Quarterly Report

Quarter 1

Fiscal Year 2019

Inspector General

Texas Health and Human Services

Office of Inspector General

Texas Health & Human Services Commission

Sylvia Hernandez Kauffman
Inspector General

I am pleased to present the first quarterly report for fiscal year 2019, summarizing the excellent work this office has performed during this period, to Governor Greg Abbott, Executive Commissioner Dr. Courtney Phillips, the Texas Legislature, and the citizens of Texas.

After a strong fiscal year 2018, the first quarter of 2019 continued the trend. Our recoveries totaled nearly $95 million; in addition, another $54 million was identified for future recovery, and $42 million was saved in cost avoidance.

The new fiscal year brings with it some changes to the OIG. Third Party Recovery has been moved back to the OIG from Medicaid and CHIP Services. TPR maintains and helps reduce Medicaid expenditures by shifting claims expense to third party payers utilizing either cost avoidance or cost recovery, and it recovered $76.1 million this quarter.

The OIG's mission is to detect, prevent, and deter fraud, waste, and abuse in the delivery of all health and human services in Texas. We work to protect the integrity of those health and human services programs, making sure that funds dedicated to providing services to those who need them are spent only for their intended purpose. I'm honored to serve with the OIG team as we work to achieve that mission every day.

Respectfully,
Sylvia Hernandez Kauffman

Quarter 1 results

Dollars recovered

Audit	
Collections (OIG Audits, UPIC Audits, RAC Audits and OIG contracted audits)	$2,365,859
Inspections	
WIC collections	$81,323
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$4,236,305
Voluntary repayments by beneficiaries	$63,901
Peace Officers	
EBT Trafficking team	$34,381
Medicaid Program Integrity	
Provider collections	$4,751,724
Medical Reviews	
Acute care provider collections	$1,498,264
Hospital collections	$4,226,871
Hospital collections, AR claims	$1,428,277
Nursing facility collections	$52,102
Third Party Recovery	
TPR recoveries	$76,065,346
Total dollars recovered	**$94,804,353**

Dollars identified for recovery

Audit	
Provider overpayments (OIG Audits, UPIC audits, RAC Audits and OIG contracted audits)	$26,384,484
Inspections	
Duplicate capitation	$2,695,832
WIC vendor monitoring	$12,301
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$10,271,054
Peace Officers	
EBT trafficking	$529,079
Medicaid Program Integrity	
MCO identified overpayments	$10,669,491
Medical Reviews	
Acute care providers	$978,366
Hospitals	$2,202,114
Nursing facility overpayments	$164,984
Total dollars identified for recovery	**$53,907,705**

Cost avoidance

Inspections	
Vendor disqualifications	$4,313,117
Benefits Program Integrity	
Client disqualifications	$1,384,116
Medicaid Program Integrity	
Medicaid provider exclusions	$5,384,910
Medical Reviews	
Pharmacy Lock-In	$1,285,215
Third Party Recovery	
TPR	$29,459,323
Total cost avoidance	**$41,826,681**

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	$34,381
Dollars identified for recovery	$529,079
Cases involving OIG peace officers	254

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

Trends

Medicaid Program Integrity

The Medicaid Program Integrity (MPI) Division's provider field investigations (formerly referred to as full-scale investigations) initiated 77 cases related to 9 provider types. The largest percentage of the cases involve dental providers. MPI uses a data-driven analytic approach developed by the OIG Data and Technology (DAT) unit to focus on providers whose billing patterns exhibit potential indicators of solicitation. Of the dental cases that were opened in this quarter, 11 were opened as a result of DAT's identification of providers with high utilization patterns on specific services, interesting patterns of new first dental home visits, or other potential billing indicators symptomatic of solicitation behavior. Two of the 11 dental providers had been examined during an MPI fraud detection operation.

MPI has also leveraged DAT's analysis to focus on behavioral health providers who appear to be billing individual psychotherapy for group sessions, and an excessive number of hours of psychotherapy per day, often across multiple managed care organizations (MCOs) and fee-for-service. Ten behavioral health cases have been opened this quarter based on DAT's analysis.

Provider types under field investigation

- Dental
- Personal care attendants
- Therapy-counseling
- Home health agency
- Hospital
- Physician (individual/group/clinic)
- Durable medical equipment
- Ambulance
- Therapy (physical, occupational, speech)

Benefits Program Integrity

The Benefits Program Integrity (BPI) Division opened 3,809 investigations involving some form of benefit recipient overpayment or the intention to commit program fraud. Seventy-five percent of the cases involved unreported income (34 percent) or an issue with the reported household composition (41 percent). Household composition cases usually include an unreported household member who has income, but could also include reporting a household member who does not actually live in the household. Both instances lead to the household receiving more benefits than allowed.

BPI completed 243 investigations where fraud was found and referred them for either prosecution (29) or an administrative disqualification hearing (214).

Type of complaints received by MPI

Personal care attendant fraud, waste, or abuse	52%
Home health agency	9%
Dental	8%
Physician (individual, clinic, or group practice)	6%
Therapy-counseling	5%
Hospital	4%
Adult day care	3%
Nursing facility	3%
Pharmacy	3%
Durable medical equipment	2%

Trends

Attendant care: The OIG continues to receive complaints alleging that attendants are clocking in but not appearing at a client's home, and often receives complaints that attendants and clients are colluding to bill for services not rendered in order to share the payments. Recent complaints have also involved allegations against home health agencies for not performing the mandatory background checks and hiring attendants with criminal history.

Dental: A common complaint is that clients are solicited by dental providers, and in those cases, the OIG performs a review of the provider's billing for procedures that are commonly up-coded or billed but not provided. The OIG also has received complaints alleging that dental providers were not credentialed to provide certain services, such as anesthesia, but appeared to have billed for them.

EBT Trafficking Unit

The Electronic Benefits Transfer (EBT) Trafficking Unit identified a trend with local, smaller businesses, mainly convenience stores and restaurants, across the state buying Supplemental Nutrition Assistance Program (SNAP) benefits from recipients. The owners or designees of those convenience stores and restaurants then go to larger retail stores and use the illegally purchased SNAP benefits to buy merchandise in order to stock their businesses. The EBT Trafficking Unit works with loss prevention units of large retail chains to identify customers who are using multiple SNAP benefits cards to make purchases and is investigating several active cases involving this type of activity.

State Center Investigative Team

The trends seen by the State Center Investigative Team and EBT Trafficking Unit in the 201 investigations opened this quarter include assault, 40 percent; injury to a child, elderly, or disabled person, 42 percent; prohibited activities (including misuse of SNAP EBT cards), 17 percent; and exploitation of child, elderly, or disabled person, 1 percent.

Fraud Hotline

Of the approximately 7,000 answered calls to the OIG Fraud Hotline this quarter, nearly half were allegations of fraud related to either SNAP or EBT system issues. The other half of the calls did not involve the OIG because the issues were unrelated to fraud, waste, or abuse. Many of the calls sought answers to eligibility issues (i.e. being denied benefits or needing to add a beneficiary). The OIG Fraud Hotline reduced the average hold time for callers to less than one minute.

Case highlights

OIG secures $3.7 million in WIC cost avoidance

A State Office of Administrative Hearings judge upheld an OIG decision to disqualify a vendor with the Women, Infants, and Children (WIC) program for three years. An OIG invoice audit had identified a pattern of unsubstantiated claims totaling $38,397. The judge's decision upholds the unsubstantiated claims, which have been recovered in full through withholding of subsequent claims. It also confirms the three-year disqualification of the vendor from the WIC program, resulting in $3.7 million in cost avoidance.

OIG joint investigation uncovers a nearly $100,000 Medicaid overpayment

The OIG was part of a joint investigation with the U.S. Department of State and the Social Security Administration Office of Inspector General of a Medicaid client in El Paso suspected of using the identity of a deceased person to obtain SNAP, Long-term Care Medicaid, and Supplemental Security Income benefits. The months-long investigation uncovered an HHSC LTC Medicaid overpayment of $98,712. The OIG submitted the case with the El Paso County district attorney as a theft charge under Chapter 31 of the Texas Penal Code.

Policy recommendations

Audit

The OIG conducted an audit of Amerigroup Texas, Inc. (Amerigroup) to assess the design and effectiveness of selected security controls over confidential HHS System information stored and processed by Amerigroup. Amerigroup is a licensed MCO that contracts with the state of Texas to provide Medicaid and CHIP services through its network of providers. As an MCO for Medicaid and CHIP program recipients, Amerigroup processes and pays medical provider claims, which contain protected health information and other confidential information. Amerigroup is required to protect and secure HHS System information according to criteria established in the Uniform Managed Care Contract. The OIG examined selected information technology controls and related activities at Amerigroup.

Audit results indicated that Amerigroup designed and implemented effective security controls in all evaluated areas except for the frequency it reviewed access logs to its data center. Amerigroup, consistent with its internal policy, conducted quarterly reviews of data center access. HHSC Information Security Controls, however, requires monthly reviews of access logs. The OIG recommended that Medicaid and CHIP Services (MCS) should consider tailored contractual remedies to address Amerigroup's delay in complying with the OIG's request for information. In addition, MCS should require Amerigroup to effectively review physical access logs monthly and update related internal policies according to the HHS Information Security Standards and Guidelines.

Inspections

The OIG conducted an inspection to determine if Texas Medicaid processes identify or prevent duplicate capitation payments to MCOs for clients enrolled in both Medicaid and CHIP. The OIG wanted to establish why clients are enrolled in both CHIP and Medicaid, and if processes may reduce incidence of duplicate capitation payments to MCOs.

Data was examined for the period of June 2015 through January 2018; the OIG identified Medicaid and CHIP capitation payments totaling just under $2.7 million made for 2,996 Medicaid ID numbers. This amount

includes correct and erroneous capitation payments paid for IDs. The OIG inspection team could not distinguish capitation payments paid correctly or incorrectly without further research being performed by eligibility staff in TIERS. The OIG recommended that HHSC MCS, in its contract oversight role, should require MAXIMUS, an eligibility system, to resolve the issues on processing VOID transactions lacking a segment identification for clients. The OIG also recommended that HHSC prioritize resolving the duplicate capitation issues by proactively and regularly monitoring the Texas Integrated Eligibility Redesign System and MAXeb to identify clients enrolled in both Medicaid and CHIP.

Rule proposals

Nursing facility utilization review criteria

The OIG recently posted a proposed amendment related to nursing facility utilization reviews in the Texas Register for formal comment. There were no comments to the proposed amendment which replaces the requirement that the OIG conduct onsite utilization reviews of all nursing facilities every 15 months with a process whereby the OIG conducts a comprehensive annual review of all nursing facilities. This comprehensive annual review considers factors such as length of time since the last review, previous review results, complaints, and referrals in order to prioritize nursing facilities for onsite utilization reviews.

The OIG expects the adopted rule to be listed in the Texas Register and become effective in early 2019.

HB 2379: MCO referrals and recoveries

The OIG recently posted proposed rule changes related to HB 2379 for informal comment. The OIG received comments from seven stakeholders, prompting some revisions before the draft rules are presented at the Medical Care Advisory Committee and HHSC Executive Council meetings in February 2019. The proposed rules are expected to be posted in the Texas Register for formal comment in March 2019.

The OIG is proposing changes to rules related to HB 2379, which passed in 2017 and instituted changes to the MCO recovery process, due to provider overpayments. The proposed amendments would align the rules with HB 2379 and update changes to MCO referral procedures.

In fiscal year 2018, the MCOs reported recoveries of $3.89 million. These recoveries will be split between MCOs and OIG per the requirements of HB 2379.

Closing investigations amendment

The OIG recently posted rule amendments and additions related to closing investigations for informal comment. These rules outline the criteria for opening, prioritizing, and closing preliminary, field, and recipient investigations. The amendments and new rule clarify for MCOs and Texas Medicaid providers the criteria OIG uses to close these investigations.

This rule provides greater transparency into the office's investigative processes. No comments were received from stakeholders during the informal comment period.

The rules will be presented to the Medical Care Advisory Committee and the HHSC Executive Council in February 2019 and published in the Texas Register in March.

Agency highlights

Provider terminations and exclusions

The OIG is partnering more closely with MCOs to terminate or exclude providers when required by federal law, such as when a provider has been excluded from Medicare, lost their license, or committed program violations that warrant exclusion or termination.

MCOs are required to assist by updating their provider networks regularly with the TMHP provider master file, or by checking the exclusions database on the OIG website (https://oig.hhsc.texas.gov/). MCOs are encouraged to notify the OIG of providers they have excluded due to fraud, waste, or abuse. These actions help ensure that bad actors are removed from networks and payments are not made to those who should not receive them.

Providers may self-report fraud, waste, or abuse

More providers are taking advantage of the opportunity to self-audit and self-disclose overpayments during the course of an investigation. In the first quarter of fiscal year 2019, 24 providers chose to self-disclose. That compares to 22 in fiscal year 2017 and 21 in fiscal year 2018.

The OIG developed a plan to encourage providers to investigate and report matters that involve possible fraud, waste, abuse, or inappropriate payment of funds, whether intentional or unintentional. The objective was to form a partnership with providers through this self-disclosure approach, allowing the OIG's overall efforts to eliminate fraud, waste, and abuse to be enhanced while simultaneously offering providers a mechanism or method to reduce their legal and financial exposure.

The OIG decides whether to accept the results of a provider's self-assessment, but findings based upon procedures that conform to the OIG Self-Disclosure Protocol will be given substantial weight in determining appropriate administrative enforcement measures, and the OIG cannot make firm commitments regarding how a particular disclosure will be resolved. Providers interested in the OIG Self-Disclosure Protocol may visit the OIG website at https://oig.hhsc.texas.gov/resources.

OIG sends warning letters through tips from fraud hotline

The OIG Fraud Hotline receives about 2,700 calls per month from callers reporting common types of client fraud, including complaints about sales of Lone Star cards. For the reports from callers that do not result in an investigation by the OIG BPI Division, the Fraud Hotline team is sending warning letters to program clients and vendors who have been reported for certain types of fraud, waste, or abuse to discourage or prevent this type of activity.

Quarter 1 data

Audit reports issued	8
Audits in progress	27
Inspections reports issued	1
Inspections in progress	9
Investigations completed (BPI, IA, Peace Officer)	3,977
Investigations opened	4,097
Medicaid provider investigations completed	
Preliminary	521
Full-scale	61
MPI cases transferred to full-scale investigation	79
MPI cases referred to Medicaid Fraud Control Unit	88
Hospital claims reviewed	6,257
Nursing facility reviews conducted	60
Medicaid and CHIP high-risk provider enrollment screenings performed	31,191
Medicaid providers excluded	43
Fraud hotline calls answered	6,986

Provider enrollment integrity screenings increase by nearly 100 percent

The number of provider applicants required to be assessed by the OIG Provider Enrollment Integrity Screenings (PEIS) team increased by nearly 100 percent this quarter compared to the first quarter of fiscal year 2018. The increase stems from the revalidation requirements under the Affordable Care Act, the automation and adjustment of criteria that causes applications to be routed to the OIG instead of the Texas Medicaid & Healthcare Partnership (TMHP), and the addition of more types of providers enrolled directly by program staff, such as the Vendor Drug Program, rather than through the TMHP or OIG.

The PEIS team completed 21 informal desk reviews of provider appeals when denied enrollment, the majority of

which were denied because the provider failed to disclose information about one of the owners or principals. Twenty of the 21 desk reviews resulted in the provider's enrollment being approved, with 67 percent recommended for approval of the full allowable enrollment period, and 33 percent for a time-limited enrollment.

OIG conducts behavioral health provider fraud detection operation

The OIG conducted a fraud detection operation (FDO) of behavioral health providers, specifically licensed professional counselors, in October. Data analytics captured information needed to select three providers from the list of outliers. The OIG investigated providers in El Paso, McAllen, and San Antonio.

During the week-long operation, investigators collected and reviewed records, and conducted provider and client or guardian interviews. The OIG was able to assemble testimonial and documentary evidence to preliminarily prove the existence of one or more program violations by the selected outliers. The previous behavioral health provider FDO, which took place in January 2018, resulted in the OIG opening full-scale investigations and referrals to the Office of Attorney General Medicaid Fraud Control Unit. This was the 16th FDO since August 2016.

HHSC and OIG partner on anti-fraud social media campaign

The OIG's BPI Division is coordinating with HHSC Access and Eligibility Services to launch an anti-fraud social media campaign. The campaign, which will include posters and social media messages, will be aimed at Medicaid providers and clients to be aware of program fraud and the role the OIG plays in investigating fraud, waste, and abuse. The campaign is scheduled to kick off in February 2019.

OIG to implement prepayment reviews

The OIG will begin asking MCOs to perform prepayment reviews for identified providers with a history of poor performance, including significant inappropriate billing. Prepayment reviews are a tool to review claims before they are paid to ensure that the provider complied with all Medicaid payment rules. Under the Texas Administrative Code and the Uniform Managed Care Contract, the OIG may require the MCOs to perform this activity. Providers will be notified of this action, and will also be removed from this action if no issues are indicated while on prepayment review.

Lock-in Program updates criteria

The number of clients in the Texas Medicaid Lock-in Program has more than doubled since fiscal year 2013, with 1,593 clients in the program as of the end of the quarter. The cost savings in fiscal year 2018 totaled nearly $1.9 million. These increases are due to managed care referrals and revisions to criteria that better identify recipients with potentially excessive or conflicting use of the pharmacy benefit. The Lock-in Program restricts a Medicaid client to one provider and/or pharmacy for health services and prescriptions when the OIG or MCO determines that a client has abused or misused Medicaid services, including prescription drugs.

The OIG this quarter sent to MCOs updated criteria to the program, based on feedback from an MCO survey in May 2018 including:

- Lowered thresholds for the number of controlled substance prescriptions within 90 days from seven to five overlapping or duplicative prescriptions from two or more prescribers.
- An additional medication added to the list of drug combinations with abuse potential to include stimulants such as amphetamines.
- Instructions added to the 24-month criteria to clarify that overdose diagnoses should reflect intentional self-harm or suicide attempt.

In fiscal year 2019, the Lock-in Program updated its cost avoidance methodology to reflect hospital and emergency care in addition to pharmacy claims.

Lock-in Program average Medicaid recipients per month and annual cost avoidance

Fiscal year	Medicaid recipients*	Cost avoidance
2014	547	$115,841
2015	989	$59,882
2016	1,141	$158,284
2017	1,052	$210,673
2018	1,222	$1,881,581

Source: OIG Medicaid Lock-in Program staff

* Medicaid clients with lock-in status include both fee-for-service and managed care recipients for STAR and STAR+PLUS.

The methodology calculates an average cost avoidance per member per month (see chart on page 6) based on the cost difference 12 months before and after the lock-in for actual pharmacy claims, emergency care, and hospitalizations.

Cost avoidance

The OIG is working with Texas Medicaid to develop standardized definitions and methodologies for measuring cost avoidance specific to fraud, waste, and abuse in Texas Medicaid. Earlier this year, the OIG released a report at the request of the Texas Legislature on cost avoidance and waste prevention activities used by Texas MCOs.

The federal government and other states' reporting on fraud, waste, and abuse cost avoidance, and healthcare industry research, indicated that there was no consistent definition, methodology, or industry standard for calculating fraud, waste, and abuse cost avoidance in Medicaid and CHIP.

After distributing a survey to all Texas Medicaid and CHIP MCOs and dental maintenance organizations (DMOs), and reviewing information in this area, the OIG found that while Texas MCOs employed prepayment and post-payment cost avoidance activities, there's not a uniform definition of cost avoidance or a standard methodology to measure the effectiveness of cost avoidance activities.

RDI team guides managed care transition efforts

The OIG Research, Development, and Innovation (RDI) team in the OIG Strategy Office is providing Medicaid managed care support to OIG divisions, assisting staff with understanding contractual requirements for MCOs, and developing a Managed Care Transition Plan to improve processes for the OIG's work in managed care. The RDI team is supporting ongoing managed care-related activities, training staff and external stakeholders on new processes and procedures, and increasing communication opportunities for feedback to and from MCOs.

The Managed Care Transition Plan will capture current OIG business practices related to auditing, reviewing, or investigating fraud, waste, or abuse in managed care, identify opportunities for business process improvements, and implement prioritized activities during each state fiscal year. The plan is being developed with input from OIG staff, other HHSC areas, and external stakeholders, including medical and provider associations.

Texas Fraud Prevention Partnership improvements

The OIG is working on improvements to the Texas Fraud Prevention Partnership (TFPP), including expanding participation in the TFPP to all health and dental plans interested in participating, and by conducting a survey of TFPP partners to gather feedback towards continuous improvement efforts.

The TFPP is a partnership among participating MCOs and DMOs, HHSC Medicaid and CHIP Services, the Office of Attorney General Medicaid Fraud Control Unit, and OIG divisions to address fraud, waste, and abuse issues seen across multiple players.

The OIG launched the TFPP initiative several years ago with the goals of:

- Enhancing communication and coordination with MCO and DMO stakeholders.
- Helping identify additional potential areas of fraud, waste, or abuse vulnerability in Texas Medicaid and CHIP.
- More broadly distributing information, analysis, trends, and best practices related to health care fraud, waste, and abuse detection, deterrence, prevention, and investigative efforts.
- Helping reduce fraud, waste, and abuse in managed care settings.
- Strengthening the investigative process.
- Focusing limited investigative resources on areas with the highest likelihood of fraud, waste, and abuse.

Hospital utilization review team to begin reviews of managed care inpatient admissions

The OIG started reviewing managed care inpatient admissions for hospital utilization reviews (HUR) this quarter. The HUR team requested a limited number of medical records from select providers after coordinating with MCOs.

Recoupments for hospital utilization review providers

Following the passage of SB 207, 84th Legislature, the OIG temporarily suspended its HUR process in order to revise diagnosis related group procedures. This delay resulted in some claims being archived without adjustment

for overpayments. This quarter, the OIG HUR team established a process with the Medicaid claims administrator to recover previously identified dollars associated with past overpayments not collected due to the suspension. These are payments made in error that may be deducted, or recouped, from future payments to Medicaid providers. The HUR team is currently reviewing claims from 2016, but through this process providers may see recoupments from reviews conducted as early as 2015.

Federal Superior waiver approved

The OIG received approval from the Centers for Medicare & Medicaid Services for its request for a 12-month extension of the Texas Superior Waiver of inpatient utilization review requirements. The waiver supports the use of Title XVIII utilization review procedures that are superior to those in 42 Code of Federal Regulations (CFR), Part 482, for Title XIX recipients in acute care general hospitals. This waiver includes utilization review of admissions by Medicaid clients under the age of 21 in freestanding psychiatric facilities paid by the Medicaid program.

Since January 1989, utilization review of hospital inpatient claims have been done under waiver authority. The Centers for Medicare & Medicaid Services authorizes the state to conduct utilization reviews through this waiver. The OIG's Utilization Review Unit conducts initial hospital claim reviews. The unit refers allegations of suspected hospital fraudulent or abusive billing activity to the OIG's MPI Division, which researches the allegations and may pursue a case or refer them to another appropriate entity.

Benefits Program Integrity workgroup tackles recoupments and prevention

The BPI Division formed a workgroup to develop initiatives to assist the OIG to recoup and prevent improper payments in Medicaid programs. The projects the workgroup will undertake in fiscal year 2019 include:

- Continuing with a new Public Assistance Reporting Information System (PARIS) Match process, which uses data to assist in maintaining program integrity and detecting improper payments. BPI has one investigator working all PARIS matches.
- Implementing a new process for working Texas Department of Criminal Justice/Prison Verification System matches.
- Expanding the Federal Tax Information (FTI) Project, which allows the OIG to compare a client's reported income when applying for benefits to the client's federal tax return.

Electronic Benefit Transfer Trafficking Unit investigates suspicious activity

The OIG completed 36 investigations of EBT cases this quarter. The cases involve clients who receive or have received benefits from SNAP while owning or operating a business that accepts SNAP benefits through EBT cards.

In two cases, the EBT Trafficking Unit conducted undercover retail transactions in Fort Worth and Grand Prairie that identified benefits trafficking by being able to purchase ineligible items. The OIG presented the cases to the respective local district attorney for prosecution, with the charge of felony trafficking of EBT funds used to purchase ineligible items. These charges are also being processed through administrative disqualification hearings (ADH) to determine if clients intentionally violated SNAP rules.

In the first quarter of fiscal year 2019, the EBT Trafficking Unit identified 35 ADH cases resulting in the identification for recovery in the amount of $391,900. EBT also identified 22 recipients who were referred for prosecution, resulting in $24,052 identified for recovery.

Electronic Benefit Transfer Trafficking Unit partners with Sam's Club to combat fraud

The OIG EBT Trafficking Unit met with Sam's Club loss prevention and investigative staff to discuss fraudulent activity at Sam's Club where SNAP retailers are using recipient SNAP cards and benefits to purchase items to stock their retail businesses. EBT staff provided information to local law enforcement agencies on investigation procedures when they arise, which has led to the apprehension and arrest of SNAP participants for fraudulent activity.

EBT is sending posters from SNAP to law enforcement agencies to help educate them about the program and provide EBT contact information, including a hotline number.

Cooperative Disability Investigations group works with feds to investigate fraud

The Cooperative Disability Investigations (CDI) unit in the OIG's Investigations and Inspections Division closed

three cases this quarter that helped Texas Medicaid realize more than $113,000 in cost avoidance. CDI partners with the U.S. Social Security Administration OIG in Dallas to investigate fraud in federal and state disability claims and social services programs such as Medicaid, WIC, SNAP and Temporary Assistance for Needy Families.

State Center Investigations Team improves case completion efficiency

The OIG's SCIT successfully completed 180 investigations this quarter. The average time it takes SCIT to investigate a case is 45 days, a quick turnaround considering SCIT examined about 865 cases in fiscal year 2018.

Completed reports

Audit

Audit of Medicaid And CHIP MCO Special Investigative Units: Blue Cross and Blue Shield of Texas. The OIG completed an audit of Blue Cross and Blue Shield of Texas' (BCBS's) special investigative unit (SIU) performance to evaluate the effectiveness of the SIU at preventing, detecting, and investigating fraud, waste, and abuse and reporting reliable information on SIU activities, results, and recoveries. BCBS is an MCO contracted to provide Medicaid and CHIP health care services in Texas. MCOs are required to establish an SIU to investigate fraudulent claims and other program waste and abuse by members and service providers.

BCBS's SIU received 15 reports of suspected fraud, waste, or abuse during the audit period, which ran from September 1, 2016, through February 28, 2018, and included a review of relevant SIU activities through the end of fieldwork in July 2018. The SIU completed preliminary investigations for all 15 cases, and concluded that full-scale investigations were not warranted. While BCBS's SIU provided results of the preliminary investigations to the individuals that made the referrals, it did not report the 15 preliminary investigations on the OIG monthly Open Case List Report as required, but did enter them as of August 30, 2018.

The OIG recommended to HHSC it should ensure that BCBS report all preliminary investigations to OIG monthly as required the by Texas Administrative Code (TAC) and the Uniform Managed Care Manual.

Audit Of Passage Of Youth Family Center, Inc.: Child-Placing Agency Residential Child-Care Contract with the Texas Department of Family and Protective Services. The OIG evaluated Passage of Youth Family Center, Inc. (Passage of Youth) to determine whether it used state funds as intended for children placed with foster parents based on the documented service level and need per child; conducted oversight of foster parents; and implemented and updated children's service plans.

Passage of Youth operates as a child-placing agency under a residential child-care contract with the Texas Department of Family and Protective Services (DFPS). Passage of Youth served 245 children in calendar year 2015, and was responsible for placing children with foster parents; paying foster parents at contracted rates that pay at least minimum amounts established by DFPS; providing case management; and monitoring to ensure the needs of the placed children were met.

Payments for services provided under this contract are based on a daily rate per child set by the level of service required. The contract provided approximately $2.5 million in funding to Passage of Youth during the scope of the audit, which included the period of January 1, 2015, through December 31, 2015.

The OIG found that Passage of Youth did not perform according to selected contract requirements. Information contained in master records for 60 children indicated that case managers did not timely review and update 14 service plans associated with 11 children. A service plan identifies a child's basic and specific needs, and how the child-placing agency will meet those needs.

Audit results indicated there were 47 instances, out of 265 payments tested, where Passage of Youth payment information differed from information in the DFPS system. There was no indication a reconciliation had been completed to identify and correct any inaccuracies in the Passage of Youth or DFPS information, and make any needed adjustments to the original payment amounts.

Passage of Youth did not include all required documents in each foster family home's master record. Of 37 family foster home master records tested, master records for 18 foster family homes were missing at least one document, with 2 of the 18 missing multiple documents. Missing required documents included background checks, financial records, and records of supervisory visits.

Passage of Youth did not include all required documents in each child's master record. Of 60 children's master

records tested, 3 did not include all pertinent information regarding service plans, and 5 did not contain documents to verify therapy services had been performed. Finally, Passage of Youth did not provide support documentation for various general ledger transactions totaling $97,293, did not provide support for salary and other expenses included in reported officer's compensation of $253,255, and submitted an incorrect cost report to HHSC.

The $97,293 was not subject to recoupment because an HHSC Rate Analysis desk review determined that, as part of the contract with Passage of Youth, no further adjustments were needed.

The OIG recommended that Passage of Youth should:

- Update service plans as required by TAC.
- Maintain complete master records for foster parents and children.
- Maintain supporting documentation for all transactions recorded in the general ledger.
- Submit correct cost reports to HHSC.
- Continue to work with accounting professionals to ensure financial reporting is correct.

Audit of Coastal Plains Community Center: A Medicaid HCS Provider. The OIG conducted an audit of Coastal Plains Community Center (Coastal Plains), a home and community-based services (HCS) provider to determine whether fee-for-service claims submitted by and paid to Coastal Plains were authorized, documented, and billed according to the HCS provider agreement and with state rules and guidelines.

The OIG audited paid claims for the period from March 1, 2016, through February 28, 2017, and reviewed relevant activities, internal controls, and information technology general and application controls through the end of fieldwork in July 2018. The claims tested indicated that Coastal Plains complied with Texas Medicaid requirements.

Audit Of Avita Drugs: A Texas Vendor Drug Program Provider: The OIG conducted an audit of Avita Drugs, a Texas Vendor Drug Program (VDP) provider, to determine whether Avita Drugs properly billed VDP for Medicaid claims submitted and complied with selected contractual and TAC requirements. VDP provides statewide access to covered outpatient drugs for individuals enrolled in Medicaid, CHIP, the Children with Special Health Care Needs Services program, the Healthy Texas Women program, and the Kidney Health Care program.

Avita Drugs, a community pharmacy, processed 2,408 Texas Medicaid claims for prescriptions through VDP during the audit period of September 1, 2012, through August 31, 2015. These claims resulted in the pharmacy receiving reimbursements of nearly $1 million from Texas Medicaid.

The OIG tested Avita Drugs' compliance with selected contractual and TAC requirements in seven areas: claims validity, represented by claims documentation maintained by the provider; National Drug Code (NDC) usage; quantity; refills; controlled substances; warehouse billing; and acquisition cost. The OIG found that Avita Drugs did not bill VDP properly, or comply with other selected contractual or TAC requirements, for 16 of 187 claims tested.

The OIG recommended that Avita Drugs should ensure that prescription documents are tamper resistant; claims contain the correct NDC; all records related to prescription services are maintained; and that quantity changes and refills are authorized by the prescriber. Based on issues identified in this audit, Avita Drugs owes the state of Texas $14,561.

Audit of Mission Road Developmental Center: A Texas Medicaid Home And Community-Based Services Program Provider. The OIG conducted an audit of Mission Road Developmental Center (Mission Road), an HCS provider, to determine whether documentation to support fee-for-service claims for residential support services and supervised living submitted by and paid to Mission Road existed and were completed according to the HCS provider agreement and with state rules and guidelines, and if authorizations for other billed HCS existed and were signed according to the HCS provider agreement and with state rules and guidelines.

Mission Road provides HCS in San Antonio and processed 63,824 Medicaid claims through the HCS program during the audit period of June 1, 2015, through May 31, 2016, for which it received reimbursements of more than $5.2 million. HCS is the largest Texas Medicaid Long-Term Services and Supports (LTSS) program with expenditures of $947 million in state fiscal year 2015. The HCS program provides more than 20 individualized services and supports to persons with intellectual disabilities who are living with their family, in their own home, or in other community settings such as small group homes.

The OIG found that Mission Road did not comply

with the HCS provider agreement or with state rules and guidelines for documentation associated with 14 of 398 claims associated with 60 Service Delivery Logs tested. Specifically, Mission Road did not always ensure providers signed service delivery logs, and did not always document services provided to clients on service delivery logs. Of the 60 service delivery logs tested, 8 were missing signatures, impacting 13 claims for which HHSC paid Mission Road $1,938.31, and one included a documentation error, impacting one claim for which HHSC paid Mission Road $143.19.

The OIG recommended that Mission Road should ensure that providers who deliver services appropriately sign service delivery logs and fully and accurately document billable services on service delivery logs. Mission Road should reimburse HHSC $2,081.50 for claims that did not have sufficient supporting documentation.

Security Controls Over Confidential HHS System Information – Amerigroup Texas, Inc. The OIG conducted an audit of Amerigroup Texas, Inc. (Amerigroup) to assess the design and effectiveness of selected security controls over confidential HHS System information stored and processed by Amerigroup. Amerigroup is a licensed MCO that contracts with the state of Texas to provide Medicaid and CHIP services through its network of providers. As an MCO for Medicaid and CHIP program recipients, Amerigroup processes and pays medical provider claims, which contain protected health information and other confidential information. Amerigroup is required to protect and secure HHS System information according to criteria established in the Uniform Managed Care Contract. The OIG examined selected information technology controls and related activities at Amerigroup.

Audit results indicated that Amerigroup designed and implemented effective security controls in all evaluated areas except for the frequency it reviewed access logs to its data center. Amerigroup, consistent with its internal policy, conducted quarterly reviews of data center access. HHS Information Security Controls, however, requires monthly reviews of access logs. Amerigroup initially provided limited, redacted, or no information at all in response to the majority of requests for evidence of activities and controls in place to protect confidential HHS System information. Amerigroup did not provide the outstanding information until June 2018, six months after the OIG initially requested the information.

The OIG recommended that MCS should consider tailored contractual remedies to address Amerigroup's delay in complying with the OIG's request for information. In addition, MCS should require Amerigroup to effectively review physical access logs on a monthly basis and update related internal policies according to the HHS Information Security Controls.

Audit Of Lakes Regional MHMR Center: A Texas Home And Community-Based Services Program Provider. The OIG conducted an audit of Lakes Regional MHMR Center (Lakes Regional), an HCS provider, to determine whether documentation to support fee-for-service claims for residential support services and supervised living submitted by and paid to Lakes Regional existed and were completed according to the HCS provider agreement and with state rules and guidelines, and if authorizations for other billed HCS services existed and were signed according to the HCS provider agreement and with state rules and guidelines.

Lakes Regional provides HCS to clients in 12 counties in northeast Texas. It processed 58,917 Medicaid claims through the HCS program during the audit periods of June 1, 2015, through January 31, 2016, and May 1, 2016, through August 31, 2016, for which it received reimbursements of nearly $4.7 million. HCS is the largest Texas Medicaid LTSS program with expenditures of $947 million in state fiscal year 2015. The HCS program provides more than 20 individualized services and supports to persons with intellectual disabilities who are living with their family, in their own home, or in other community settings such as small group homes.

The OIG found that Lakes Regional did not comply with the HCS provider agreement or with state rules and guidelines for documentation associated with 39 of the 407 claims associated with the written service logs tested, resulting in $5,475.02 in unsupported Medicaid reimbursements. Lakes Regional did not always ensure providers signed written service logs, did not always document services provided to clients on written service logs, and did not always document client offsite visits correctly. HCS Program Billing Guidelines state that claims must be supported by written documentation, including a written service log written and signed by the provider who delivered the service.

The written service logs tested, associated with a sample of 60 weeks in which there were paid claims for residential support services or supervised living for a unique client,

were missing:

- Signatures to support 8 claims, for which HHSC paid Lakes Regional $1,159.91.
- The specific services provided for 25 claims, for which HHSC paid Lakes Regional $3,509.35.
- Specific documentation for clients visiting family members or friends away from the client's residence for 6 claims, for which HHSC paid Lakes Regional $805.76

The OIG recommended that Lakes Regional should ensure that providers who deliver services appropriately sign written service logs, fully and accurately document billable services on written service logs, and fully and accurately document client offsite visits with family members or friends on written service logs. Lakes Regional should reimburse HHSC $5,475 for claims that did not have sufficient supporting documentation.

Audit of Cystic Fibrosis Services, Inc's Vendor Drug Program. The OIG conducted an audit of Cystic Fibrosis Services, Inc.'s VDP claims to determine whether Cystic Fibrosis Services, Inc. properly billed VDP for Medicaid claims submitted, and complied with contractual and TAC requirements for the period of May 1, 2013, through February 28, 2015. The auditors tested documentation supporting claims contained in two separate samples selected from a population of 14,227 claims Cystic Fibrosis Services, Inc. submitted to VDP for reimbursement during the audit period. One sample contained 120 initial fill claims. The other sample included 120 refill claims. Results indicated that Cystic Fibrosis Services Inc. complied with Texas Medicaid requirements.

Inspections

Duplicate Capitation Payments to Managed Care: Inspection of Duplicate Capitation and the Texas Medicaid System: The OIG conducted an inspection to determine if Texas Medicaid processes identify or prevent duplicate capitation payments to MCOs for clients enrolled in both Medicaid and CHIP. The OIG wanted to establish why clients are enrolled in both CHIP and Medicaid and whether processes may reduce incidence of duplicate capitation payments to MCOs.

Medicaid and CHIP have different eligibility requirements. Clients should not be enrolled in both programs at the same time. When individuals apply for health coverage, the application is first screened for Medicaid eligibility. If determined ineligible for Medicaid, the application is then screened for CHIP eligibility.

The inspection found that eligibility and enrollment information exchanged between the Texas Integrated Eligibility Redesign System and MAXeb is not processed without errors. The result is duplicate coverage for clients in both Medicaid and CHIP, and duplicate capitation payments paid in error to MCOs. Data was examined for the period of June 2015 through January 2018. The OIG identified Medicaid and CHIP capitation payments totaling just under $2.7 million made for 2,996 Medicaid ID numbers.

Annual reports

The OIG issued this quarter the following required annual reports for fiscal year 2018:

- Joint Annual Report on Fraud and Abuse in Medicaid, compiled by the OIG and the Office of Attorney General's (OAG) Medicaid Fraud Control Unit, is a joint interagency report on the coordinated efforts between the OIG and OAG on fraud.
- Annual Report of State Hospital Investigations is a report on the number and types of investigations at state hospitals.
- Annual Report of State Supported Living Center Investigations is a report on the number and types of investigations at state supported living centers.
- Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations is a report on the amount of recoveries made by MCOs and DMOs not referred to the OIG, or referred but returned to the MCO or DMO.
- Consolidated Senate Bill 30 Report is a report on eligibility and timely recoveries made through the data matching efforts from HHSC with Information from Neighboring States and the Texas Department of Criminal Justice.
- The Public Assistance Reporting Information System (PARIS) U.S. Department of Veterans Affairs (VA) Match Report is an overview of project information from Texas Health and Human Services, Texas Veterans Commission, and Texas Veterans Land Board to analyze and data received from PARIS in ways that generate fiscal savings for the state, improve communication to veterans, and maximize the availability of and access to benefits for veterans.

Stakeholder outreach

Legislative

OIG staff provided testimony at the House Committee on General Investigating and Ethics on interim charge 10, which monitors agencies and programs under the Committee's jurisdiction and oversees implementation of relevant legislation passed by the 85th Legislature. Staff primarily spoke on the OIG's report OIG Review of the HHS Procurement Process: 2013-2018.

IG Sylvia Hernandez Kauffman presented the OIG's Legislative Appropriation Request for Fiscal Years 2020-21 in a joint budget hearing of the Governor's Office of Budget and Policy and the Legislative Budget Board.

IG Kauffman met House Human Services Chairman Richard Raymond to discuss provider enrollment issues. She also attended a town hall on managed care hosted by Rep. Raymond and attended by agency staff, MCOs, and providers.

OIG staff met with these legislators to offer introductions and interim updates on fraud, waste, and abuse efforts at the OIG:

- Rep. Donna Howard
- Sen. Jane Nelson
- Sen. Dawn Buckingham
- Rep. J.D. Sheffield
- Sen. Charles Perry
- Rep. Giovanni Capriglione
- Rep. John Zerwas
- Rep. Bobby Guerra
- Sen. Royce West
- Rep. Ina Minjarez

Regional visits

IG Kauffman met with Sen. Royce West, Parkland Hospital staff, and MHMR (My Health My Resources) of Tarrant County staff in Dallas to discuss program integrity. IG Kauffman also visited with staff at the Mexia State Supported Living Center.

OIG staff met with the Grimes County district attorney (DA) in Anderson, Texas, to discuss accepting the OIG's prosecution cases. Staff attended a meet and greet with the Parker County DA to discuss prosecution cases and new initiatives to file more cases now that the Dallas area office is fully staffed. OIG staff met with the Taylor County assistant DA and Pecos County DA to discuss the type of cases the OIG submits and its budgeting policy to determine restitution.

Medical association meetings

OIG staff met with representatives of the HHSC Medical and Social Services Division's Medicaid and CHIP Services, Texas Health Care Association, Leading Age, Texas Medicaid Coalition, and nursing facility providers at its quarterly Nursing Facility Utilization Review (NFUR) Stakeholders meeting in September. They discussed trends and quality control reports, an NFUR proposed rule change, and provided a draft survey on improving telephone exit processes for nursing facilities. Other topics included electronic clinical records and affidavits, and restorative nursing.

OIG staff met with representatives of the HHSC Medical and Social Services Division's Medicaid and CHIP Services, hospital associations, and health plan associations at its quarterly Hospital Utilization Review Stakeholders meeting in October. They provided information on hospital claims quality control, saw a presentation on diagnosis-related group coding, and discussed how to improve the process for coding reviews.

IG Kauffman gave a presentation at the annual Texas Association of Health Plans meeting in Houston on the role of the Inspector General in Medicaid managed care.

OIG staff gave a presentation at the annual Texas Association for Home Care & Hospice Convention in San Antonio on the inspection of the Electronic Visit Verification System.

OIG staff met with MCO SIUs this quarter to discuss the rollout of prepayment reviews, and to discuss medical record review findings and fraud, waste, and abuse schemes.

OIG staff met with Texas Academy of Pediatric Dentistry staff for education and outreach in the forms of webinars and conference presentation for them next year.

Texas Pharmacy Magazine Features OIG chief pharmacy officer

Texas Pharmacy Magazine featured OIG Chief Pharmacy Officer Catherine Coney in its fall 2018 edition, highlighting the OIG's focus on monitoring potential fraud, waste, and abuse in Medicaid provider pharmacies; providing education and outreach to stakeholders, such as the Texas Pharmacy Association, on pharmacy issues; and the OIG's Lock-in Program to prevent the abuse of

prescription drugs.

Focus groups

The team developing the OIG Managed Care Transition Plan met with internal and external stakeholders, including HHSC Medicaid and CHIP Services staff and focus groups, to gather input about managed care as it relates to fraud, waste, and abuse.

HHSC and MCS

- HHSC Financial Services -Actuarial Analysis
- MCS Finance Reporting & Audit Coordination
- MCS Results Management
- MCS Program Enrollment & Support
- MCS Pharmacy Benefits Management, Operations
- MCS Managed Care Contract Compliance and Operations
- MCS Medicaid Director's Office and Utilization Review
- MCS Quality & Program Improvement
- MCS Operations
- MCS Policy and Program Development and Medical Benefits
- MCS State Medicaid Deputy Director

Provider Groups

- Texas Association of Health Plans
- Texas Medical Association
- Texas Association of Community Health Plans
- Texas Hospital Association
- Texas Health Care Association

WIC program outreach

OIG WIC Vendor Monitoring Unit staff met with the federal WIC program's Vendor Management and Operations leadership to discuss program and policy updates, compliance activity results, and vendor issues.

The OIG WIC Vendor Monitoring Unit team conducted 98 onsite store reviews across the state. These visits are educational. The team conducts a review of the store's compliance with WIC policy and no penalties are assessed. These reviews give the store manager an opportunity to discuss the issues and challenges of the WIC program and receive recommendations from the OIG on more efficient labeling procedures, transaction processing best practices, and point of sale system issues.

Program Integrity Spotlight

Data Review: Medicaid Lock-in Program

Patient review and restriction programs, commonly called "Lock-in" programs, are used to restrict the overuse of medical services, such as prescription drugs. Lock-in programs operate by "locking in" an individual to one provider and/or pharmacy to prescribe/dispense certain prescription medication, like controlled substances, to prevent their abuse or overuse. Individuals enrolled in a lock-in program must receive all of their prescriptions from the pharmacy in which they are "locked." Generally, persons can be considered by the MCO or the state for Medicaid lock-in programs when a predefined threshold of prescriptions of controlled substances, provider visits, or both are reached.

Federal regulations authorize states to operate lock-in programs. The OIG manages and operates the Texas Lock-in Program. The Texas Administrative Code and the Texas Medicaid Provider Procedures Manual give additional guidance about their operation and eligibility requirements. Medicaid contracts require managed care organizations (MCOs) providing services to persons enrolled in STAR, STAR+PLUS, STAR Health, and STAR Kids to maintain written policies to operate lock-in programs. MCOs are required to submit documentation annually to the OIG.

Medicaid Lock-In Program Referrals From MCOs

Referrals to place individuals in the program are submitted to the OIG by a provider, the public, law enforcement, and Medicaid MCOs. The majority of referrals come from MCOs. In fiscal year 2015, the OIG received 550 referrals from MCOs; in fiscal year 2016, 444; and in fiscal year 2017, 474.

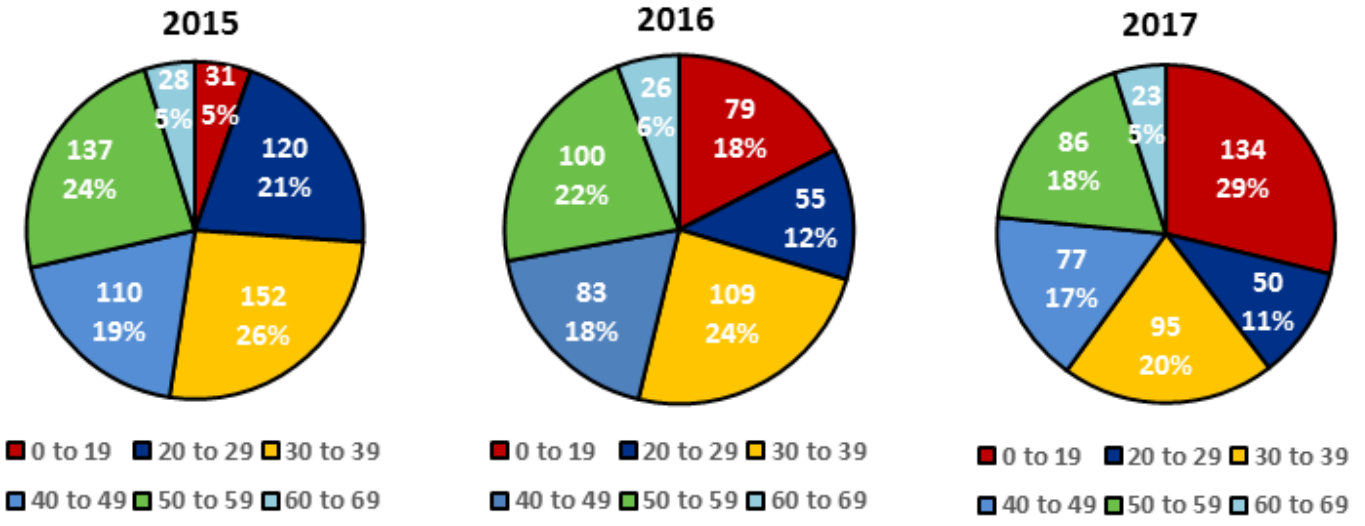
Per legislative direction in 2017 to increase participation in the Lock-in Program, the OIG collaborated with the MCOs to establish revised criteria that lowered thresholds for referral to the program. The new criteria takes advantage of some of the monitoring tools available to MCOs and their pharmacy benefit managers. These tools include morphine equivalent dosing, which determines a patient's total intake of any opioid class drugs within 24 hours.

Referrals For Youth Increasing

The demographics of persons MCOs have referred to the Lock-in Program have shifted since state fiscal year 2015. At that time, youth ages 0 to 19 accounted for 5 percent of referrals, while adults between the ages of 20 to 59 accounted for 90 percent of the referrals. However in state fiscal year 2016, referrals for youth ages 0 to 19 increased to 18 percent. In state fiscal year 2017, referrals for youth ages 0-19 increased further to 29 percent and represented the largest percentage of referrals for any age group since 2015.

Nationally, young adults between ages 18 to 25 are the most frequent users of prescription drugs for non-medical

Medicaid Managed Care Lock-in Program Referrals by Age Group and State Fiscal Year, 2015 to 2017



Note: In state fiscal year 2015, data was insufficient to determine the age of 1 person; in state fiscal year 2016, data was insufficient to determine the age of 7 persons and in state fiscal year 2017, data was insufficient to determine the age of 2 persons.

use than other age groups, according to the National Institute on Drug Abuse. In Texas, lock-in referrals for young adults age 18 to 25 have decreased since state fiscal year 2015. However, referrals for youth age 11 to 17 have dramatically increased, by 1,000 percent, from state fiscal year 2015 to 2016 and a further 115 percent increase in state fiscal year 2017. Driscoll, an MCO that serves youth age 20 and younger, is responsible for almost all the referrals in state fiscal year 2017 for youth age 11 to 17.

Future Issues

Lock-in restrictions for prescriptions can be avoided by clients if they pay out of pocket for the medication instead of allowing Medicaid to cover the cost and documenting the transaction with a claim. Prescription monitoring programs (PMP) are one way to improve detection of persons exploiting this regulatory gap. PMPs are databases that collect and analyze controlled substance prescription information submitted by pharmacies. Prescribers and dispensers of medication can access the PMP to view patient history of controlled substances regardless of payment source. As part of the OIG responsibility to detect fraud, waste, and abuse in Texas Medicaid, the OIG will be seeking access to the PMP database to identify patterns of patient and physician behavior that may be abusive or unnecessary use of controlled substances.

To read the complete Data Review on the Medicaid Lock-in Program, visit the OIG website:

https://oig.hhsc.texas.gov/reports?category%5B%5D=26

Division performance

Inspections and Investigations

The OIG Inspections and Investigations divisions were combined in 2018 to form the Inspections and Investigations Division.

Inspections inspects HHS programs, systems, and functions for fraud, waste, abuse, and systemic issues in order to improve the HHS System and help assess risk in the 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.

Investigations is comprised of the State Centers Investigative Team and the Electronic Benefit Transfer 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 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	$34,381
Cases opened	26
Cases completed	71

State Centers Team performance

Overpayments identified (EBT trafficking)	$24,052
Cases opened	175
Cases completed	180

Cooperative Disability Investigations Team performance

Overpayments identified	$113,127
Cases completed	3

Inspections report issued

- Duplicate Capitation Payments to Managed Care

Inspections in progress

- Durable Medical Equipment - Power Wheelchairs
- Ineligible Enrollment
- Managed Care Organization (MCO) Complaints (Series I)
- MCO Complaints (Series II)
- MCO/Pharmacy Benefit Managers - Monitoring of Pharmacies
- Personal Care Services - Attendant Background Checks
- Value Based Purchasing (Series 1)
- Program Integrity of Provider Directories (Network Adequacy)
- Eligibility Determinations for Out-of-State Clients

Inspections performance

Overpayments recovered	$0
Overpayments identified	$2,695,832

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 and is the single point of contact with the Centers for Medicare & Medicaid Services for Unified Program Integrity Contractors (UPIC) audits and Payment Error Rate Measurement (PERM) activities.

Audit performance

Overpayments recovered	$2,365,859
Overpayments identified	$26,384,484
Audit reports issued	8

Audit reports issued

- Audit of Medicaid and CHIP MCO Special Investigative Units: Blue Cross and Blue Shield of Texas
- Audit of Coastal Plains Community Center: A Medicaid HCS Provider
- Audit of Passage of Youth Family Care Center, Inc.: Child-Placing Agency Residential Child-Care Contract with the Texas Department of Family and Protective Services
- Audit of Avita Drugs: A Texas Vendor Drug Program Provider
- Audit Of Lakes Regional MHMR Center: A Texas Home And Community-Based Services Program Provider
- Security Controls Over Confidential HHS System Information – Amerigroup Texas, Inc.
- Mission Road Developmental Center: A Texas Medicaid Home And Community-Based Services Program Provider
- Audit of Cystic Fibrosis Services, Inc.'s Vendor Drug Program

Audits in progress

The Audit Division had 27 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
- Third-party recovery activities managed or performed by a claims administrator
- IT security and business continuity and disaster recovery planning assessment
- Speech therapy providers
- Home and community-based services providers
- Medicaid air ambulance providers
- Medical transportation program vendor performance
- MCO STAR Kids and STAR Health programs
- Dental maintenance organization performance
- MCO STAR+PLUS waiver program
- MCO service coordination
- Statewide nursing facility therapy service analysis
- DFPS child-specific contract payments

Medicaid Program Integrity

The Medicaid Program Integrity Division (MPI) investigates and reviews allegations of fraud, waste, and/or abuse 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 Office of Attorney General's Medicaid Fraud Control Unit when there are indications of criminal Medicaid fraud.

Now part of the MPI Division, the Medical Services unit 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 unit provides clinical consultation to the Investigations, Audit, and Inspections divisions on dental, medical, nursing, and pharmacy services.

Medical Services includes the Clinical Subject Matter Expert team (a physician, dentist, dental hygienist, and pharmacist) who provide clinical expertise to all OIG areas; the Acute Care Surveillance team, which identifies patterns of aberrant billing, performs Surveillance Utilization Reviews required by the federal Centers for Medicare & Medicaid Services, develops and runs targeted data queries to identify acute care billing outliers, and collects Medicaid overpayments; and the Quality Review team, which conducts retrospective utilization reviews of hospitals and nursing facilities, and administers the pharmacy Lock-in Program.

Medicaid Program Integrity performance

Preliminary investigations opened	452
Preliminary investigations completed	521
Full-scale investigations completed	61
Cases transferred to full-scale investigation	79
Cases referred to AG's Medicaid Fraud Control Unit	88
Open/active full-scale cases at end of quarter	145

Medical Services performance

Acute Care provider recoveries	$1,498,264
ACS identified MCO overpayments	$978,366
Hospital UR recoveries	$4,226,871
Hospital UR claims reviewed	6,257
Hospital AR claims recoveries	$1,428,277
Nursing facility UR recoveries	$52,102
Nursing facility reviews conducted	60

Third Party Recovery

The Third Party Recovery (TPR) Division includes the Third Party Liability (TPL) unit and the Medicaid Estate Recovery Program (MERP). TPL works to reduce Medicaid expenditures by shifting claims expenses to third-party payers. TPL ensures Medicaid is the payer of last resort through cost avoidance and recovery efforts and other cost containment initiatives. Approximately 7 percent of people with Medicaid have other health insurance, which allows Medicaid to shift costs to the other insurance carrier. The Texas Medicaid & Healthcare Partnership (TMHP) operates the TPL program on behalf of HHSC, but TPL staff oversees those operations and provides program and policy guidance to TMHP, other HHSC areas, MCOs, and stakeholders.

The Omnibus Budget Reconciliation Act of 1993 requires all states to attempt to recover the costs paid by Medicaid for long-term care benefits received by Medicaid clients, 55 years and older, who applied for certain long-term care services. Texas implemented MERP in 2005, and it is only applicable to the estates of these Medicaid clients upon their death. Texas outsources the majority of the daily operations of MERP to a contractor, but MERP staff oversees those operations and provides program and policy guidance to the vendor, other HHSC areas, and stakeholders.

Third Party Recovery performance

Dollars recovered	$76,065,346
Cost avoidance	$29,459,353

Benefits Program Integrity

The Benefits Program Integrity 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.

Benefits Program Integrity performance

Overpayments recovered	$4,236,305
Cases completed	3,646
Cases opened	3,809
Cases referred for prosecution	29
Cases referred for Administrative Disqualification Hearings	214

Chief Counsel

The Chief Counsel Division provides legal counsel to the IG and all OIG divisions so that each division is best able to accomplish the OIG mission. The Chief Counsel Division includes:

Litigation: The Litigation section receives referrals from Investigations 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 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 performance

Investigations completed	77
Cases with sustained allegations	23

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 (OSI) develops and implements OIG-wide related initiatives and special projects, and coordinates and performs complex research concerning program integrity activities related to Texas HHS programs. OSI also provides expert assistance and advice on coordinating and implementing OIG cross-functional projects and strategic initiatives.

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.

Operations performance

Provider enrollment inventory (applications and informal desk reviews) processed	31,191
Individual screenings processed	8,498
Fraud hotline calls answered	6,986

Chief Strategy Office

The Chief Strategy Office includes the Government Relations, Public Affairs and Publications, Policy, and Data and Technology (DAT) units. 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 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.

DAT 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.

Data and Technology performance

Data requests received	220
Data requests completed	219
Outliers identified through data analytics for the Behavioral Health II Fraud Detection Operation (FDO)	97
Outliers selected by MPI for FDO	3
Algorithms run	51
New algorithms developed	10

Policy and Publications report issued

- Data Review: Medicaid Lock-in Program

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