Quarterly Report

Quarter 3

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 third 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.

During this quarter, the OIG recovered nearly $145 million, an outstanding amount that reflects the hard work, focus and dedication of the OIG team. In addition, nearly $43 million was identified for potential future recoveries, and another $43 million was achieved in cost avoidance by deterring potentially questionable spending before it occurs.

As health care delivery in Texas continues to evolve, the OIG is also changing to keep pace. This quarter we implemented an organizational update that aligns similar functions in mission-critical work and enhances the office's efficiency and innovations in the managed care environment. The OIG will continue to evaluate how we do our work and take any needed steps to ensure that we are able to achieve our mission.

The OIG has four core values that guide us in our mission: Accountability, Integrity, Collaboration, and Excellence. This office is committed to protecting the integrity of Texas health and human services programs, and to making sure that funds dedicated to providing services to those who need them are spent only for their intended purpose. The OIG team is committed to that mission and embodies those values every day. I am honored to work with them.

Respectfully,
Sylvia Hernandez Kauffman

Quarter 3 results

Dollars recovered

Audit	
Collections	$604,784
Inspections	
WIC collections	$1,085
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$17,854,012
Voluntary repayments by beneficiaries	$86,659
Medicaid Program Integrity	
Provider collections	$8,248,012
Acute care provider collections	$946,485
Hospital collections	$5,344,124
Nursing facility collections	$3,329
Third Party Recoveries	
TPR recoveries	$111,656,471
Peace Officers	
EBT Trafficking team collections	$99,432
Total dollars recovered	**$144,844,393**

Dollars identified for recovery

Audit	
Provider overpayments	$360,943
Inspections	
WIC vendor monitoring	$0
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$11,766,641
Medicaid Program Integrity	
MCO identified overpayments	$6,499,364
Medical Reviews	
Acute care providers	$1,036,253
Hospitals	$5,398,204
Nursing facility overpayments	$599,571
Third Party Recoveries	
RAC audits	$12,977,273
Peace Officers	
EBT trafficking	$4,334,878
Total dollars identified for recovery	**$42,973,127**

Cost avoidance

Inspections	
Vendor disqualifications	$0
Benefits Program Integrity	
Client disqualifications	$1,605,550
Medicaid Program Integrity	
Medicaid provider exclusions	$101,124
Medical Reviews	
Pharmacy Lock-In	$1,414,010
Third Party Recoveries	
TPR	$39,892,130
Peace Officers	
Disability Determination Services	$193,932
Total cost avoidance	**$43,206,746**

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	$99,432
Dollars identified for recovery	$4,334,878
Cost avoidance	$193,932
Completed cases involving OIG peace officers	248

Trends

Medicaid Program Integrity

The Medicaid Program Integrity (MPI) Division's provider field investigations initiated 79 investigations related to 10 provider types during the quarter. A number of cases were opened based on data analytics that suggest potential Medicaid program violations in behavioral health. Among the provider types that bill for these services are licensed professional counselors, clinical psychologists and psychology group practices. MPI is currently examining providers for possible program violations related to:

- Billing for higher-paying psychotherapy codes when a lesser-paying code is appropriate, also known as upcoding;
- Billing for an impossible number of timed procedure codes in a single day;
- Exceptionally high rates of annual reimbursement for an individual provider when reviewed against their provider type peer group;
- Billing for services not rendered.

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

- **After-hours services settlements.** The OIG reached a settlement in March with a physician in Pharr for $297,549. The investigation determined that the provider was reimbursed for after-hours services when reimbursement was not appropriate, as per managed care organization and Texas Health and Human Services (HHS) program policy. After-hours services include office visits and other services, which are reimbursed at a higher rate than services provided during regular business hours. In a similar after-hours case, OIG settled in March with a physician practice in Mission for $61,310.
- **Dental provider settlement.** The OIG reached a settlement with a dental provider in Garland who was found to have been reimbursed for medically unnecessary services. Allegations against the provider included extractions of teeth that would have shed on their own and overutilization of x-rays. The provider also was alleged to have wrongfully solicited patients in violation of Medicaid policy. OIG reached a settlement in March for $150,000.
- **Durable medical equipment settlement.** The OIG reached a settlement with a durable medical equipment provider in Corpus Christi. The investigation found that the provider violated Medicaid policy by failing to maintain proof of delivery slips for spacers and to maintain documentation to support items billed. OIG reached a settlement with the provider in April for $119,099.

Types of complaints received by MPI

Attendants	46%
Physician (individual, clinic, or group practice)	15%
Dental	8%
Home health agency	8%
Durable medical equipment	4%
Pharmacy	3%
Nursing facility	3%
Adult day care	2%
Hospital	2%
Lab/radiology/X-ray	1%

Types of MPI field provider investigations

Physician (individual, clinic, or group practice)	30%
Dental	18%
Attendants	14%
Durable medical equipment	13%
Home health agency	10%
Lab/radiology/X-ray	8%
Therapy — Counseling	3%
Dialysis	3%
Adult day care	1%
Rehabilitation center	1%

Benefits Program Integrity

The Benefits Program Integrity (BPI) division opened 2,587 investigations involving some form of benefit recipient overpayment or fraud. Eighty percent involved unreported income (30 percent) or an issue with the reported household composition (50 percent). Household composition cases usually involve an unreported household member who has income but could also include a household member who does not actually live in the same residence. Both instances cause the household to receive more benefits than it is entitled to. Other types of opened investigations (20 percent) include prison matches,

felony drug convictions, felony fugitive matches or dual participation of benefits in other states.

BPI completed 311 investigations where fraud was found. BPI referred 36 investigations for prosecution and 275 for an administrative disqualification hearing. Ninety percent of fraud investigations completed involve either unreported income (17 percent) or an issue with the reported household composition (73 percent).

A sample of cases worked by BPI this quarter include:

- **Fraudulently obtained benefits.** BPI resolved a case with the Hays County District Attorney in April regarding a former HHS employee who fraudulently obtained benefits. While employed as an HHS advisor, the individual received Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF) and Medicaid benefits using family and friends' biographical information from approximately November 2008 through May 2014. The employee was charged with theft and ordered to pay $45,000, disqualified from the SNAP program, and placed on 10 years' probation.
- **Household composition.** BPI resolved a case involving a SNAP client who had continuously renewed SNAP benefits since 2017. The client from Potter County reported herself and six children in the home and, for each instance, failed to report the children's father in the home and his employment. At the end of the BPI investigation, an overpayment claim was submitted for administrative disqualification. In March, the client signed a waiver of disqualification, was disqualified for 12 months, and was ordered to repay $18,820.

EBT Trafficking Unit

This quarter, the Electronic Benefits Transfer (EBT) unit completed 79 investigations and presented another 34 investigations for either administrative disqualification hearings (23) or prosecution (11).

Trends identified by the unit include:

- **Excessive SNAP card replacement.** The EBT Trafficking Unit utilized data analytics to identify a trend of SNAP recipients receiving an excessive number of replacement cards in a 12-month period. This fluctuation, a possible indicator of fraudulent activity, was discovered through a Food and Nutrition Service (FNS) audit. OIG staff initiated investigations and a process to communicate results of the research and investigations with HHS Access and Eligibility Services.
- **Selling SNAP benefits.** In addition, the unit identified and continues to monitor trends regarding the selling of SNAP benefits for illegal activities. One of the trends EBT identified involves non-recipient business owners fraudulently obtaining SNAP benefits by illegally purchasing SNAP cards for 50 cents on the dollar and using SNAP to purchase supplies and products for their own business. Another illegal activity involves SNAP recipients trading their benefits for cash to pay for illegal gaming, such as casino-style, eight-liner slot machines.

A sample of cases worked by EBT this quarter include:

- **SNAP indictments.** The EBT Unit investigated allegations of SNAP recipients receiving unauthorized refunds provided by a retailer in Dallas. The investigation, which involved 41 recipients who received $1,000 or more for their SNAP benefits, resulted in identified recoveries of $165,236. The district attorney's office indicted 26 recipients. Thus far, 10 people have been found guilty and permanently disqualified from SNAP.
- **Retailers disqualified.** The EBT Trafficking Unit received an allegation that a Corpus Christi retailer's transaction history showed a pattern of high-dollar questionable SNAP transactions. These transactions were a dollar amount greater than the store size and inventory could support. The investigation determined that the retailer was allowing store credits that were later paid with SNAP benefits.

Internal Affairs

The Internal Affairs (IA) Division received 98 complaints in the third quarter alleging employee misconduct in the delivery of health and human services, employee benefits fraud, and other issues. IA investigated 37 of those complaints with the remaining referred to the appropriate business areas including the Department of Family and Protective Services (DFPS) Office of Consumer Relations and HHS.

Trends identified by the unit include:

- **Employee benefits fraud.** IA saw an increase in complaints involving alleged employee benefits fraud, from 1 in the second quarter to 14 in the third quarter of fiscal year 2019. Ten of the seventeen cases were sustained and sent to Administrative Disqualification Hearings. The cases included $56,166 of fraudulent activity. To date, four local district attorneys have agreed to review the cases for prosecution.
- **CPS perjury allegations.** IA saw an increase in perjury allegations involving the courtroom testimony of CPS caseworkers, from 9 in quarter 2 to 19 in quarter 3 of fiscal year 2019. Although the number of complaints increased, there were zero sustained perjury cases against CPS caseworkers in either quarter.

A sample of cases worked by IA this quarter include:

- **DFPS contractor indicted.** A Travis County Grand Jury indicted a DFPS contractor for aggravated theft and tampering with a governmental record related to billing for therapy services not provided.
- **HHS employee charged.** A former HHS contractor is accused of forging government records to obtain a state job. The IA investigation found that the contractor utilized a fictitious degree and fictitious surveyor certification during the application process. The case was referred to the Travis County Attorney for criminal prosecution. Charges include tampering with a governmental record and forgery.

State Centers Investigations Team

The OIG's State Center Investigations Team (SCIT) opened 166 investigations and completed 169 investigations in the third quarter, with an average completion time of 24 days. This compares to 183 opened investigations and 194 completed investigations in the second quarter of fiscal year 2019. In the third quarter of 2018, SCIT opened 239 investigations and completed 273 investigations.

During the third quarter, several suspects were sentenced in SCIT cases. At the Brenham State Supported Living Center, a suspect was accused of assaulting a client. Subsequent interviews and review of video confirmed the allegation. The Washington County District Attorney accepted a plea agreement, with the suspect sentenced to two years community supervision and imposed court costs. In another case, a suspect plead guilty after assaulting a client at the Rio Grande State Hospital. The client suffered minor injuries. The Cameron County District Attorney accepted a plea agreement, with the suspect sentenced to five years of community supervision and ordered to pay court costs.

Type of cases closed by IA this quarter

Benefits fraud	17
HHS agency or law enforcement assistance	12
Perjury	10
Privacy incident/breach	9
Falsifying records	9
Criminal misconduct	7
Vital records fraud	3
Conflict of interest	1
Contract fraud	1
Misuse of state property	1

Rule proposals

Closing investigations amendment

Proposed amendments to 1 TAC §§371.1305, 371.1307, and proposed new rule 1 TAC §371.1312, related to closing investigations, were published in the Texas Register for formal comment from March 22, 2019 through April 21, 2019. The OIG received comments from one stakeholder group. The final rules will be adopted in the fourth quarter of 2019. These rules outline the criteria for opening, prioritizing and closing preliminary, full-scale and recipient investigations. The amendments and new rule clarify the criteria the OIG uses to close these investigations. This rule provides greater transparency into the office's investigative processes.

HB 2379: MCO referrals and recoveries

Proposed amendments to 1 TAC §353.502, §353.505, and §371.1311 related to HB 2379 were published in the Texas Register for formal comment from March 22, 2019 through April 21, 2019. HB 2379 specifies MCO procedures for providing notice of and recovering payments made as a result of fraud or abuse investigations. The OIG received comments from one stakeholder group. The final rules will be adopted in the fourth quarter of 2019. The proposed amendments would align the rules with HB 2379 (85th Legislative Session) and update changes to MCO referral procedures.

Agency highlights

OIG announces realignment

OIG implemented an organizational realignment to enhance the work of protecting the integrity of health and human services programs in Texas. The new office structure aligns similar functions in mission critical work and supports the agency's innovations in the managed care environment. The changes were effective April 1 and include:

- The Chief Strategy Office was expanded to include Audit. The Strategy and Audit Division now includes Audit, Policy, and Data and Technology.
- Communications, Government Relations and the Office of Strategic Initiatives were combined to form the External Relations Division. This division focuses on engaging OIG stakeholders and leading agency initiatives and special projects and is led by the chief of staff.
- The Inspections and Investigations Division was expanded to include Benefits Program Integrity (BPI), which investigates allegations of overpayments related to HHS program clients enrolled in SNAP, TANF, Medicaid, Children's Health Insurance Program (CHIP) and WIC.
- The Operations Division was expanded to include Third Party Recoveries, which helps reduce Medicaid expenditures by shifting claims expense to third party payers utilizing either cost avoidance or cost recovery.
- Medicaid Program Integrity Division was expanded to include Program Enrollment Integrity Screening, which is responsible for conducting certain federal- and state-required screening activities for providers seeking to enroll in Medicaid, CHIP and other state health care programs.

Legislative session concludes

The regular session concluded on May 27 with Texas lawmakers adopting a budget that fully funded the OIG. The upcoming fiscal year 2020-21 budget matches fiscal year 2018 spending levels. As part of the OIG's exceptional item request, legislators also funded five additional full-time MPI-BPI investigator positions. The budget also requires the OIG to continue reviewing MCO cost avoidance and waste prevention activities, with new reporting requirements on the OIG's efforts to combat fraud, waste and abuse in Medicaid managed care programs.

This session, more than 300 bills were filed that affected the OIG. OIG staff worked cross-divisionally to identify and analyze the impact these pieces of legislation would have on the agency. The OIG was asked on several occasions to be available as a resource witness for members' bills.

Legislators adopted several bills that impact the OIG:

- S.B. 619 moves the limited-review of the OIG by the Sunset Commission to 2023 from 2021.
- S.B. 241 eliminates the quarterly Electronic Benefits Trafficking Report sent to the Comptroller, by request of the OIG's EBT team. S.B. 241 also eliminates unnecessary recipients of SCIT investigation reports.
- S.B. 2138 requires the OIG and HHS's appeals units to comply with federal coding guidelines, which are already used by MPI Medical Services.
- S.B. 1207 will require TPR to work with HHS and MCOs to adopt a clear policy to ensure the coordination and timely delivery of Medicaid wrap-around benefits.

Quarter 3 data

Audit reports issued	2
Audits in progress	27
Inspections reports issued	1
Inspections in progress	8
Investigations completed (BPI, IA, Peace Officer)	4,137
Investigations opened	4,106
Medicaid provider investigations completed	
Preliminary	558
Full-scale	69
MPI cases transferred to full-scale investigation	75
MPI cases referred to Medicaid Fraud Control Unit	118
Hospital claims reviewed	2,491
Nursing facility reviews conducted	132
Medicaid and CHIP provider enrollment screenings performed	28,764
Medicaid providers excluded	96
Fraud hotline calls answered	6,447

Self-report leads to settlement agreement

A self-report by a provider to both the federal OIG and Texas OIG led to a successful collaboration between the state and federal agencies to achieve a settlement agreement for $7,000,000. Under the agreement executed in May, Texas will receive $1,400,000 to be paid semi-annually over seven years. The remaining amount will be collected by the federal government. The provider from Gaines County self-reported it improperly paid physicians more than the fair market value for their services in violation of the federal Anti-Kickback Statute.

Liquidated damages update

The OIG previously recommended liquidated damages (LD) to HHS Medicaid and CHIP Services (MCS) in the amount of $1.8 million that were assessed during the third quarter of fiscal year 2016 through the fourth quarter of fiscal year 2017. LD is one method OIG holds MCOs and dental maintenance organizations (DMOs) accountable when found to be non-compliant with program integrity requirements in their contracts. When found non-compliant, the OIG recommends to HHS that it assess LD. As of May 2019, $1.7 million in LD has been collected based on final assessments of the OIG's recommendations to HHS MCS. Contract non-compliance where the OIG has recommended LD include the lack of effectiveness of MCO special investigative units and MCOs delivering untimely and/or inaccurate documents when requested. The OIG continues to work on recommendations for HHS MCS related to identified issues of non-compliance for additional quarters.

OIG recommendations implemented for opioid prescriptions

HHS and MCOs are implementing recommendations from the Opioid Drug Utilization Inspection report published in May 2017.

The purpose of the inspection was to assess the effectiveness of the Texas Medicaid program at reducing prescription opioid abuse and to determine whether there are alternative programs that may further reduce opioid abuse. Opioids are controlled substances commonly prescribed for pain relief.

As a result of the inspection, HHS implemented in January 2018 morphine-equivalent dose limitations, measuring a patient's total opioid use across all prescriptions. When a patient exceeds specific dose limitations, the related claim is flagged for a prior authorization clinical review prior to dispensing. This change was a recommendation from the inspection report. Additionally, the report made recommendations limiting refills and days' supply of opioids, but new Federal requirements now require a new prescription to be issued for additional opioids. Refills are no longer allowed.

MPI analyzing results from Fraud Detection Operation

Medicaid Program Integrity (MPI) conducted its quarterly Fraud Detection Operation (FDO) in May. This was the 18th FDO led by MPI since August 2016. The investigative focus was on Chemical Dependency Treatment Facility providers. OIG's Data and Technology provided MPI with analysis to help select four providers from the list of identified outliers. The providers were located in Edinburg, Harlingen, Palmview and Taft, Texas.

During the five-day operation, MPI investigators collected records from the four providers and interviewed select staff. Additionally, investigators made telephonic and/or personal contact with clients for these providers where Medicaid had paid for services.

The OIG was able to collect testimonial and documentary evidence to preliminarily establish the existence of one or more program violations with respect to the selected outliers. The results of the FDO are under analysis.

MPI implements prepayment review

MPI implemented a prepayment review in April for a Pasadena provider who had been billing for allergy testing services that appeared to indicate over testing or inadequate testing. Prepayment review is a fraud, waste and abuse prevention tool that requires a provider to submit claims and supporting documentation before receiving payment for claims billed. MCOs assist this process by providing monthly billing updates for codes under review.

This is the first prepayment review implemented by the OIG and is a safeguard against the delivery of unnecessary services, to monitor quality of services and to ensure payments are appropriate. In the three months prior to the placement of the prepayment review, records reflects that the provider had been paid approximately $61,000, an amount more than twice what peers were being paid. Since implementation, the payments decreased to under $1,000.

El Paso team receives award

The El Paso BPI team is part of the Document Benefit Fraud Task Force (DBFTF), a joint task force that collaborates with federal, state and local law enforcement to identify and investigate fraud, waste and abuse in health and human services benefits. Homeland Security Investigations held its annual awards ceremony and presented the DBFTF with the "Best Team" award. The BPI team has been a part of the task force since 2015. During that time, the group's enforcement statistics include 58 arrests, 28 indictments, 25 convictions and the seizure of $610,000.

Hospice reviews underway

The OIG Nursing Facility Utilization Review unit is reviewing hospice residents in nursing facilities to determine if there are any emerging trends, such as issues with physician hospice recertifications, coordination of care or duplication of services. Residents are eligible for hospice care when their hospice provider has the required documentation that establishes a prognosis of six months or less to live. Texas Medicaid pays the hospice for room and board in the nursing facility based on the level of care.

OIG nurse reviews noted a trend of residents receiving extensive amounts of therapy during their final days in hospice. OIG wants to determine if services not appropriate for hospice are being billed, such as billing and payment for physical therapy. OIG is also reviewing medical necessity for hospice stays of more than 180 days and recertifications by the physician. The project plan includes a review of care plans, nursing facility and hospice records, nursing facility and hospice required forms and other records for a sample of hospice residents in nursing facilities. This initial review is expected to be completed by August 2019.

Medical Services utilized new tools for hospital screenings

In April 2019, the Texas Health and Human Services Commission, on behalf of OIG, awarded a contract to Change Healthcare, a privately held company affiliated with McKesson Corporation, for the use of their InterQual ® web-based evidence-based guidelines. In accordance with 1 Texas Administrative Code §371.204(a), the Hospital Utilization Review unit uses recognized evidence-based guidelines for inpatient hospital screening criteria in conducting utilization reviews, including the initial approval or the referral of reviews to physicians for medical necessity decisions. All Medical Services staff who conduct or oversee medical record reviews began online instructor-led and web-based training modules on the use of the InterQual® criteria in April.

OIG utilizing technology to improve efficiency

The Acute Care Surveillance team has implemented a process that saves providers time and money by allowing them to submit medical records online. This will reduce paper record submissions and improve the process of record review, retention and sharing with other reviewers when appropriate. Providers still have the option to submit paper records.

Electronic submission allows the provider to submit requested records without the expense of converting their electronic health records to paper copies and mailing the documents at their expense. Providers are assured by the OIG that HIPPA is maintained. Records do not need to be stored in paper either on site or offsite at the state's expense. Electronic submission was first utilized by MCOs in September 2018. Due to the positive response from MCOs, implementation was expanded in March to individual providers.

New OIG team collects delinquent recoveries

The OIG formed a Collections Unit to centralize collection of Medicaid overpayments from providers that are delinquent on repayment agreements. The unit also works to reclaim the federal share related to overpayments that are subsequently deemed uncollectible per federal regulations. Remedies to help OIG collection efforts include letters of demand, warrant holds, and contract terminations and exclusions from Texas Medicaid. The OIG Collections Unit also sends letters to managed care organizations as a reminder that prompt submittal of one half of provider overpayments collected by the MCO to OIG is required as directed by HB 2379 passed in 2017.

Medicaid actuary joins OIG

The OIG has hired an actuary through the end of state fiscal year 2019 to review the potential impact of OIG recommendations on Medicaid managed care payments and processes. The actuary will advise the OIG on the impact of overpayment recovery options in Medicaid managed care and provide guidance as the office moves further into examining Medicaid managed care issues.

Rolling audit plan updated

The OIG published its updated rolling audit plan in April 2019. The plan lists audit projects the OIG expects to initiate, as well as the objectives and scopes for audits in progress. Audits expected to be initiated are categorized into four focus areas: the prevention of fraud, waste and abuse; program integrity in Medicaid managed care; non-Medicaid programs and contracts; and selected provider audits.

To be responsive to continuously changing risks and an evolving environment, and to accommodate requests for audit services, the audit plan will be updated periodically. Updates could include revisions to the list of audits planned to be initiated and may reflect decisions to initiate audits that were not previously listed. The OIG also considers current priorities and the availability of staff members needed to form audit teams when determining which audits to initiate. The plan is available on the OIG website (https://oig.hhsc.texas.gov/audit)

OIG team offers new managed care training tools

The OIG's Research Development and Innovation (RDI) Team has created new resources for staff to continuously gain insight into the changing health care landscape. During this fiscal year, RDI focused on strengthening the OIG's work in managed care by identifying managed care topics for staff trainings, developing written materials and identifying internal expertise.

- **Trainings:** The OIG has established a series of trainings that bring in different areas from HHS MCS such as Managed Care Compliance and Operations to provide details on ongoing managed care oversight. This quarter, four trainings were offered to OIG staff.
- **Managed Care Reference Guide:** The OIG has developed an internal reference guide that provides information on managed care topics, such as member enrollment into a managed care plan and service delivery areas.
- **Subject Matter Expert Index:** The OIG is creating an inventory of staff with knowledge-based skills in managed care. The goal is to identify internal resources with prior experience in managed care topics to provide background information based on previous work to staff assigned to new managed care projects.

The OIG will continue to expand professional development opportunities as it moves into the next quarter and fiscal year.

Clarifying managed care requirements in contracts

MCOs now have a new chapter in the Uniform Managed Care Manual (UMCM) that consolidates specific deliverables to the OIG. The UMCM provides additional technical guidance for operationalizing contract requirements and defines specific deliverables. The new UMCM chapter that went into effect in April consolidates existing OIG deliverables and guidance into one place as an easily accessible reference for MCOs. The chapter includes information on six types of deliverables, provides a brief description of each deliverable, and includes references to applicable state and federal law, rules and guidance. For example, the chapter provides information about reporting suspected fraud, waste and abuse practices and specifics about how MCOs must develop a plan to prevent and reduce fraud, waste and abuse. The OIG will continually review the document to ensure it complies with statutory obligations.

Completed reports

Audit

Pharmacy Alternatives, LLC: A Texas Vendor Drug Program Provider. The audit determined whether Pharmacy Alternatives properly billed the Vendor Drug Program (VDP) for submitted Medicaid claims and complied with selected contractual and Texas Administrative Code (TAC) requirements. Pharmacy Alternatives processed 118,560 Texas Medicaid claims for prescriptions through the VDP during the audit period of May 1, 2013 through August 31, 2015.

Audit results indicated that for 75 of 231 sampled claims tested, Pharmacy Alternatives did not bill the VDP properly or comply with other contractual or TAC requirements. Sixteen claims were identified for recoupment at the dollar-for-dollar amount of $7,084. The remaining 59 claims totaling $22,583 were identified for extrapolated recoupment. The OIG applied these errors to all of the claims from which the sample was selected, resulting in an extrapolated overpayment amount of $256,938. There were also 75 claims which may be subject to penalty.

Auditors offered recommendations to Pharmacy Alternatives which, if implemented, will correct deficiencies in compliance with contractual and TAC requirements.

Fee-for-Service Claims Submitted by Longhorn Health Solutions, A Texas Medicaid Durable Medical Equipment and Supplies Provider. The audit evaluated whether documentation to support the authorization and delivery of fee-for-service DME and supplies associated with Medicaid claims submitted by and paid to Longhorn existed and were completed in accordance with state laws, rules and guidelines.

During fiscal year 2017, Longhorn submitted and was reimbursed for 39 claims totaling $1,784 with service dates more than 30 days after the beneficiaries' date of death. Additionally, Longhorn did not meet authorization requirements for DME and supplies for 839 of 2,003 claims in the general population, and 1,680 of 3,403 claims in the deceased population. The 839 general population claims with authorization issues resulted in $34,128 reimbursed in error. The 1,680 deceased population claims with authorization issues resulted in $61,010 reimbursed in error. The total amount due to the state is $96,922.

Longhorn agreed with the audit findings and indicated it has implemented processes to prevent future errors and plans to reimburse overpayment amounts.

Inspections

Member Complaints Received by Texas Medicaid: Series 1 - Inspection of Intake of Member Complaints. This inspection was conducted to determine if managed care organization (MCO) member complaint intake processes are consistent with the Uniform Managed Care Contract (UMCC) and Uniform Managed Care Manual (UMCM) requirements. The inspection also assessed the validity, accuracy and reliability of data contained in quarterly MCO member complaint reports. The inspection focused on how complaints and inquiries are discerned, logged and reported to HHS.

The OIG found complaint reporting amongst the MCOs differs due to:

- Multiple complaint definitions and lack of clarity on contract terms allows for inconsistent reporting by MCOs.
- MCOs do not report member complaints consistently with UMCC definition of the term "complaints."

The inspection identified several potential causes for the variances in the complaint rate for MCOs. Two MCOs have a policy to not report member concerns as complaints if they were resolved in 24 hours. The UMCC does not grant an exception based on the timeframe of the resolution. There are several definitions of complaint and no definitive guidance as to which to use. Additionally, the UMCC does not define specific terminology within the definition of complaint.

Utilizing a sample population, the OIG identified an estimated average of 7.4 percent of calls as complaints, while MCOs reported an approximate average of 1.5 percent of the calls as complaints. The estimation indicates MCOs underreported member complaints by 5.9 percent.

This equates to an estimation of 4,489 additional complaints in fiscal year 2018 first and second quarters than the MCO reported. This inspection is the first in a series of three. Series II focuses on determining the effectiveness of the MCOs' complaint resolution process, and Series III focuses on reviewing MCO complaint appeal processes.

Stakeholder outreach

Legislator meetings with the IG

Inspector General Sylvia Hernandez Kauffman met with several members of human services and budget committees this quarter, discussing the OIG's budget priorities and providing updates on pending managed care audits and inspections:

- Sen. Chuy Hinojosa
- Dr. Tom Oliverson
- Rep. Candy Noble
- Rep. Richard Raymond
- Rep. Giovanni Capriglione
- Rep. Cole Hefner
- Rep. James Frank

Provider associations feature OIG

Chief Pharmacy Officer Catherine Coney had an article, "Pharmacy Fraud Detection Operations," published in the Texas Pharmacy Association's spring edition of Texas Pharmacy Magazine. The article explained what a Fraud Detection Operation (FDO) is. FDOs are data-driven investigations that review providers who appear as statistical outliers and assess if program violations or instances of fraud, waste or abuse are the cause. The article also discussed how an FDO is conducted and the results of recent pharmacy FDOs. The OIG Dental Team had an article titled "Submitting Diagnostic Dental X-rays for a Texas Health and Human Services Office of

Inspector General Review" published in the Texas Dental Association's April 2019 edition of TDA TODAY. The article explained how the OIG uses dental records in reviews, and how to prepare, maintain and deliver them to the OIG.

OIG Medical Services meets with stakeholders

The Hospital Utilization Review Stakeholders Quarterly Meeting on April 15, 2019 included discussions of quality control, an update on conducting reviews of managed care admissions, ICD-10 coding errors and the submission of records. The Nursing Facility Utilization Review Stakeholders Quarterly Meeting on March 11, 2019 included discussions on an OIG Audit update on the financial impact of long-term care nursing facility therapy practices on Research Utilization Group (RUG) payments; an overview of common errors and trends found during onsite reviews; an update on the OIG quality control activities; Hurricane Harvey's impact on utilization reviews; other RUG issues; and a presentation by HHS Medicaid and CHIP Services on antipsychotic medications and adding the appropriate diagnosis.

OIG holds one-on-one meetings with MCOs

The OIG held one-on-one meetings with Texas Children's Health Plan and United Healthcare during the third quarter of fiscal year 2019. The agendas included a status update on the MCO's referrals to the OIG, a discussion of pending investigations, and fraud, waste, and abuse schemes and trends. The attendees also discussed the implementation of HB 2379, which amended the Government Code to require sharing of recoveries under managed care. Staff from the Office of the Attorney General's Medicaid Fraud Control Unit also participated in the MCO one-on-one discussions.

OIG updates MCOs about prescription drugs

The Lock-in program's quarterly MCO Teleconference on March 21, 2019 covered topics including the effective date of a lock, appeals, referrals, and the website, Dose of Reality: Prevent Prescription Painkiller Misuse in Texas (http://doseofreality.texas.gov/). The Dose of Reality website is a joint effort by the Office of Attorney General, Health and Human Services Commission, and the Texas Department of State Health Services to provide individuals, patients, health care providers, teachers, coaches and others with opioid-related resources in one location, allowing quick and easy access to vital information.

OIG engages with local prosecutors to prevent fraud, waste and abuse

BPI staff continues to build relationships with district attorneys across the state. BPI client investigations can be referred to district attorneys, in the county where the client resides, with a recommendation for prosecution. This quarter, BPI has worked with the Bexar County and Cameron County district attorneys to more effectively collaborate on investigations and ensure cases are properly structured for potential prosecution.

OIG prepares for dental solicitation stakeholder meetings

OIG staff continued to build off the findings from the Medicaid Dental Services Workgroup, established to address select fraud, waste and abuse issues. The OIG analyzed Medicaid provider data to identify potential risk around the issue of dental solicitation and drafted preliminary recommendations to combat this issue. The OIG presented this analysis and the findings to HHS Medicaid and CHIP Services in March to solicit comments prior to presenting the information to stakeholders. Stakeholder meetings will be held the fourth quarter of fiscal year 2019 with the dental maintenance organizations, dental associations and other stakeholders to present the data for input and feedback.

Conferences

- IG Kauffman presented at the American Association of Medical Audit Specialists, a national organization composed of health care professionals (payers and providers) focused on health care reimbursement issues. The conference, in its 25th year, took place in San Antonio. IG Kauffman's presentation informed the national audience about program integrity trends within Texas and the innovative tools the OIG is deploying to fight fraud, waste and abuse.
- OIG Chief Dental Officer Janice Reardon gave a presentation as part of a Texas Medicaid/CHIP forum at the Texas Dental Association meeting in San Antonio on May 3, 2019. The presentation provided information on risk management in preventing fraud, waste and abuse. Also participating in the forum were representatives from the Texas Medicaid and Healthcare Partnership and the Texas Medicaid dental maintenance organizations.
- OIG Senior Dental Analyst Sherry Jenkins gave a presentation on risk management issues in Medicaid

and CHIP on April 25 and May 31, 2019 to dental hygiene students at Austin Community College and Concord College.

- Interim Chief of Medicaid Program Integrity Steve Johnson presented in the Basic Skills and Techniques in Medicaid Fraud Detection on May 14-16, 2019 at the U.S. Department of Justice's Medicaid Integrity Institute (MII). The mission of the MII is to raise national integrity standards and professionalism among state Medicaid Program Integrity employees. The presentation centered around identification and interpretation of key federal health care statutes and regulations and improving investigators' testimonial skills, including providing testimony under cross examination.

Trainings

- The State Centers Investigations Team (SCIT) provided training for new HHS employees who care for intellectually and developmentally disabled individuals at state supported living centers and state hospitals. The presentations educated employees about the types of investigations conducted by SCIT at the facilities. SCIT coordinated with HHS Competency Training and Development Division to conduct the 32 new employee orientation presentations across the state.
- In April, the SCIT team underwent its biannual peace officer training. The training consisted of hands-on activities including performing tourniquet techniques with a third party, self-aid and wound care techniques, as well as traumatic brain injury causes and effects, legislatively mandated civilian interaction training and firearms training.

Program Integrity Spotlight

Strengthening the decision-making process in Texas Medicaid rate setting

Background

Over 93 percent of Texas' Medicaid population receives covered services under the managed care model. In Medicaid managed care, the Health and Human Services Commission (HHS) contracts with managed care organizations (MCOs) and pays them a monthly per member per month (PMPM) rate for the delivery of covered health services to members enrolled in their health plan. This monthly amount paid to the MCOs is a called a capitation rate. Per federal regulation, Medicaid capitation rates must be actuarially sound and approved by the Centers for Medicare and Medicaid Services (CMS). These requirements help to ensure reasonable and appropriate payment to each MCO for the covered services provided to enrolled Medicaid clients.

Overview

Since the vast majority of Medicaid members are enrolled in managed care, MCO capitation rates are the primary way the state pays for services. At the request of HHS's Executive Commissioner, the OIG independently assessed HHS's Medicaid capitation rate setting process in 2017 to identify any inefficiencies in the process and safeguard the use of state resources in the capitated managed care model.

The OIG's assessment did not identify any issues relating to the actuarial soundness of the current rate setting process and identified potential opportunities to strengthen the decision-making processes involved in the capitation rate setting process by providing management focused insight early in the rate setting process. This could bolster decision-makers' ability to proactively weigh and determine potential impacts of policy, program, cost and utilization changes and trends on rate development.

Decision support in the rate setting process

The OIG's assessment confirmed the Texas Medicaid rate setting process for setting annual rates as of state fiscal year 2017 involved sufficient and effective coordination among all relevant parties for the purpose of setting rates. As of the OIG's 2017 assessment, HHS's capitation rate setting process essentially involved four steps:

- Data collection.
- Trend setting.
- Adjustments based on policy contract changes.
- External approval.

Opportunities to enhance decision support in the rate setting process

While the OIG found that the actuarial soundness of the rates should continue to be the top priority of the rate setting process, it also offered the following considerations for HHS to potentially improve the decision-making processes involved in the Texas Medicaid rate setting process for MCOs.

The OIG found HHS should focus on:

- Communicating significant rate-related information and updates to HHS leadership on a regular basis.
- Analyzing trends and performance along key business drivers more granularly by risk group and service delivery area.
- Generating additional management input earlier in the rate setting process.
- Integrating insights, trends and other significant information more formally into the rate setting process.

To further enhance the decision-making process involved in rate setting, the OIG provides HHS actuarial staff the amount of recoveries for fraud, waste and abuse semi-annually, for consideration in the rate setting process.

Initial steps to potentially enhance decision support in the rate setting process

The OIG identified five initial steps HHS could take to strengthen the integration of insights, trends and other significant information across HHS divisions throughout the rate setting process. Since OIG's review of the fiscal year 2017 rates, HHS has made significant progress in each of these areas. As applicable, recent improvements are listed under each recommended step:

1. Define rate setting analytic activities that could help identify and communicate early warnings of anomalies in costs and utilization trends. Trend analysis could highlight aberrant patterns for an extensive and thorough investigation by Medicaid CHIP Services (MCS), Center for Analytics and Decision Support (CADS) and others as warranted.
   Recent improvements: HHS has implemented

various workgroups and monthly meetings to address Medicaid and CHIP costs and trends.

2. Consider revising the rate setting process timeline to incorporate earlier HHS leadership review of costs, utilization and other trends that could possibly impact capitation rates.

3. Develop dashboard templates for ongoing monitoring of rate development inputs at both the service delivery area and risk group levels of analysis, incorporating specific utilization and unit cost trends. In this effort, the OIG recommends defining the role of CADS in support of rate development and monitoring (e.g., dashboards) to provide key information during rate development to HHS leadership. Recent improvements: MCDA creates and maintains a library of dashboards displaying health care utilization by select service topics. MCDA is nearing completion of additional dashboards to examine trends in programs and other services.

4. Incorporate "look-back" assessments of rate setting estimates vs. actual experience to continue to improve rate setting accuracy and potential program impacts. Understanding the primary drivers of deviation between expected and actual performance could help prioritize areas for revision.

5. Formalize and define an enhanced engagement model for integrating additional insights from HHS leadership into the rate setting process. Developing a formal communication plan to effectively engage these parties on a more frequent basis (e.g., distribute a quarterly briefing, regular meetings with HHS Executive Leadership) could help to ensure the generation of management insight throughout the rate setting process. It is important to note that the OIG did not analyze any potential fiscal impact of developing this enhanced engagement model.

You can read the full review on the OIG website: https://oig.hhsc.texas.gov

Division performance

Inspections and Investigations

Inspections conducts inspections of HHS programs, systems and functions. Inspections also oversees the state's Women, Infants and Children (WIC) Vendor Monitoring Unit. This unit conducts in-store evaluations, compliance buys, and invoice audits to monitor vendors participating in the WIC program.

Investigations includes commissioned peace officers and non-commissioned personnel. It has three units:

- State Centers Investigations Team conducts criminal investigations of allegations of abuse, neglect and exploitation at state supported living centers and state hospitals.
- Cooperative Disability Investigations investigates statements and activities that raise suspicion of disability fraud.
- Electronic Benefit Transfer Trafficking conducts criminal investigations related to trafficking of Supplemental Nutrition Assistance Program (SNAP) benefits.

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

EBT Trafficking Unit performance

Overpayments recovered	$95,646
Cases opened	31
Cases completed	79

State Centers Team performance

Overpayments recovered	$3,786
Cases opened	166
Cases completed	169

Peace Officers performance

Cost avoidance	$193,932

Inspections report issued

- Member Complaints Received by Texas Medicaid: Series 1 - Inspection of Intake of Member Complaints

Inspections in progress

- Value-Based Purchasing
- Data Integrity of Online Provider Directories
- MCO Complaints Series II: Inspection of Resolution of Member Complaints
- MCO Complaints Series III: Inspection of Appeals Process of Member Complaints
- Eligibility Determinations for Out-of-State Clients
- Recovery of Unclaimed Funds
- Value-Based Purchasing Series II: Molina Quality of Living
- Inspection of Child and Adolescent Needs and Strengths (CANS) Assessments in Community Based Care

Inspections performance

Overpayments recovered	$1,085
Overpayments identified	$0

Benefits Program Integrity performance

Overpayments recovered	$17,854,012
Cases completed	3,773
Cases opened	3,850
Cases referred for prosecution	52
Cases referred for Administrative Disqualification Hearings	253

Strategy and Audit

The Strategy and Audit Division includes the Data and Technology (DAT), Audit and Policy units.

- DAT implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of fraud, waste and abuse. DAT assesses trends and patterns regarding behavior of providers, clients and retailers participating in Texas Health and Human Services (HHS) programs. DAT consists of four units 1) Fraud Analytics, 2) Data Research & Analysis, 3) Statistical Analysis, and 4) Data Operations.
- Audit conducts risk-based audits related to the accuracy of medical provider payments; the performance of HHS agency contractors; and programs, functions, processes and systems within the HHS system. Protocols of provider audits are periodically published on the Resources page on the OIG's website. Audit also coordinates all federal government audits of the HHS System.
- Policy serves as the health care policy subject matter expert and liaison across the OIG. The unit conducts analysis of program policies and coordinates and ensures timely and effective communication with a variety of stakeholders.

Data and Technology performance

Data requests received	238
Data requests completed	272
Algorithms executed	63
New algorithms developed	27

Reports issued by Policy unit

- OIG Review: Strengthening the Decision-Making Process in Texas Medicaid Rate Setting

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 (https://oig.hhsc.texas.gov/audit).

- STAR+PLUS enrollment
- Statewide nursing facility therapy service analysis
- Pharmacy providers
- Managed care pharmacy benefit managers' compliance
- IT security and business continuity and disaster recovery planning assessments
- Medical transportation program vendor performance
- MCO STAR Kids and STAR Health programs
- HHSC oversight and management of the Medically Dependent Children's Program (MDCP)
- Dental maintenance organization performance
- MCO STAR+PLUS waiver program
- MCO service coordination
- MCO clean claims for nursing facility providers
- Selected DFPS contract areas
- Selected Local Intellectual and Developmental Disability Authority (LIDDA) contractors

Audit reports issued

- Pharmacy Alternatives, LLC: A Texas Vendor Drug Program Provider
- Fee-for-Service Claims Submitted by Longhorn Health Solutions, A Texas Medicaid Durable Medical Equipment and Supplies Provider

Audit performance

Overpayments recovered	$604,784
Overpayments identified	$360,943
Audit reports issued	2

Medicaid Program Integrity

Medicaid Program Integrity Division includes four units:

- The Provider Investigations unit investigates and reviews allegations of fraud, waste and 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. Some referrals come through the OIG Fraud Hotline or complaints from the OIG's online Waste, Abuse and Fraud Electronic Referral System. Referrals are also received from managed care organizations throughout the state. When criminal Medicaid fraud is detected, MPI refers the matter to the Attorney General's Medicaid Fraud Control Unit. The two work together on joint investigations by sharing resources and information that will lead to successful administrative disposition or criminal prosecution.
- The Medical Services unit conducts claims and medical record reviews on a variety of health and human services, including acute care utilization, hospital utilization, nursing facility utilization, research and detection, and pharmacy lock-in. Medical Services also provides clinical consultation to the Benefits Program Integrity and Audit units, and the Inspections and Investigations Division on dental, medical, nursing and pharmacy services.
- The Program Integrity Development and Support (PIDS) unit provides support and process improvements to other MPI units. Responsibilities include developing projects to improve MPI investigative outcomes, reporting MPI statistics, acting as the Managed Care Organization Special Investigative Unit liaison, planning and conducting Investigative Initiatives and Fraud Detection Operations, and acting as the lead on open records requests.
- The Provider Enrollment Integrity Screenings (PEIS) unit is responsible for conducting certain federal- and state-required screening activities for providers seeking to enroll in Medicaid, CHIP and other state health care programs. The screenings and reviews conducted by PEIS promote compliance with federal provider enrollment program integrity requirements; increase accountability for the appropriate use of taxpayer resources by helping to prevent fraud, waste and abuse; and protect the health and safety of Texans.

Medicaid Program Integrity performance

Preliminary investigations opened	528
Preliminary investigations completed	558
Full-scale investigations completed	69
Cases transferred to full-scale investigation	75
Cases referred to AG's Medicaid Fraud Control Unit	118
Open/active full-scale cases at end of quarter	161

Medical Services performance

Acute Care provider recoveries	$946,485
ACS identified MCO overpayments	$1,036,253
Hospital and nursing home UR recoveries	$5,347,453
Hospital UR claims reviewed	2,941
Nursing facility reviews conducted	132

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	7,971
Individual screenings processed	28,764

External Relations

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

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

Operations

The Operations Division is comprised of five core functions:

- Operations Support includes OIG purchasing, contract management and the OIG Fraud Hotline. The Fraud Hotline receives allegations of fraud, waste and abuse and refers them for further investigation or action as appropriate.
- Finance and Budget oversees the OIG budget, tracks recoveries, reports Legislative Budget Board performance measures and works closely with HHSC Central Budget on the agency's LAR/Exceptional Items.
- Strategic Operations and Professional Development promotes OIG training services and internal policy development.

Operations performance

Fraud hotline calls answered	6,447

Third Party Recoveries performance

Dollars recovered	$111,656,471
Cost avoidance	$39,892,130

- Third Party Recoveries (TPR) works to ensure that Medicaid is the payor of last resort, oversees the Recovery Audit Contract and operates the Medicaid Estate Recovery Program.
- The Ombudsman provides an independent and neutral process for OIG employees to address concerns and work towards resolution.

Chief Counsel

The Office of Chief Counsel Division provides legal counsel and is comprised of the following:

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

Internal Affairs performance

Investigations completed	116
Cases with sustained allegations	24

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To report fraud, waste or abuse

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