and abuse may also overlap with their cost avoidance activities.

MCOs are also required to establish an SIU to prevent, detect, and investigate fraudulent claims and other types of program abuse by members and service providers. Establishing an SIU with the right staffing configuration, education, experience, and necessary resources can lay the foundation for MCOs to develop effective fraud, waste,

and abuse activities that produce cost avoidance savings, recoveries, and referrals to the OIG. Effective SIUs are an essential part to ensuring that state and federal funds are spent appropriately on the provision of health care services while protecting the health and safety of clients.

MCOs are also required to report annually to the OIG the dollar value of their recovered overpayments. MCOs are responsible for detecting and identifying improper payments. Overpayments may be identified through SIUs' fraud, waste, and abuse investigations or from detection methods used by other MCO business areas.

To prevent, detect, and investigate fraud, waste, and abuse, MCOs implement their FWA Compliance Plans and establish an SIU. MCO FWA Compliance Plans activities may be carried out by other business areas. Given that a variety of MCO business areas may be involved, the amount of recoveries may not be solely dependent on an SIU's composition and activities. The total dollar value of MCOs' annual fraud, waste, and abuse recoveries do not provide a comprehensive view of the MCOs' efforts to prevent, detect, and investigate fraud, waste, and abuse. To have a comprehensive view, other variables should be considered including the MCOs' prepayment efforts in addition to their post-payment efforts.

Based on the OIG's research, and in collaboration with the Medicaid CHIP Services department and the MCOs, the OIG developed recommendations to improve the effectiveness of MCO SIUs and fraud, waste, and abuse activities. Medicaid and CHIP MCOs may consider adopting one or more of the following recommendations based on their assessment of their specific needs and whether they have already adopted these recommendations:

Recommendation 1: Employ an SIU manager whose only focus is to direct oversight of their MCO's SIU and fraud, waste, and abuse activities, and is considered key personnel in Medicaid and CHIP managed care contracts with HHSC.

Recommendation 2: Meet contract requirements that will be developed by the state for the method and frequency of member verification of services.

Recommendation 3: Employ or subcontract SIU staffing that includes, at minimum, a full-time equivalent position who is either an accredited investigator or an

Program Integrity Spotlight

investigator who is a certified fraud examiner.

Recommendation 4: Use standardized methodologies developed by the state, with stakeholders' input, to calculate and evaluate their cost avoidance savings related to fraud, waste, and abuse prevention activities.

Recommendation 5: Require SIU staff, including those employed by a third party to conduct SIU activities, to attend national organizations' fraud, waste, and abuse-focused trainings to learn and adopt innovative techniques for the prevention, detection, and investigation of fraud, waste, and abuse.

Recommendation 6: Ensure program integrity activities are integrated into each business area responsible for providing support to the SIU and/or executing fraud, waste, and abuse activities through documented and up-

to-date policies and procedures that clearly define roles, responsibilities, and performance expectations.

Recommendation 7: Periodically review and revise algorithms for fraud, waste, and abuse detection-focused data analytics.

Recommendation 8: Use non-traditional third-party resources to gather information to aid in fraud, waste, and abuse detection and investigation efforts.

Non-traditional resources may enhance detection efforts and supplement ongoing investigations by providing additional insight and supplemental information not found in traditional detection and investigation sources. Seven MCOs reported using non-traditional third-party resources to further enhance their detection and investigation efforts.

Division performance

Peace Officers

The Peace Officer Division is comprised of the following units: The State Centers Investigative Team and the Electronic Benefit Transfer (EBT) Trafficking Unit. The division protects the integrity of HHS programs through investigations of employee misconduct involving abuse, neglect and exploitation in State Supported Living Centers and State Hospitals as well as vendor and recipient EBT trafficking.

Cases are referred for Administrative Disqualification Hearings (ADH) and prosecution to appropriate state or federal regulatory and law enforcement authorities. Commissioned Peace Officers in the division conduct criminal investigations of allegations of abuse, neglect, and exploitation in State Supported Living Centers and State Hospitals, and EBT trafficking.

EBT Trafficking Unit performance

Overpayments recovered	\$58,230
Cases opened	61
Cases completed	67

State Centers Team performance

Overpayments recovered (EBT trafficking)	\$1,885
Cases opened	239
Cases completed	273

Inspections

The OIG Inspections Division inspects HHS programs, systems, and functions for fraud, waste, abuse, and systemic issues in order to improve the HHS system. Inspections oversees the state's WIC Vendor Monitoring Unit. This unit conducts in-store evaluations, compliance buys, and invoice audits to monitor vendors participating in the WIC program.

Inspections reports issued

- Medicaid Payments for Deceased Clients: Inspection of Capitation Payments Made for Deceased Clients in the Texas Medicaid System
- Electronic Visit Verification: Inspection of Electronic Visit Verification System Inspection

Inspections in progress

- Managed Care Organizations/Pharmacy Benefit Manager (PBM) Pharmacy Monitoring
- Durable Medical Equipment - Motorized Wheelchairs
- Access and Eligibility Services (AES) Interstate and Income Eligibility & Verification System (IEVS) Alerts
- Duplicate Capitation Payments to Managed Care
- Long-term Services and Supports - Community Attendant Services

Inspections performance

Overpayments recovered	\$1,919,756
Overpayments identified	\$121,175,512

Audit

The Audit Division conducts risk-based audits that examine the performance of contractors, providers, and HHS programs to reduce fraud, waste, and abuse throughout the HHS System, and provide independent assessments of HHS programs and operations.

Audit coordinates federal government audits, serves as the project lead for the Recovery Audit Contractor (RAC) contract, and is the single point of contact with the Centers for Medicare and Medicaid Services (CMS) for Unified Program Integrity Contractors (UPIC) audits and Payment Error Rate Measurement (PERM) activities.

Audit performance

Overpayments recovered	\$10,924,952
Overpayments identified	\$10,512,227
Audits completed	5

Audit reports issued

- Audit of Medicaid and CHIP Special Investigative Units: Driscoll Health Plan
- Audit of R Medical Outreach and Associates, LLC: A Texas Medicaid Durable Medical Equipment and Medical Supplies Provider
- Audit of Cook Children's Home Health: A Texas Vendor Drug Program Provider
- Assessment and Evaluation Practices at Mission Nursing and Rehabilitation Center
- Audit of Specialty Therapeutic Care, L.P., A Texas Vendor Drug Program Provider:

Audits in progress

The Audit Division had 29 audits in progress this quarter on the topics listed below. A list of audits in progress and audit topics the OIG plans to initiate can be found in the two-year rolling audit plan located on the OIG's website.

- STAR+PLUS enrollment
- DME claims
- Pharmacy providers
- Managed care pharmacy benefit managers' compliance
- MCO SIU performance
- Third-party recovery activities managed or performed by a claims administrator
- IT security assessments
- IT security and business continuity and disaster recovery planning assessment
- Residential child care services contractor
- Speech therapy providers
- Home and community-based services providers
- Medicaid air ambulance providers
- Pharmacy Inventory Reconciliations
- Medical transportation program vendor performance)
- Medically dependent children's program
- Dental maintenance organization performance

Medicaid Program Integrity

The Medicaid Program Integrity Division investigates and reviews allegations of fraud, waste, and/or abuse committed by 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. Referrals are made to the Attorney General's Medicaid Fraud Control Unit when there are indications of criminal Medicaid fraud.

Medicaid Program Integrity performance

Preliminary investigations opened	780
Preliminary investigations completed	690
Full-scale investigations completed	49
Cases transferred to full-scale investigation	31
Cases referred to AG's Medicaid Fraud Control Unit	176
Open/active full-scale cases at end of quarter	163

Medical Services

The Division of Medical Services reviews a variety of health and human services claims and medical records, including acute care utilization, hospital utilization, nursing facility utilization, and pharmacy lock-in. The division provides clinical consultation to the Investigations, Audit, and Inspections divisions on dental, medical, nursing, and pharmacy services.

Medical Services includes:

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

Acute Care Surveillance (ACS) team identifies patterns of aberrant billing, performs Surveillance Utilization Reviews required by the federal Centers for Medicare and Medicaid Services, develops and runs targeted data queries to identify acute care billing outliers, and collects Medicaid overpayments. The ACS team also performs

Medical Services performance

Acute Care provider recoveries	\$2,676,265
ACS identified MCO overpayments	\$939,035
Hospital UR recoveries	\$8,577,899
Hospital UR claims reviewed	10,038
Nursing facility UR recoveries	\$106,455
Nursing facility reviews conducted	116

medical record reviews as requested by OIG Audit, Inspections, or Investigations divisions. When a case does not meet criteria for action by other divisions, it is referred to ACS team for record review and completion.

Quality Review team conducts retrospective utilization reviews of hospitals and nursing facilities, and administers the pharmacy Lock-in Program. The Utilization Review (UR) team performs on-site and desk reviews of hospital claims and nursing facility Minimum Data Set forms for appropriate billing. Lock-in Program staff work with MCOs to monitor client use of prescription medications and acute care services.

General Investigations

The General Investigations Division 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. Clients can be disqualified from a program, denied benefits, and/or ordered to repay all benefits fraudulently received

General Investigations performance

Overpayments recovered	\$21,059,406
Cases completed	3,281
Cases opened	4,630
Cases referred for prosecution	27
Cases referred for Administrative Disqualification Hearings	180

Chief Counsel

The Chief Counsel Division provides legal counsel to the OIG and all OIG divisions, so that each division is best able to accomplish the OIG mission. Chief Counsel processes all provider cash recoupments for the OIG and produces a monthly report for each division so they can track recoveries. The Chief Counsel Division includes:

Litigation: The Litigation section receives referrals from Investigations Division staff to determine the amount of any overpayments that may have been made to Medicaid providers and recommend whether any further sanctions should be pursued in a case.

Litigation handles the appeals of investigations and audits that have determined that providers received Medicaid funds to which they were not entitled. These investigation cases are settled by agreement or resolved by hearing before a State Office of Administrative Hearings judge. Audit files are settled by agreement or resolved by hearing before an HHSC appeals judge.

Litigation terminates and excludes Medicaid provider enrollment for certain program violations and also works with providers who want to self-report a potential Medicaid violation.

General Law: The General Law section provides legal advice and support to all aspects of the OIG's operations, including researching termination/exclusion issues, drafting

Internal Affairs performance

Investigations completed	135
Cases with sustained allegations	38

policies and procedures related to the OIG mission, determining federal share obligations, and proposing rule and statute changes. General Law is responsible for taking initial actions to terminate or exclude providers when a provider has been terminated or excluded from Medicare or another state Medicaid program.

Internal Affairs: The Internal Affairs section investigates employee misconduct as it relates to the delivery of health and human services, and contract fraud within the HHS System.

Office of Strategic Initiatives : The Office of Strategic Initiatives develops and implements IG related initiatives, special projects and coordinates and/or performs complex research concerning program integrity activities related to Medicaid, the Children's Health Insurance Program (CHIP), Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and other Texas Health and Human Services programs. OSI also provides expert assistance and advice on coordinating and implementing IG cross-functional projects and strategic initiatives.

Support Services

The Support Services divisions promote efficiency and effectiveness throughout the OIG office.

Operations

The Operations Division includes: the Fraud Hotline, which receives allegations of fraud, waste, and abuse and refers them for appropriate further investigation or action; the Program Integrity Research team, which completes the required state and federal disclosure and screening activities for high-risk providers seeking to enroll or re-enroll in Medicaid and other HHS programs; Business Operations and Operations Support, which is responsible for oversight of OIG purchasing and contract management, acting as a liaison for facility support and handling OIG administrative services; Strategic Operations and Professional Development, which promotes training services, internal policy development, and organizational support for all OIG divisions; and Finance, which is responsible for overseeing the OIG's budget and reporting Legislative Budget Board performance measures.

Chief Strategy Office

The Chief Strategy Office includes Government Relations, Public Affairs and Publications, Policy, and Data and Technology. The division coordinates and ensures timely and effective external communication with a variety of stakeholders. It provides outreach and communication with legislators, consumers, family members, MCOs, other agencies within the HHS System, and the media, and is the

Operations performance

Provider enrollment inventory (applications and informal desk reviews) processed	5,861
Individual screenings processed	17,547
Fraud hotline calls answered	6,476

Data and Technology performance

Data requests received	196
Outliers identified through data analytics for the Pharmacy Fraud Detection Operation (FDO)	35
Outliers selected by MPI for FDO	6
Algorithms run	31
New algorithms developed	2

primary division for managing government relations for the OIG. The division analyzes legislation, conducts analysis of program policies, and handles all legislative and media inquiries.

The Data and Technology group implements tools and innovative data analytic techniques that streamline OIG operations and increases the identification of fraud, waste, and abuse in HHS programs. DAT uses data research, and data analytics to identify, monitor, and assess trends and patterns of behavior of providers, clients, and retailers participating in HHS programs.

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