Inspector General

Texas Health and Human Services

20D0108

OIG Quarterly Report

Quarter 1, Fiscal Year 2020

Table of Contents

Executive Summary

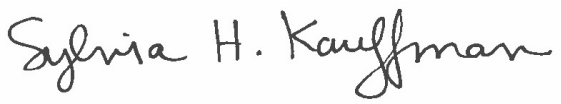
I am pleased to present the first quarterly report for fiscal year 2020, summarizing the excellent work this office has performed during this period, to Governor Greg Abbott, Executive Commissioner Dr. Courtney Phillips, the Texas Legislature and the citizens of Texas.

During this quarter, the OIG recovered just more than $73 million. In addition, more than $44 million was identified for potential future recoveries, and another nearly $25 million was achieved in cost avoidance by deterring potentially questionable spending before it occurs. These outstanding results are a testament to staff's commitment to ensuring the integrity of state health and human services.

The new fiscal year brings a renewed commitment to innovation as health care delivery continues to change in the state. The OIG quarterly report will now feature information previously published in the Expansion of Managed Care, Rider 149 report. This edition of the quarterly report reflects how the OIG continues to improve efficiency, streamline business functions and engage critical stakeholders. The OIG is committed to constantly evaluating how we accomplish our mission and taking any needed steps to adapt.

The OIG has four core values that guide us in our mission: Accountability, Integrity, Collaboration and Excellence. This office is dedicated 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
Inspector General

Quarter 1 Results

Dollars recovered

Audit	
Collections	$218,362
Inspections	
WIC collections	$6,835
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$4,323,186
Voluntary repayments by beneficiaries	$47,638
Medicaid Program Integrity	
Provider overpayments	$14,442,320
Acute care provider overpayments	$371,310
Hospital overpayments	$2,614,605
Nursing facility overpayments	$206,282
Third Party Recoveries	
TPR recoveries	$51,003,271
Peace Officers	
EBT Trafficking retailer overpayments	$50,570
Total dollars recovered	**$73,284,379**

Dollars identified for recovery

Audit	
Provider overpayments	$170,820
Inspections	
Unclaimed property program inspection	$1,004,119
WIC vendor monitoring	$394
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$13,244,759
Medicaid Program Integrity	
MCO identified overpayments	$22,542,486
Acute care provider overpayments	$309,500
Hospital overpayments	$6,199,881
Nursing facility overpayments	$130,434
Peace Officers	
EBT trafficking	$636,235
Total dollars identified for recovery	**$44,238,628**

Cost avoidance

Inspections	
WIC vendor monitoring	$608,262
Benefits Program Integrity	
Client disqualifications	$1,914,167
Medicaid Program Integrity	
Medicaid provider exclusions	$837,133
Medical Reviews	
Pharmacy Lock-In	$675,094
Third Party Recoveries	
Front-end claims denials	$20,849,068
Peace Officers	
Disability determination services	$74,496
Total cost avoidance	**$24,958,220**

Liquidated damages

Dollars recovered	$0

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.

Trends

Medicaid Program Integrity

The OIG continues to receive a high number of attendant care services calls to the OIG fraud hotline. During the last quarter, Medicaid Program Integrity (MPI), in collaboration with OIG Litigation, excluded eight attendant care workers from participation in Texas Medicaid. The investigative findings identified attendants clocked in and out as though working for the client when the clients were incarcerated, hospitalized or otherwise not receiving services. A review of records also identified attendants who submitted overlapping time through the Electronic Visit Verification System for two different clients.

MPI is opening more cases as the result of an initiative to focus on fraud, waste and abuse trends involving multiple providers. For example, an investigator identifying or receiving an allegation concerning the behavior of one provider will conduct data analysis and investigative research to determine if the pattern of behavior is exhibited in other providers. This proactive and efficient use of resources results in an increase in self-initiated cases as investigators uncover more potential waste or wrongdoing. The percentage of self-initiated cases transferred to Provider Field Investigations (PFI) increased from 49 percent to 66 percent in the first quarter, which can ultimately provide opportunities for more provider education, program exclusion or recoveries.

Self-initiated cases are developed through a collaborative approach between MPI and other OIG teams, such as Policy, Medical Services, Data Analytics and Technology, and Litigation. Together, these groups employ a variety of research and analytical tools and strategies to identify potential wrongdoing by health care providers.

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

Types of allegations received by MPI

Attendants	46%
Home health agency	15%
Physician (individual/group/clinic)	12%
Medical transportation program	5%
Hospital	3%
Dental	3%
Durable medical equipment	3%
Pharmacy	3%
Nursing facility	2%
Therapy (counseling)	2%

12 other categories at 1% or less

Types of MPI field provider investigations

Home health agency	39%
Physician (individual/group/clinic)	31%
Dental	9%
Durable medical equipment	6%
Therapy (counseling)	6%
Attendants	1%
Rehabilitation center	1%
Pharmacy	1%
Therapy (physical/occupational/speech)	1%
Hospital	1%
Lab (radiology/X-ray)	1%

Referrals to OIG

HMO/DMO referrals to OIG	79

- **School district self-report leads to $7.6 million settlement.** The OIG entered into a settlement agreement in September with an independent school district in Bexar County for $7,607,653. The district is a provider in the School Health and Related Services (SHARS) Program. SHARS provides nursing, counseling and various therapy services for Medicaid-eligible students with a disability or chronic medical condition. SHARS program providers are required to submit a Medicaid Cost Report

at the end of every school year. The provider self-reported that an internal investigation discovered SHARS reporting discrepancies dating back to the 2011-2012 through 2015-2016 Medicaid Cost Reports. The records improperly included non-reimbursable costs, i.e., costs for duplication of salaries and benefits related to Personal Care Services, Workers' Compensation and Unemployment, Teacher Retirement System of Texas, and Medicaid program administrative costs. The OIG considered, verified and accepted the provider's self-report.

- **Settlement agreement reached with two hospitals.** The OIG entered into settlement agreements with two Central Texas hospitals related to Emergency Department services for $370,872 and $412,926, respectively. The first hospital self-reported that it discovered an overpayment was due to Texas Medicaid related to services billed for certain ineligible patients. The second hospital billed and was paid for non-reimbursable injections/infusions in the emergency department when the same services were already covered by another code paid for the same date of service.
- **Durable medical equipment settlement.** In October 2019, the OIG settled a case against a durable medical equipment (DME) provider from McAllen who was identified using data-driven algorithms. The DME initiative identifies providers with inconsistencies in their billing for supplies in relation to their intended use. The provider agreed to a settlement of $160,000.

Benefits Program Integrity

The Benefits Program Integrity (BPI) division completed 3,928 investigations involving some form of benefit recipient overpayment or fraud allegation. Eighty-five percent of all investigations completed involved unreported income (32%) or an issue with the reported household composition (53%). Household composition cases usually deal with an unreported household member who has income or 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 they are eligible for.

BPI completed 261 investigations where fraud was determined. BPI referred 42 investigations for prosecution and 219 for an Administrative Disqualification Hearing. Ninety-seven percent of fraud investigations completed involved either unreported income or an issue with the reported household composition.

A sample of cases worked by BPI this quarter include:

- **Falsifying SNAP application.** BPI resolved a case in October in Hidalgo County involving a client who fraudulently obtained $32,002 in SNAP and Medicaid benefits. The client falsified benefit applications by failing to report her husband and his income from August 2014 to July 2017 in her household composition. As a result, the client pleaded guilty, received a judgment of deferred adjudication, community supervision, spent two days in jail and was ordered to pay full restitution.
- **Failing to report residential status.** BPI received a referral alleging a client failed to report her residential status while receiving benefits. During the investigation, the client confessed to residing in Mexico the entire period she was receiving both SNAP and Medicaid benefits. The case was filed with the Maverick County District Attorney. The client was found guilty, disqualified from SNAP for 12 months, sentenced to ten years of probation and ordered to pay full restitution in the amount of $66,161.
- **Excess SNAP and Medicaid benefits.** BPI resolved a case in October where a client in Parker County falsified applications by failing to report her husband and his income as part of her household. As a result, the client received $25,417 in excess SNAP benefits and $42,737 in excess Medicaid benefits from 2014 to 2018. The client was found guilty, disqualified from SNAP for 12 months,

received a suspended sentence of 365 days in county jail, 25 hours of community service and was ordered to pay $45,000 upfront, with monthly payments on the remaining balance of $23,154.

Electronic Benefits Transfer

This quarter, the Electronic Benefits Transfer (EBT) unit completed 67 investigations and presented another 31 investigations for either administrative disqualification hearings (14) or prosecution (17).

Trends identified by the unit include:

- **Excessive SNAP card replacement.** The EBT Trafficking Unit used data analytics to identify a trend of approximately 4,000 SNAP recipients receiving an excessive number of replacement cards. This fluctuation of receiving four to 50 replacement cards in a 12-month period is a possible indicator of fraudulent activity. Many of the cases involved people who are homeless and receive an average of $192/month in benefits. OIG staff initiated investigations and shared the results with HHS Access and Eligibility Services.
- **Selling SNAP benefits.** The unit continues to monitor trends regarding the selling of SNAP benefits for illegal activities. One of the trends involves business owners illegally buying SNAP cards for 50 cents on the dollar and using the SNAP benefits to buy supplies for their food service businesses. Another fraudulent activity involves SNAP recipients trading their benefits for cash to pay for illegal gaming.

A sample of cases worked by EBT this quarter:

- **SNAP indictments.** The EBT Trafficking Unit collaborated with Homeland Security Investigations and the United States Department of Agriculture Office of Inspector General to serve search warrants on a business and residence in Brownsville. More than 100 SNAP recipients were identified as part of a four-year long scheme involving $1.3 million in trafficked SNAP benefits. Investigators found a meat market owner allowed SNAP recipients to swipe their EBT cards at the register without making a purchase and gave them a receipt. The SNAP recipient would take the receipt to the home of the owner's associate and receive 2/3 the amount of the receipt in cash. The associate would later reconcile the receipt with the owner for meat products and then sell the meat to a third party. The United States District Attorney indicted six people believed involved in the fraudulent scheme. The Cameron County District Attorney agreed to pursue indictments of 50 SNAP recipients. The remainder of the recipients involved will be handled administratively.
- **Undercover investigation.** EBT Trafficking Unit investigated allegations of a non-SNAP participant retailer in Austin, who owns a food truck, purchasing SNAP benefits to buy items to stock inventory for his food truck. EBT Trafficking Unit investigators, acting in an undercover role, successfully sold SNAP benefits to the owner of the food truck. EBT Investigators sold $915 in EBT benefits and received $462 in cash in exchange for the benefits. The case is being referred to Travis County District Attorney for prosecution.
- **Restaurant owners purchasing SNAP.** EBT Trafficking Unit investigated allegations of non-SNAP participant restaurant owners in Brackettville purchasing SNAP benefits and using the benefits to buy inventory for their restaurant. Undercover EBT investigators successfully sold SNAP benefits on multiple occasions to the restaurant owners totaling $1,038. In exchange, the EBT Trafficking Investigators received $540 in cash. The case is being referred to Val Verde County District Attorney for prosecution.

Internal Affairs

Internal Affairs (IA) had 73 active cases in the first quarter involving fraud, waste and abuse in the delivery of health and human services, employee benefits fraud and other issues and closed 74 cases at quarter's end. IA processed 97 referrals this quarter and investigated 59 of those referrals, with the remaining forwarded to the

appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers, DFPS Office of Consumer Relations, and HHSC Complaint and Incident Intake.

Trends identified by IA include:

- **CPS perjury.** The number of perjury allegations involving testimony or affidavits by Child Protective Services (CPS) case workers decreased from 12 at the end of fiscal year 2019 to one this quarter. IA provides investigative support to the Department of Family and Protective Services (DFPS) Office of Consumer Relations in matters associated with criminal or gross misconduct of CPS case workers.
- **Employee misconduct.** IA has not seen any significant increase or decrease in cases involving employee misconduct this quarter. IA routinely investigates allegations related to the delivery of health and human services under different categories.

A sample of cases concluded by IA this quarter:

- **Contract compliance.** IA collaborated with OIG Audit and an OIG forensic accountant to examine the contract and services of an HHS contractor. IA made a preliminary determination that there was a lack of contractual fiscal compliance totaling $1,563,247 in questionable costs for the first seven months of a 20-month contract. The matter was referred to the Audit division for a complete review of the entire contractual period.
- **Recoveries and Restitutions.** IA completed two cases this quarter which identified $22,042 of financial loss to the state. One case involved a psychiatric nursing assistant with the Rio Grande State Center and the other a rehabilitation therapy technician with the North Texas State Hospital. Both falsified benefits application information resulting in overpayments. Unrelated, a local district attorney sent OIG a $28,843 restitution check as a result of an IA investigation of benefits recipient fraud committed by a former HHS employee.

Open IA cases by type

Benefits fraud	24%
Falsifying information/documents	19%
Unprofessional conduct	16%
Contract fraud/procurement issues	7%
Vital records fraud	6%
Bribery	3%
Conflict of interest	3%
Unauthorized release of information	3%
Child death	1%
Perjury	1%
Privacy incident/breach	1%
Tampering with a government record	1%
Whistleblower violation	1%
Workplace violence	1%
Other	10%

State Centers Investigations Team

The OIG's State Center Investigations Team (SCIT) opened 194 investigations and completed 209 investigations in the first quarter, with an average completion time of 24 days. This compares to 205 opened investigations and 181 completed investigations in the fourth quarter of fiscal year 2019. In the first quarter of fiscal year 2019, SCIT opened 175 investigations and completed 180 investigations, with an average completion time of 26 days.

A sample of cases worked by SCIT includes one involving a registered nurse at the Waco Center for Youth. The nurse was accused of dispensing psychoactive medication to a juvenile patient without a court order or consent of the juvenile's parent. SCIT investigators determined that the juvenile's father had been advised of all medications and had given the facility verbal consent to administer the medications. The psychoactive medications administered to the juvenile were determined to be appropriate for the juvenile's diagnoses.

Rule Proposals

Administrative enforcement

Proposed amendments to 1 TAC §371.1603 and §371.1715 related to Administrative Enforcement were presented at the Medical Care Advisory Committee meeting on November 7, 2019. The Medical Care Advisory Committee voted to move the proposed rules forward for posting in the Texas Register. The proposed rules were also presented at the HHS Executive Council meeting on November 14, 2019. No public comments were received at either meeting. The proposed rules clarify the factors that the agency applies when determining the seriousness, prevalence of error, harm or potential harm of a violation, as required by statute. The amendments add examples of mitigating factors and clarify that a person potentially subject to an enforcement action may introduce such mitigating factors in any contested case, as well as during the agency's informal resolution process. The rule amendments also clarify that the agency assesses penalties in accordance with relevant law, particularly Texas Human Resource Code Section 32.039. The proposed rules were published December 13 in the Texas Register for formal public comment through January 13, 2020.

Managed care organization audit coordination

Draft amendments to 1 TAC §371.37 related to Managed Care Organization (MCO) Audit Coordination were posted by the HHS Rules Coordination Office for informal comment from August 21, 2019 through September 4, 2019 along with the HHS companion rule 1 TAC §353.6. The rule amendments clarify OIG and HHS Medicaid and CHIP Services Department roles and jurisdiction related to audits of MCOs. The amendment to 1 TAC §371.37 adds new detail that describes the coordination - in planning and performance - between OIG and HHS when OIG plans and conducts MCO audits. OIG received comments from one stakeholder during the informal comment period. The proposed rules will be presented to the Medical Care Advisory Committee and the HHS Executive Council in February 2020.

Policy Recommendations

Policy recommendation 1: Implement changes to prevent overpayment for drug testing

The OIG's Data and Technology (DAT) unit uncovered irregularities in provider billing that led to a policy recommendation to Texas Medicaid. Investigators discovered providers billing disproportionate amounts of urine drug tests (UDTs). This was revealed through data mining, outlier detection and literature review. Providers were billing additional procedure codes for validity tests to verify that urine specimens were not tampered with; however, these validity tests are already included in the existing UDT procedure codes and should not be billed a second time.

Based on these findings, DAT made the following recommendations to Medicaid/CHIP Services (MCS):

- Define requirements for medical necessity of certain drug tests.
- Deny validity tests billed with UDTs on the same day, by the same provider.
- Exclude specific procedure codes related to UDTs billed on the same day by the same provider.

In response to the recommendation, MCS is revising Medicaid policy to clarify that documentation of medical necessity is required and is adding claims edits to prohibit inappropriate Medicaid reimbursement. MCS states the changes may take several months to implement.

Policy recommendation 2: Standardize telemonitoring procedures

An MPI investigation launched after a Medicaid client's complaint led to policy recommendations surrounding telemonitoring. The service includes remote monitoring of an individual's health-related data for certain diagnoses. Telemonitoring information is transmitted from the client's home to a licensed home health agency or a hospital and reviewed for problematic results by a designated staff person; results outside the normal range are reported to the physician.

Investigators found the following fraud, waste and abuse risks in the current policy:

- Lack of standard procedures for "scheduled periodic reporting" makes it difficult to identify whether providers are meeting the needs of Medicaid clients as the telemonitoring benefit intended.
- Lack of standard procedures for reporting results from telemonitoring equipment makes it difficult to identify if Medicaid clients' treating physicians are receiving and/or reviewing the clients' health data.
- Discrepancies between the physicians ordering telemonitoring services and the physicians treating Medicaid clients have led to treating physicians left unaware that their patients are receiving telemonitoring services and without access to the data.

The OIG recommended the following additional requirements for prior authorization:

- Documentation in the patient's medical record on how often the results from telemonitoring equipment should be transmitted to the treating physician's office for review;
- Documentation that supports the medical necessity and ongoing use of telemonitoring equipment based on the patient's health status; and
- Documentation that demonstrates the use of the monitoring equipment upon renewal of a prior authorization.

HHS is considering the recommendations.

Agency Highlights

Settlement agreement reached with early childhood intervention provider

The OIG entered into a $6.9 million settlement agreement in October with an early childhood intervention (ECI) provider. ECI provides therapy services for infants and toddlers with developmental delays and disabilities. MPI investigators found that over a six-year period the provider billed for more units of therapy than were provided, submitted claims for items not reimbursable by the Medicaid program and billed for services with either inadequate or missing documents to support the amount billed. The investigation was initiated following a third-party complaint.

Settlement agreement reached with dental provider

The OIG entered into a settlement agreement in October with a dental provider for $50,000 in penalties and a three-year exclusion from Medicaid. The investigation found that the provider subjected a recipient to unnecessary treatment, and the treatment was below the standard of care. Failed procedures on 14 teeth resulted in their extraction by a subsequent and unrelated provider. The provider paid the penalties in a lump sum, and their exclusion took effect November 1.

Fraud detection operation leads to preliminary investigations

Medicaid Program Integrity (MPI) is analyzing results from a November pharmacy fraud detection operation (FDO). An FDO is a data-driven investigative operation designed to review providers who appear as statistical outliers among their peers and determine whether this outlier status is attributable to fraud, waste, or abuse or other program violations. FDOs are an advanced data analytics method of assessing issues that may or may not lead to a full-scale investigation.

Quarter 1 performance

Audit reports issued	2
Audits in progress	20
Inspections reports issued	1
Inspections in progress	8
Investigations completed (BPI, IA, Peace Officer)	4,278
Investigations opened	3,521
Medicaid provider investigations completed	
Preliminary	569
Full-scale	86
MPI cases transferred to full-scale investigation	66
MPI cases referred to Medicaid Fraud Control Unit	131
Hospital claims reviewed	6,814
Nursing facility reviews conducted	28
Medicaid and CHIP provider enrollment screenings performed	26,023
Medicaid providers excluded	60
Fraud hotline calls answered	6,931

MPI uses this approach to conduct FDOs across the state. DAT identified four pharmacy providers in the Houston region who exhibited patterns of fraud, waste or abuse. The preliminary investigative findings are pending completion of analysis of the FDO results.

WIC activities across the state

The Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) conducted 193 compliance buys across the state for this quarter. A compliance buy is a covert in-store inspection. An OIG inspector poses as a WIC client and uses a WIC Electronic Benefits Transfer food card to make purchases to ensure vendors are following WIC rules. The compliance buys for this quarter resulted in $6,777 recovered. The team also completed 18 invoice audits across the state. An invoice audit is a comparison of a vendor's

paid claims and their purchase invoices for WIC food items. The purpose of the invoice audit is to determine if the vendor had a sufficient inventory of WIC food items to justify their submitted claims. The invoice audits for this quarter resulted in $189 recovered. Cost avoidance associated with vendor disqualifications was $608,262. The team also conducted 74 on-site store reviews. The review is an overt in-store assessment where the OIG works with the respective WIC vendor to identify any deficiencies which may or may not exist in association with the sale of authorized WIC products.

MCO contract changes

The OIG requested amendments to the Texas Medicaid and CHIP managed care contracts that went into effect September 1. Texas Medicaid and CHIP managed care organizations are required to hire a full-time special investigative unit (SIU) manager dedicated solely to Texas Medicaid and CHIP. MCOs are also required to designate the SIU manager as a key employee and employ a qualified investigator. The goal of these changes is to strengthen the SIU requirements for MCOs to provide sufficient resources dedicated to fraud, waste, and abuse (FWA) detection and prevention activities.

NFUR team begins new process for managed care recoveries

Medical Services Nursing Facility Utilization Review (NFUR) team performs retrospective onsite utilization reviews of nursing facility records to evaluate whether facilities correctly assessed and documented residents' needs. The reviews also seek to determine if the appropriate level of care was provided and medically necessary. The OIG submits information to the STAR+PLUS MCOs based on their findings. In November, the NFUR team initiated a process to notify STAR+PLUS MCOs to recoup or withhold from future payments to providers the amount of these estimated overpayments and remit actual overpayment amounts to the OIG based on NFUR findings.

Hospital managed care reviews underway

Medical Services Hospital Utilization Review (HUR) began reviewing managed care admissions in February 2019. The goal of hospital utilization review is to validate inpatient admissions for medical necessity, correct diagnosis and procedures, diagnosis-related group assignment and quality of care issues. The HUR unit notified providers of 1,172 approved admissions in July and requested prior authorizations (PAs) from MCOs in September. PAs are pre-approval of an inpatient admission based on supporting documentation submitted to a MCO for Medicaid reimbursement. HUR physician consultants are currently reviewing 390 admissions with PAs for potential denial.

TPR streamlines MCO reporting

Third Party Recoveries (TPR) is collaborating with the MCOs to improve their required reports. The enhancements are intended to increase efficiencies during the report submission process and during the OIG's monitoring and data reporting process. For example, TPR consolidated several reports to allow MCOs to report all plan code data on one report versus separate reporting per plan code. TPR also enhanced several reports that self-calculate the data, thus eliminating manual calculations.

OIG improving efficiency

The Data and Technology (DAT) team is using SharePoint as a safe and secure way for stakeholders (providers, managed care and dental maintenance organizations, and others) to provide information to the OIG. Stakeholders and OIG staff have embraced the technology; more than 45 gigabytes of information were exchanged in 659 file uploads during an 11-working day period in November 2019 alone. DAT is responsible for acquiring data from MCOs for use in investigations, audits and inspections. To increase efficiency in completing the data requests, DAT worked in collaboration with the MCOs to implement a new data request process that was implemented in September. DAT will monitor the

process and measure its effectiveness over the next few quarters.

The new WIC SharePoint case tracking system has also been deployed. This system allows for efficient accounting of compliance and monitoring activities within the WIC vendor population. This project is in its second month of trials for the entire WIC Vendor Monitoring Unit and was built through a collaboration with DAT.

Medical Services Lock-In Program survey and MCO training

Medical Services Lock-In Program restricts a Medicaid recipient's access to a single designated pharmacy and/or primary care provider based on inappropriate use of Medicaid benefits and services, such as prescription drugs. A recent survey revealed that only six MCOs submitted a referral to the Lock-In Program in the previous 90 days. In response, the Lock-In Program is developing a refresher training on the pharmacy lock-in process for MCOs. The goal is to improve referral rates and educate MCO staff on the lock-in criteria and referral process. As of November 30, more than 2,000 people with Medicaid have been locked into a designated pharmacy or primary care provider.

OIG creating new training to enhance professional rigor

MPI is developing new training methods and approaches for its investigators to combat Medicaid FWA. New approaches include enhanced provider case study trainings in collaboration with Litigation and other division stakeholders. Case study trainings allows MPI investigators to present the cases they worked to investigators across different regions, providing an opportunity to learn from each other and share different approaches to their work. The trainings also foster collaboration between investigators, medical services, DAT and litigation. MPI completed a case study training on dental provider solicitation and kickbacks in October 2019. Additional case study trainings are anticipated throughout 2020.

OIG has been working with Medicaid/CHIP and HHS Learning Resource Network to develop an FWA computer-based training for HHSC staff. This training is designed to define FWA and give examples, identify common findings in the areas where OIG has oversight, and inform staff on how to report suspected FWA. This training is one part of OIG's strategy to increase awareness of the role of OIG in preventing FWA.

Supplemental recoveries reports to HHS

The OIG in November gave MCS its first annual report of settlement and recovery payments between the OIG and MCOs/DMOs for consideration in the Experience Rebate calculation. The Experience Rebate is a profit-sharing arrangement between MCOs and the state. The rebate is the portion of the MCO's net income before taxes that is returned to the state in accordance with an MCO's contract with HHS. This supplemental reporting could help MCS adjust the Experience Rebate if appropriate.

The OIG also submitted its second semi-annual Report of Final Debts Determined by the OIG in Managed Care to HHS Actuarial Analysis for consideration in the Texas Medicaid rate-setting process. This reporting could help HHS Actuarial Analysis remove OIG-identified overpayments from the data used to set capitation rates, which could lower the rates paid to MCOs. The first report was submitted in April.

BPI compliant with IRS review

The IRS completed its triennial review in October of HHS safeguarding of Federal Tax Information. The review found BPI to be significantly compliant, with only three minor administrative findings related to visitor log signatures, review of after-hours building access and frequency of audit report reviews.

Completed Reports

Audit

Symphony Diagnostic Services No. 1, LLC. The audit determined whether services reimbursed by Medicaid to Symphony Diagnostic Services No. 1, LLC (Symphony), a portable X-ray supplier provider, were (a) billed and paid in accordance with federal and state laws and regulations, (b) medically necessary and (c) provided and appropriately documented in the medical records.

Audit results indicated that Symphony billed and was paid by Medicaid for 53 claims with missing records. The 53 exceptions resulted in overpayments of $6,464. Auditors also identified issues of non-compliance that did not have monetary findings associated with them but were presented to the provider for educational purposes. Specifically, there were 104 claims in which the order was signed after the services were rendered.

Auditors recommended that Symphony refund the overpayment of $6,464 to the State of Texas and comply with all federal and state laws, regulations, and billing instructions provided under the Texas Medicaid Program.

Texas General Hospital. The audit determined whether inpatient and outpatient services reimbursed by Medicaid to Texas General Hospital were (a) billed and paid in accordance with federal and state laws and regulations, (b) medically necessary, (c) provided and appropriately documented in the medical records and (d) coded properly.

Audit results indicated that Texas General Hospital billed and was paid by Medicaid for seven claims for inpatient services that were not medically necessary. The seven exceptions resulted in overpayments of $29,877. Audit results also indicated that Texas General Hospital inappropriately billed and was paid by Medicaid for 14 claims for outpatient services. The 14 exceptions resulted in overpayments of $134,479.

Auditors recommended that Texas General Hospital refund the total overpayment of $164,355 to the State of Texas and comply with all federal and state laws, regulations, and billing instructions provided under the Texas Medicaid Program.

Inspections

Unclaimed Funds: Inspection of the Process to Recover HHS Funds from the Texas Comptroller's Unclaimed Property Program: The Inspections Division conducted this inspection to determine if the Texas Medicaid & Healthcare Partnership (TMHP) Third Party Liability (TPL) has effective processes to recover HHS identifiable funds from the Texas Comptroller of Public Accounts, Unclaimed Property Program (UPP). The inspection identified HHS System funds totaling $1,004,119 in the UPP not previously recovered.

The OIG found TMHP-TPL and HHS Accounts Receivable (AR) have a process to identify and recover HHS identifiable funds from the UPP. TMHP-TPL and AR performed this process annually from 2014 to 2018 using a limited number of keywords to search the UPP database for funds. However, the contract regulating TMHP-TPL does not require them to identify or recover all HHS funds from the UPP. Additionally, checks sent to HHS related entities may not always be forwarded to AR for deposit. The OIG recommended HHS-AR coordinate with TMHP-TPL to recover claims from the UPP annually and request insurance carriers provide annual notification of uncashed checks.

Stakeholder Outreach

IG engages policy makers

Inspector General Sylvia Hernandez Kauffman continues to highlight the work of this office through discussions with lawmakers and members of the medical community. Her visit with Dr. Sherif Zaafran, M.D., Texas Medical Board President, focused on continued collaboration to improve health care delivery for Texans. IG Kauffman briefed House Human Services Committee Chairman James Frank, R-Wichita Falls, on the OIG Star Kids Programs Audit; STAR Kids is Medicaid's managed care plan for children with disabilities. IG Kauffman toured the Brenham State Supported Living Center facility with State Sen. Lois Kolkhorst, R- Brenham, and HHS Executive Commissioner Dr. Courtney Phillips. The facility provides services and support to people with intellectual and developmental disabilities who have behavioral problems or are medically fragile.

Attendant Care Services Workgroup

OIG continued to meet with members of the Attendant Care Services Workgroup to compile a document that outlines each HHS division's roles and responsibilities around the oversight and administration of attendant care services program integrity activities. Attendant care services are home and community-based services that provide people the assistance they need to stay in their community, instead of living in a long-term care facility such as a nursing home. In response to recommendations within the 2019 Centers for Medicare and Medicaid Services Texas Personal Care Services Focused Program Integrity Review Final Report, the OIG created the workgroup and has met monthly with the workgroup through the fall to draft the document.

Medical Services meets with stakeholders

The Nursing Facility Utilization Review (NFUR) unit held its quarterly stakeholder meeting in September. Discussion included NFUR proposed review changes; an overview of common errors and trends found during onsite reviews; an update on OIG quality control activities and review exits; an overview of the Restorative Nursing Program; and other Resource Utilization Group issues.

The Hospital Utilization Review (HUR) unit held its quarterly stakeholder meeting in October. Discussion included peer quality control reviews of HUR coders; reminding hospitals of their responsibility to provide records requested by OIG even if they use a third-party vendor; an overview of common errors and trends found in coding; and a managed care admissions review update.

The OIG is now conducting ongoing monthly OIG Medical Services Coordination webinars with MCOs/DMOs. Webinars in the fall covered deconfliction, requests for additional information to support OIG processes and provided opportunities for MCOs/DMOs to ask questions and give feedback for process improvement.

OIG engages local prosecutors to prevent fraud, waste and abuse

EBT trafficking team continues to reach out to local district attorneys to inform them about the types of EBT trafficking investigations and how those cases impact local communities. These efforts led to the Harris County District Attorney accepting 10 referred cases for prosecution. EBT Investigators also met with the Val Verde County District Attorney and provided the same information, resulting in cases accepted for prosecution.

OIG publishes dental brochure

At the request of the Texas Dental Association (TDA), the OIG published a dental solicitation brochure for providers that explains what dental providers need to know to avoid illegally soliciting clients who have Medicaid. Dental providers are prohibited from offering cash, gifts or other items to people who have Medicaid in order to influence their health care decisions, which is referred to as dental solicitation. The brochure was distributed to TDA to share with its members in October and is available on the OIG's website.

Trainings and Conferences

- IG Kauffman attended a seminar organized by HHS Texas Health Steps in Corpus Christi. IG Kauffman gave a presentation to physicians who accept Medicaid about the OIG's role in ensuring the integrity of health and human services.
- IG Kauffman attended the Texas Association of Health Plans annual conference in Austin. IG Kauffman presented about some of the office's innovate work, including the OIG's use of data analytics to detect FWA and increased collaboration between MCOs and the OIG to fight FWA in the healthcare system.
- In October, the SCIT team underwent its biannual TCLOE-required peace officer training. The training consisted of defensive tactics, baton certification and firearms training.
- The SCIT team provided 37 trainings this quarter for new HHS employees who care for intellectually and developmentally disabled individuals at state supported living centers and state hospitals. The presentations highlighted the types of investigations conducted at the facilities.
- In October, OIG Chief Medical Officer Ted Spears, M.D., presented to OIG external physician consultants on InterQual, the current evidence-based guidelines used in hospital utilization review. This training highlighted the transition from MCG, HUR's former evidence-based guidelines vendor, to InterQual, as well as HUR's transition to review managed care inpatient admissions. OIG HUR transitioned from MCG to InterQual in April.
- DAT team members recently attended healthcare fraud conferences. These conferences featured data analysis and detection methods as key topics. Staff collaborated with other state Medicaid programs on trends, schemes and data analysis methods. Team leaders presented their expertise in dental analytics and Electronic Visit Verification data analysis at the Medicaid Integrity Institute's Data Experts Symposium in Columbia, South Carolina in September.
- Medical Services staff attended the National Health Care Anti-Fraud Association annual training conference held in Nashville, Tennessee. This conference provided OIG staff insights into FWA within fee-for-service versus value-based delivery and reimbursement models. Emphasis was placed on the importance of proactive FWA measures for the health care system and public/private payers.
- Medical Services Acute Care Surveillance held a training in November of internal controls outlined in the Association of Inspectors General Principles and Standards for Offices of Inspector General, also known as the "Green Book," and their relevance to OIG Medical Services staff. This overview course explored the internal controls that contribute to efficient and effective operations, operational reporting and compliance with applicable laws and regulations.
- The Texas Health Steps (THSteps) Dental Forum held in October featured the OIG FWA in Health and Human Services Programs training. OIG Professional Development Manager Todd Shaw, in coordination with OIG Chief Dental Officer Dr. Janice Reardon, developed and presented this training to DSHS staff, THSteps providers and to the Dental Maintenance Organizations (DMOs). This training provided an overview on how to identify and report FWA, the investigation process and the common dental FWA findings for both the OIG and DMOs.

Training summary

Internal trainings conducted this quarter	46

Program Integrity Spotlight

Actuary advises on OIG recoveries and capitation rates

The OIG engaged the services of an actuary in fiscal year 2019 to conduct a review of the impact of overpayment recovery options in Medicaid managed care. The actuary also provided guidance as the agency examines Medicaid managed care program integrity issues.

The actuary concluded that the OIG, in most circumstances, may collect provider overpayments from either the provider or the MCO without negatively impacting the actuarial soundness of capitation rates paid to MCOs by the state. A capitation rate is a fixed amount Texas Medicaid pays MCOs monthly for each individual enrolled in the MCO, regardless of the level of services required. Multiple capitation rates are calculated annually based on Medicaid program, geography and age of the member. The OIG recovers improper payments made by MCOs to providers as a result of fraud, waste and abuse (FWA). The OIG actuary's findings include:

- The current level of OIG recoveries does not impact the actuarial soundness of Texas capitation rates overall.
- The OIG may collect overpayments due to FWA from either the provider or MCO without impacting the actuarial soundness of capitation rates, unless there are materially large overpayments. Materially large overpayments are discussed with the HHS rate-setting actuaries, who determine whether the recovery of the overpayments would impact the actuarial soundness of capitation rates.
- Recoveries not reflected within encounter data and anticipated changes in recoveries processes and trends should be reported to HHS actuarial analysis, which ultimately decides whether OIG recoveries impact the actuarial soundness of capitation rates and when rate adjustments are necessary.
- The OIG can consider tracking a cost removal metric that calculates the fiscal impact of OIG recoveries on future Medicaid managed care capitation rates. This metric would provide the HHS rate-setting actuaries with data to adjust future capitation rates based on OIG recoveries.

The OIG communicated closely with HHS during the analysis. The OIG is already monitoring the cumulative impact of recoveries on individual rate cells and has implemented a three-year plan for expanded managed care recovery efforts. The OIG Office of Chief Counsel will consider the complex circumstances of FWA recovery decisions on a case-by-case basis. The OIG is moving forward with procuring actuary services in fiscal year 2020 and will continue to collaborate with HHS.

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 WIC; SNAP; the Temporary Assistance for Needy Families program; Medicaid; and the Children's Health Insurance Program.

EBT Trafficking Unit performance

Overpayments recovered	$50,570
Cases opened	27
Cases completed	67

State Centers Team performance

Overpayments recovered	$0
Cases opened	194
Cases completed	209

Peace Officers performance

Cost avoidance	$74,496

Inspections report issued

- Unclaimed Funds: Inspection of the Process to Recover HHS Funds from the Texas Comptroller's Unclaimed Property Program

Inspections in progress

- Molina Quality Living Program
- Child and Adolescent Needs and Strengths Assessment in Community-Based Care
- Local Mental Health Authorities
- Overlapping Long-Term Care Claims During Hospital Stays
- Mental Health Targeted Case Management and Rehabilitative Services in Managed Care
- State Supported Living Centers' Background Checks and Training Processes
- OIG Review of Value-Based Purchasing
- Member Complaints Received by Texas Medicaid Managed Care Organizations - Series III: Inspection of Member Complaint Appeals

Inspections performance

Overpayments recovered	$6,835
Overpayments identified	$1,004,513

Benefits Program Integrity performance

Overpayments recovered	$4,370,824
Cases completed	3,928
Cases opened	3,236
Cases referred for prosecution	42
Cases referred for Administrative Disqualification Hearings	219

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 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.

Medicaid Program Integrity performance

Preliminary investigations opened	513
Preliminary investigations completed	569
Full-scale investigations completed	86
Cases transferred to full-scale investigation	66
Cases referred to AG's Medicaid Fraud Control Unit	131
Open/active full-scale cases at end of quarter	123

Medical Services performance

Acute care provider recoveries	$371,310
ACS identified MCO overpayments	$309,500
Hospital and nursing home UR recoveries	$2,820,887
Hospital UR claims reviewed	6,814
Nursing facility reviews conducted	28
Average number of Lock-in Program clients	2,037

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	7,878
Individual screenings processed	26,023

- 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.

Audit

The Audit Division 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.

Audit performance

Overpayments recovered	$218,362
Overpayments identified	$170,820
Audit reports issued by contractors	2

Audits in progress

The Audit Division had 20 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).

- IT Security and Business Continuity and Disaster Recovery Plans
- MCO Special Investigative Units (SIU)
- Dental Maintenance Organization
- Managed care pharmacy benefit managers' compliance
- STAR+PLUS Enrollment
- Durable Medical Equipment claims
- Selected DFPS Contracts
- Selected Local Intellectual and Developmental Disability Authority (LIDDA) contractors
- Pharmacy providers
- MCO STAR+PLUS waiver program
- MCO clean claims for nursing facility providers
- IT security and business continuity and disaster recovery planning assessments
- Substance Use Disorder Contract
- Performance of Selected Contractors Supporting the Texas Integrated Eligibility Redesign System (TIERS)
- Cost Allocation of MCO Shared Services

Strategy

The Strategy Division implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of fraud, waste, and abuse. Data and Technology (DAT) assesses trends and patterns regarding behavior of providers, clients and retailers participating in HHS programs. DAT consists of four units: Fraud Analytics, Data Research & Analysis, Statistical Analysis, and Data Operations.

Strategy also serves as the health care policy subject matter expert and liaison across the OIG. The unit makes recommendations for contract and policy changes, liquidated damages and corrective action plans that promote program integrity.

Strategy performs the following activities in support of the primary tools the OIG uses to conduct its work:

- Identify and implement innovative practices to advance the OIG's mission.
- Support OIG critical projects and other priorities through project management and collaboration.
- Coordinates within the OIG, Medicaid CHIP Services, and external stakeholders including Texas MCOs.
- Conducts research, policy analysis, writes concise policy documents, and develops and conducts trainings to boost OIG knowledge and application of managed care and other topics.

Data and Technology performance

Data requests received	249
Data requests completed	218
Algorithms executed	48
New algorithms developed	10

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	6,931

Third Party Recoveries performance

Dollars recovered	$51,003,271
Cost avoidance	$20,849,068

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

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	74
Cases with sustained allegations	19

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.

Texas Health and Human Services Office of Inspector General

Sylvia Hernandez Kauffman, Inspector General

Mailing address: P.O. Box 85200, Austin, TX 78708

Main phone number: 512-491-2000

Email: OIGCommunications@hhsc.state.tx.us

To report fraud, waste or abuse

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

Website: oig.hhsc.texas.gov

OIG on Twitter: @TexasOIG

OIG on Facebook: TxOIG

Produced by OIG Communications: Andres Araiza, manager; Emily Hummel and Art Moore, staff

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