

OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

Cigna-HealthSpring SIU



August 24, 2016
IG Report No. IG-16-012



HHSC IG

TEXAS HEALTH AND HUMAN
SERVICES COMMISSION

INSPECTOR GENERAL

WHY THE IG CONDUCTED THIS AUDIT

Cigna is one of 22 managed care organizations (MCOs) contracted to provide Medicaid and CHIP health care services in Texas. Approximately 84 percent of Medicaid and CHIP enrollees are members of an MCO. At nearly \$27 billion a year, the Medicaid and CHIP programs constitute over 27 percent of the total Texas budget.

MCOs are required to establish a special investigative unit (SIU) to investigate fraudulent claims and other program waste and abuse by members and service providers. Effective SIUs are essential to support overall MCO cost containment efforts, and to ensure that state and federal funds spent on managed care are used appropriately.

The Texas Health and Human Services Commission is responsible for oversight of MCO contracts. The IG is responsible for approving SIU annual plans, and evaluating and sometimes investigating SIU referrals.

This is one of a series of performance audits to determine how effective selected MCO SIUs are at (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries.

WHAT THE IG RECOMMENDS

HHSC should require Cigna to implement corrective actions to strengthen Cigna's SIU fraud, waste, and abuse investigation and detection activities.

View [IG-16-012](#)

For more information, contact:
IG.AuditDivision@hhsc.state.tx.us

AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

Cigna-HealthSpring SIU

WHAT THE IG FOUND

Though Cigna Health-Spring (Cigna) maintains the contractually required annual SIU fraud, waste, and abuse plan, Cigna needs to improve the function of its SIU in order to effectively implement the plan.

Cigna received approximately \$333.2 million in Medicaid and CHIP capitation and delivery supplemental payments in 2014, and \$713.7 million in 2015, and paid approximately \$889.3 million in medical claims dollars over those two years. During this two-year period, Cigna's SIU identified a limited number of cases for investigation, recovered 0.01 percent of its total medical claims dollars, and did not refer any fraud, waste, or abuse cases to the IG or the Office of Attorney General.

Year	Medical Claims	Medical Claims \$	# of SIU Investigations	SIU Recoveries	# of Referrals to IG
2014	1,405,428	\$ 287,943,218	22	\$ 51,716	0
2015	2,509,017	\$ 601,313,929	46	\$ 55,708	0
Total	3,914,445	\$ 889,257,147	68	\$ 107,424	0

Although Cigna's annual fraud, waste, and abuse plan outlined the essential activities needed for an effective SIU, Cigna's SIU investigation activities were limited in scope. During preliminary investigations, Cigna performed a review of provider payment histories but for much shorter and varied durations than the required three-year review. During full-scale investigations, Cigna often narrowly limited its claims reviews to the individual employee or attendant level rather than the provider organization level. These limited reviews were too narrowly focused to find provider patterns and effectively capture potential cases of fraud, waste, and abuse.

In addition, Cigna's SIU did not effectively perform activities that could have resulted in the detection of fraud, waste, and abuse, such as verification of services or data analytics. Cigna's SIU did not conduct recipient verifications to confirm that services billed by providers were delivered to the recipient, and, while it performed limited prepayment activities, it did not apply any post-payment data analytics that would effectively detect potential fraud, waste, and abuse.

Until Cigna increases the scope and effectiveness of its SIU investigation and detection activities, HHSC does not have assurance that Cigna is maintaining an effective SIU that successfully guards against losses due to fraud, waste, and abuse.

The HHSC Medicaid/CHIP Division concurred with the IG Audit Division recommendations outlined in this report, and will facilitate Cigna's development of a corrective action plan designed to improve Cigna's SIU function.

The IG Audit Division will continue to publish reports during its ongoing audit of Medicaid and CHIP SIUs as it completes fieldwork, audit testing, and validation for selected MCOs.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Inspector General (IG) Audit Division is conducting an audit of Medicaid and Children’s Health Insurance Program (CHIP) special investigative units (SIUs). The objective of the audit is to evaluate the effectiveness of managed care organization (MCO) SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC. The audit includes state fiscal years 2014 and 2015, which covers the period from September 2013 through August 2015, and includes a review of relevant SIU activities through the end of fieldwork in March 2016.

This audit report is one of a series of reports on MCO SIUs. The first report was an informational report that provided background, context, and a compilation of information provided by the 22 Texas Medicaid and CHIP MCOs¹. This audit report is focused on SIU activities at Cigna-HealthSpring (Cigna). The IG Audit Division will continue to release audit reports for selected MCO SIUs as the audit proceeds.

Background

Cigna is a licensed Texas MCO contracted to provide Medicaid services through its network of providers. Cigna is not contracted to provide CHIP services. Cigna coordinates health services for the Medicaid State of Texas Access Reform Plus (STAR+PLUS) program for members² in Hidalgo and Tarrant Counties, and in the Medicaid Rural Service Area (MRSA) Northeast region of Texas. Cigna began providing services in the MRSA Northeast area in state fiscal year 2015.

Cigna is one of 22 contracted MCOs responsible for administering, on behalf of the State of Texas, billions of dollars of Medicaid and CHIP health care services each year through its health plans. By contract and by state law, MCOs are required to establish and maintain SIUs to investigate potential fraud, waste, and abuse by members and health care service providers.³

¹ An MCO is an organization that delivers and manages health care services under a risk-based arrangement. The MCO receives a monthly premium or capitation payment for each managed care member enrolled, based on a projection of what health care for the typical individual would cost. If members’ health care costs more, the MCO may suffer losses. If members’ health care costs less, the MCO may profit. This gives the MCO an incentive to control costs. In this report, health plans, dental maintenance organizations, and behavioral health organizations are collectively referred to as MCOs.

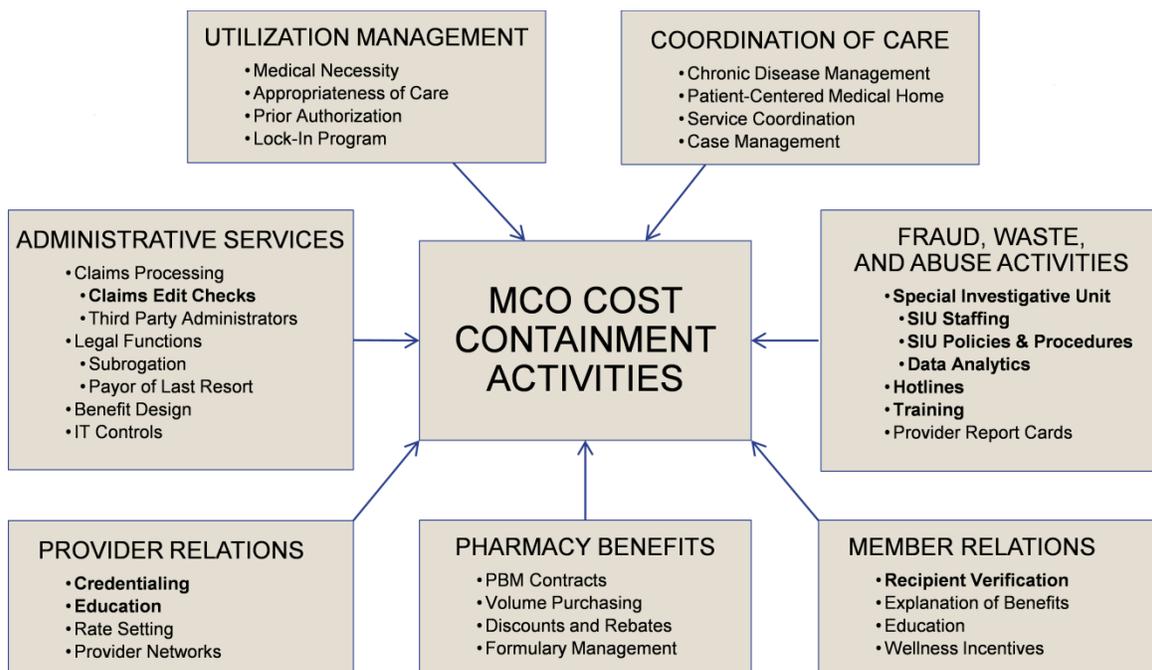
² MCOs refer to enrollees as “members.” An “enrollee” is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

³ Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015); Texas Government Code, Title 4, Subtitle 1, § 531.113 (September 1, 2003). *See also* Texas Administrative Code Title 1, Part 15, § 353.502 and § 370.502 (March 1, 2012).

An MCO may contract with an outside organization to perform all or part of the activities associated with the SIU. Cigna utilizes internal staff along with contracted vendors to perform the SIU function.

SIUs support MCO efforts at cost containment through the prevention and detection of fraud, waste, and abuse. MCOs maintain many functions and activities outside of the SIU to control costs, and SIUs may conduct activities that relate to other business areas of the MCO besides Medicaid and CHIP. As a result, the functional and organizational structure of cost containment activities varies across MCOs. Figure 1 below provides a partial overview of the many types of activities MCOs employ to help reduce costs and impact fraud, waste, and abuse. This information is not meant to represent a complete set of activities, nor does it represent the structure of the business units at Cigna or any other specific MCO.

Figure 1. MCO Functions and Activities Related to Cost Containment



Source: IG Audit Division

The activities shown above in bold designate some of the areas of focus of this audit. This performance audit evaluated Cigna's SIU efforts related to:

- Prevention processes, such as the organizational code of ethics, credentialing and re-credentialing, exclusion verification, and fraud, waste, and abuse training.
- Detection activities, such as complex data analysis, periodic provider audits, intake of fraud referrals, and verification that recipients received billed services.

- Investigation efforts, such as conducting preliminary investigations and SIU case management.
- Disposition of fraud, waste, and abuse investigations, including referrals to the IG, corrective action plans, and monetary recovery.
- Reporting of SIU activities to IG, including a monthly report of ongoing investigations and annual reporting of SIU recoveries.

Texas Health and Human Services (HHS) agencies administer public health programs for the State of Texas. Within HHS, the HHSC Medicaid/CHIP Division oversees Medicaid and CHIP, which are jointly funded state-federal programs that provide medical coverage to eligible individuals. In 2013, there were approximately 4.3 million individuals enrolled in Medicaid or CHIP.⁴

The HHSC Medicaid/CHIP Division is responsible for overall management and monitoring of the contract with Cigna. The IG is responsible for approving Cigna's annual fraud, waste, and abuse plan,⁵ and evaluating and sometimes investigating any fraud referrals it receives from Cigna. Cigna is required to refer suspected fraud, waste, and abuse to IG. When the IG determines it will not pursue an SIU referral, Cigna is responsible for recovery of any Medicaid overpayments associated with the referral.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. Through the STAR+PLUS program, Medicaid provides health services for individuals age 65 or older, or with a disability requiring long-term health care services. CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid. In federal fiscal year 2013, Texas spent \$26.8 billion on Medicaid and CHIP. This represented 27 percent of the entire 2013 Texas state budget.⁶

Medicaid and CHIP programs deliver health care services (including medical, dental, prescription drug, disability, behavioral health, and long-term support services) to eligible individuals.⁷ CHIP provides services to individuals in Texas through a managed care model.

⁴ This is the 2013 average monthly number of enrollees in Medicaid and CHIP.

⁵ Texas Government Code, Subtitle I, Subchapter C, § 531.113 (September 1, 2003).

⁶ Texas Medicaid and CHIP expenditures in 2013 are "all funds" (which include federal and state dollars), but excludes Medicaid funding for Disproportionate Share Hospital, Upper Payment Limit, Uncompensated Care, and Delivery System Reform Incentive Payment funds. Medicaid and CHIP amounts are for the federal fiscal year, and the state budget reflects the state fiscal year which begins one month prior to the federal fiscal year.

⁷ Cigna's contract with HHSC does not include the provision of CHIP health care services, or Medicaid disability or long-term support services.

Texas Medicaid provides services to some individuals through a traditional fee-for-service model⁸, but most are enrolled through a managed care model⁹. For providing these services, MCOs receive capitation payments, which are monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to MCOs at fixed, per member, per month, rates based on members' associated risk groups.¹⁰ These payments include federal and state funds.

In 2013, 100 percent of CHIP enrollees were in managed care. Collectively, approximately 84 percent of the combined Medicaid and CHIP populations (3.6 million individuals) were enrolled in managed care.

The IG Audit Division conducted this performance audit of Cigna in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Unless otherwise described, any year that is referenced is the state fiscal year, which covers the period from September 1 through August 31.

The IG Audit Division presented the audit results, issues, and recommendations to the HHSC Medicaid/CHIP Division and to Cigna in a draft report dated August 2, 2016. Each was provided the opportunity to study and comment on the recommendations. HHSC Medicaid/CHIP Division management responses are included in the report following each recommendation. HHSC Medicaid/CHIP Division concurred with the IG Audit Division recommendations, and will facilitate Cigna's development of a corrective action plan designed to improve Cigna's SIU function.

⁸ Medicaid fee-for-service was the original service delivery model for Texas Medicaid introduced in 1967. In this model, enrolled Medicaid providers are reimbursed retrospectively for a Medicaid eligible health care service or services provided to a Medicaid eligible patient.

⁹ Medicaid managed care was first introduced in pilot programs in Texas in 1993. In this model, the state contracts with MCOs who contract with Medicaid providers for the delivery of health care services to Medicaid enrollees. MCOs must provide the same services under managed care as provided under the traditional fee-for-service model.

¹⁰ A "risk group" is a group of MCO members that have a similar health status and are expected to have a similar Medicaid or CHIP spending pattern. HHSC applies an acuity risk adjustment to capitation rates to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. Final capitation payments are based on this acuity risk-adjusted premium for each combination of service area and risk group.

ISSUES AND RECOMMENDATIONS

Cigna maintains a fraud, waste, and abuse plan; the fundamental contractual and regulatory SIU requirement for MCOs. The plan describes ways Cigna can strengthen program integrity by monitoring service providers, auditing claims, identifying overpayments, and educating members and providers. Though the fraud, waste, and abuse plan is in place, Cigna needs to improve the function of its SIU in order to effectively implement the plan. During this audit, the IG Audit Division evaluated Cigna’s SIU and identified issues related to the:

- Number of fraud, waste, and abuse investigations and referrals; and the amount of recoveries.
- Review of provider payment histories.
- Scope of full-scale investigations.
- Verification of member services.
- Use of data analytic techniques to detect fraud, waste, or abuse.

Cigna received approximately \$333.2 million in Medicaid capitation payments in 2014, and \$713.7 million in 2015. Cigna maintained an average monthly membership of 24,872 Medicaid members during 2014, and 48,900 during 2015. Cigna’s significant increase in Medicaid members and \$380.4 million increase in capitation payments from 2014 to 2015 is primarily attributable to the addition of the MRSA Northeast service area, and secondarily to higher enrollment in its existing service areas. Table 1 shows the breakdown of capitation and delivery supplemental payments¹¹ by program and year. Capitation payments include both medical and pharmacy payments.

Table 1: Cigna Capitation and Delivery Supplemental Payments by Program¹²

Program	2014	2015	Total
Medicaid	\$ 333,247,668	\$ 713,670,064	\$ 1,046,917,732
CHIP	0	0	0
Total	\$ 333,247,668	\$ 713,670,064	\$ 1,046,917,732

Source: HHSC 2014 Year-End 334-Day FSR and HHSC 2015 Year-End 90-Day FSR

¹¹ A “delivery supplemental payment” is a one-time payment per pregnancy to STAR, CHIP, and CHIP Perinatal MCOs for the delivery of live or still births.

¹² Cigna did not participate in CHIP, and did not receive any delivery supplemental payments in 2014 or 2015.

Issue 1: THE SCOPE OF SIU INVESTIGATION ACTIVITIES WAS LIMITED

As specified by contract and regulations, SIU fraud, waste, and abuse plans define the essential activities of the SIU. Performance of these activities is critical for successful prevention, detection, investigation, and reporting of fraud, waste, and abuse.

In 2014 and 2015, 68 Investigations Opened, \$107,424 Recovered, and No Referrals Made

Though Cigna is maintaining an SIU function, Cigna's SIU identified a limited number of cases¹³ and recovery amounts of potential fraud, waste, or abuse in 2014 and 2015.

Consequently, during the two-year period under review, Cigna:

- Opened a total of 68 fraud, waste, or abuse investigations¹⁴.
- Recovered \$107,424 in Medicaid overpayments that occurred due to health care provider fraud, waste, or abuse. This represents 0.01 percent, or one one-hundredth of one percent, of Cigna's total medical claims dollars.
- Did not refer any cases to the IG or to the Office of Attorney General's Medicaid Fraud Control Unit.

During the two-year audit period, Cigna's SIU opened 68 investigations of suspected fraud, waste, or abuse. From September 2015 through February 2016, Cigna opened and investigated another 60 cases. While Cigna reported all 128 cases to IG as open investigations, Cigna did not refer any fraud, waste, or abuse cases to IG for IG investigation.

During the same two-year period, Cigna's health care providers submitted 3,914,445 Medicaid medical claims and were paid \$889.3 million medical claims dollars¹⁵. Table 2 shows a breakdown of the number and amount of medical claims by year along with the numbers of investigations and referrals, and amounts recovered.

¹³ SIU investigations are also referred to as "cases".

¹⁴ SIU investigations include both preliminary and full-scale investigations. A preliminary investigation may be closed without becoming a full-scale investigation.

¹⁵ "Medical claims dollars" are the total amounts submitted to MCOs by health care providers as payment requests for medical services performed. MCOs pay these medical claims as expenses for delivering covered health care services to members. Medical claims dollars include claims with a date of service that falls within the referenced year, and may or may not have been paid during the referenced year. Medical claims dollars for 2014 and 2015 include both medical and pharmacy amounts, but do not include MCO administrative costs. The informational report previously published for this audit did not include pharmacy amounts in medical claims dollars.

Table 2: Cigna Medicaid Medical Claims and SIU Performance Results

Year	Medical Claims	Medical Claims \$	# of SIU Investigations ¹⁶	SIU Recoveries ¹⁷	# of Referrals to IG
2014	1,405,428	\$ 287,943,218	22	\$ 51,716	0
2015	2,509,017	\$ 601,313,929	46	\$ 55,708	0
Total	3,914,445	\$ 889,257,147	68	\$ 107,424	0

Source: Cigna Correspondence; HHSC 2014 Year-End 334-Day FSR and HHSC 2015 Year-End 90-Day FSR; IG Investigations Referral Data

Audit results indicated that Cigna met required timeliness targets for preliminary investigations and full-scale investigations. For the cases reviewed by IG Audit Division, Cigna successfully recovered the overpayments identified in its investigations.

The IG Audit Division evaluated Cigna's investigation and reporting processes and identified the following issues related to SIU performance: Cigna's SIU (a) did not perform three-year reviews of provider payment histories and (b) focused its investigations too narrowly by focusing on the individual rather than the provider level.

A Three-Year Review of Provider Payment Histories Was Not Conducted

Cigna did not perform the payment history review of its providers that was required by its fraud, waste, and abuse plan^{18,19} and by Texas Administrative Code²⁰. When an SIU begins a preliminary investigation, it is required to evaluate "the provider's payment history for the past three years, if available, to determine if there are any suspicious indicators."²¹ Cigna performed a review of provider payment histories but for much shorter, and varied, durations than the standard three-year requirement. Reviewing three years of payments provides the SIU with a long enough timeframe to see patterns in provider claims that may indicate issues requiring further investigation.

By not conducting the three-year payment history review, potential suspicious provider patterns and common indicators of fraud, waste, and abuse may not have been detected or investigated by Cigna's SIU.

¹⁶ This includes the number of new investigations opened during the referenced year, regardless of whether they resulted in recoveries during the current or future years.

¹⁷ This includes the amounts recovered during the referenced year: 2014 recoveries resulted from 5 cases, all of which were opened in 2014; 2015 recoveries resulted from 17 cases, all of which were opened in 2015.

¹⁸ HealthSpring Fraud, Waste, and Abuse Compliance Plan, STAR+PLUS Program (2014).

¹⁹ Cigna-HealthSpring Fraud, Waste, and Abuse Compliance Plan, STAR+PLUS Program (2015, 2016).

²⁰ Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c)(2)(B)(iv) (March 1, 2012).

²¹ Ibid.

Investigations Were Often Limited to the Individual Rather than the Provider Organization Level

During full-scale investigations, Cigna often narrowly limited its claims reviews to the individual employee or attendant²² level rather than the provider organization level. Texas Administrative Code requires MCOs to select and review a sample of at least 50 recipients²³ during a full-scale investigation of suspected fraud, waste, and abuse. Texas Administrative Code states: “The sample must consist of a minimum of 50 recipients or 15% of a provider’s claims related to the suspected waste, abuse, and fraud; provided, however, that if the MCO selects a sample based upon 15% of the claims, the sample must include claims relating to at least 50 recipients.”²⁴

If Cigna saw suspicious patterns of billing related to an individual employee or attendant working for a home health provider, Cigna would often take a sample of claims related only to the individual employee or attendant. That employee or attendant may be caring for only one or two recipients, so rather than sampling 50 recipients from a broader sampling of the home health provider, Cigna would sample these one or two recipients, which would be 100 percent of the employee or attendant’s recipients. This approach assumes that the detected claim errors are limited to the employee or attendant, and that there is no broader issue with the way that claims are handled by that provider.

This limited review was too narrowly focused to find provider patterns of potential fraud, waste, and abuse. If no samples are taken from other recipients, no additional cases will be detected for the provider. By not expanding its samples to include other employees or attendants of the same provider, Cigna did not reach the minimum sample size of 50 recipients, and did not comply with the requirements of Texas Administrative Code.

For the two-year audit period through February 2016, 112 of 128 investigations were investigated and closed, and 16 cases remained open. The IG Audit Division reviewed 24 closed full-scale investigations²⁵ and found 11 cases without error. Thirteen of the cases, however, focused the investigation at the employee or attendant level rather than the provider organization level. The cases that focused on the individual level had lower average recoveries of \$472 compared to \$4,507 for investigations focused at the provider organization level. Table 3 shows the number of cases by investigation focus for the 24 full-scale investigations reviewed by the IG Audit Division.

²² An “attendant” is a person who provides direct patient care, and may be working as an employee of the provider or on a contract basis for the provider.

²³ A “recipient” is an MCO member that has received Medicaid or CHIP services.

²⁴ Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c)(2)(C) (March 1, 2012).

²⁵ The IG Audit Division reviewed 26 closed cases, but 2 of those cases were preliminary investigations only.

Table 3: Audited Sample of Cigna Investigations, by Full-Scale Investigation Focus and Amount Recovered²⁶

Full-Scale Investigation Focus	# of Sampled Investigations	Total Recoveries	Average Recovery
Individual Level	13	\$ 6,130.37	\$ 472
Provider Organization Level	11	\$ 49,577.69	\$ 4,507
Total	24	\$ 55,708.06	\$ 4,979 ²⁷

Source: IG Audit Division sample from Cigna schedule of closed full-scale investigations for September 2013 through February 2016

Although Cigna does investigate and recover overpayments, Cigna's SIU may miss potential fraud, waste, and abuse cases, and may not identify and recover all potential overpayments because of the limited focus of many of its full-scale investigations. Expanding samples to include other employees or attendants of the provider could reveal systemic issues with the provider and identify substantial additional dollars to be recovered by Cigna's SIU.

Recommendation 1

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Cigna to put corrective actions in place to strengthen its fraud, waste, and abuse activities, including:

- Reviewing three years of provider payment histories for suspicious patterns and indicators of fraud, waste, and abuse.
- Expanding full-scale investigations from the individual employee or attendant level to the provider level when substantiated or supported by risk.

The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel Cigna to perform SIU activities effectively.

HHSC Medicaid/CHIP Division Management Response

The Medicaid/CHIP Division is in agreement with the recommendation and will allow Cigna-HealthSpring ten (10) days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of the following:

- *Review three years of provider payment histories for suspicious patterns and indicators of fraud, waste, and abuse.*
- *Expand full-scale investigations to the provider level when substantiated or supported by risk.*

²⁶ Includes full-scale investigations closed and amounts recovered for sampled cases. Not all cases had recoveries. All recoveries were from the 17 cases with recoveries in 2015.

²⁷ This figure represents the average of the combined totals, \$55,708.06 total recoveries divided by 24 total closed investigations.

The Medicaid/CHIP Division expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Cigna-HealthSpring. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Cigna-HealthSpring to effectively perform SIU activities.

Prior to approving actions within the CAP, the Medicaid/CHIP Division will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: December 2016

Issue 2: SIU ACTIVITIES NECESSARY TO DETECT FRAUD, WASTE, AND ABUSE WERE NOT PERFORMED

SIU fraud, waste, and abuse plans define the activities of the SIU that are critical for the successful prevention, detection, investigation, and reporting of fraud, waste, and abuse.

The IG Audit Division evaluated Cigna’s prevention processes and found no issues with provider credentialing, re-credentialing, or training related to ethics and fraud, waste, and abuse. In the samples tested, Cigna completed the credentialing process prior to the addition of each provider to the Cigna network, and completed the re-credentialing process every three years. The IG Audit Division found no exceptions in the samples tested regarding the provision of fraud, waste, and abuse training to employees and subcontractors, and found no issues with the training materials and support that Cigna delivers to the 14,400 providers in its network.

The IG Audit Division evaluated Cigna’s detection processes and determined that the hotline referral system is effective and contributed several cases to Cigna’s SIU for investigation.

Cigna did not, however, effectively perform SIU activities that could have resulted in the detection of fraud, waste, and abuse. The only potential fraud, waste, and abuse cases Cigna detected came either through referrals or from its third-party claims administrator. Cigna detected no fraud, waste, or abuse cases through SIU efforts such as verification of services or data analytics.

The IG Audit Division reviewed 26 cases that were closed by Cigna’s SIU. Table 4 shows the number of investigations by the method of case detection. The closed cases were either referred to Cigna or generated by the third-party claims administrator.

Table 4: Cigna Case Detection Method

Case Detection Method	Number of Cases
Referrals from Cigna Employees	3
Referrals from SIU Hotline / Members	11
Referrals from the IG	1
Detected by third-party claims administrator	11
Total cases received	26

Source: IG Audit Division sample from Cigna schedule of closed investigations for September 2013 through February 2016

The IG Audit Division evaluated Cigna’s prevention and detection processes and identified the following issues related to SIU performance: Cigna’s SIU did not (a) perform verification of services or (b) utilize effective data analytics for fraud, waste, and abuse detection.

Verification of Services Was Not Performed

Cigna's SIU did not conduct recipient verifications to confirm that services billed by providers were delivered to the recipient. Cigna's approved fraud, waste, and abuse plan states that the SIU will perform this verification by developing and implementing "a procedure for verifying with beneficiaries whether services billed by providers were actually received. This consists of sending Explanations of Benefits (EOBs) to a random sample of our Texas Medicaid beneficiaries."²⁸ Though required by its fraud, waste, and abuse plan, Cigna did not send out EOBs to any of its Medicaid members.

By not performing verification procedures, Cigna was less likely to detect potential fraud, waste, and abuse committed by providers that would indicate the need for further investigation and possible recovery.

Limited Manual Prepayment Processes and No Post-Payment Data Analytic Processes Were Utilized for Fraud, Waste, and Abuse Detection

Cigna's SIU performed limited prepayment activities for detection of fraud, waste, and abuse. During the audit period, Cigna engaged a third-party claims administrator that provides routine prepayment edit checks of claims, and detection of potential issues related to duplicate payments, incorrect coding, and rate errors. These prepayment reviews are standard business practice, but do not constitute prepayment analysis for fraud, waste, and abuse detection. Cigna's three SIU staff performed manual prepayment reviews of some claims and did not detect any fraud, waste, or abuse cases through this manual review.

Cigna's SIU also did not apply post-payment data analytics, including applying algorithms or other techniques that are effective for detecting potential fraud, waste, and abuse. Cigna's SIU did not implement automatic triggers or establish application parameters that would identify and report suspected fraud and other abnormal claims to the SIU for further research, nor did Cigna establish standardized queries for monthly reporting or trend analysis related to fraud, waste, and abuse, or for any other post-payment claims analysis.

Texas Administrative Code requires SIUs to detect and identify "Medicaid program violations and possible waste, abuse, and fraud overpayments through data matching, analysis, trending, and statistical activities...monitoring of service patterns for providers, subcontractors, and recipients...[and] use of edits or other evaluation techniques."²⁹ Post-payment claims analysis enables more complex data analysis over larger periods of time than is available at a prepayment level. Both post-payment claims analysis and prepayment analysis are critical components of an effective SIU function.

²⁸ Cigna-HealthSpring Fraud, Waste, and Abuse Compliance Plan, STAR+PLUS Program (2014, 2015).

²⁹ Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c)(1) (March 1, 2012).

Recommendation 2

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Cigna to put corrective actions in place to strengthen its fraud, waste, and abuse activities, including:

- Conducting recipient verifications to confirm that services billed by providers were delivered to the recipient.
- Enhancing data analytic techniques to identify unusual trends and anomalies in provider claims, and applying data analytics to effectively detect fraud, waste, and abuse.

The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel Cigna to effectively perform SIU activities.

HHSC Medicaid/CHIP Division Management Response

The Medicaid/CHIP Division is in agreement with the recommendation and will allow Cigna-HealthSpring ten (10) days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of the following:

- *Conduct recipient verifications to confirm that services billed by providers were delivered to the recipient.*
- *Enhance data analytic techniques to identify unusual trends and anomalies in provider claims, and apply data analytics to effectively detect fraud, waste, and abuse.*

The Medicaid/CHIP Division expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Cigna-HealthSpring. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Cigna-HealthSpring to effectively perform SIU activities.

Prior to approving actions within the CAP, the Medicaid/CHIP Division will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: December 2016

CONCLUSION

The IG Audit Division's audit of Cigna's SIU performance included an evaluation of policies and practices associated with preventing, detecting, investigating, and reporting fraud, waste, and abuse. The IG Audit Division conducted a site visit from March 7, 2016 through March 10, 2016, at a Cigna facility in Bedford, Texas.

HHSC and Cigna share accountability for ensuring that state and federal dollars are used to deliver cost-effective health care services to eligible Medicaid enrollees. An effective SIU function is essential to ensure that:

- State and federal funds spent on managed care are used appropriately.
- Suspected fraud is detected, investigated, and when substantiated, reported to the IG or the Office of Attorney General's Medicaid Fraud Control Unit.
- Funds lost to fraud, waste, and abuse are recovered and reported to HHSC.
- Capitation rates established for Medicaid accurately reflect the cost of providing health care services to eligible beneficiaries.

Based on the results of its audit of Cigna's SIU, the IG Audit Division concludes that:

- Cigna's SIU investigations resulted in limited recoveries, due to the limited scope of Cigna SIU activities.
- Cigna's SIU preliminary investigations were consistently limited in scope, and many full-scale investigations were limited as well.
- Cigna's SIU did not perform key fraud, waste, and abuse detection activities, including recipient verifications and post-payment data analytics.

The IG Audit Division offered recommendations to the HHSC Medicaid/CHIP Division which, if implemented, will:

- Increase the scope of Cigna SIU investigations, providing greater opportunity to successfully investigate, refer, and recover fraud, waste, and abuse.
- Improve detection capabilities, increase identification of potential fraud, waste, and abuse, and increase recoveries.

The IG Audit Division thanks management and staff at the HHSC Medicaid/CHIP Division and at Cigna for their cooperation and assistance during this audit.

Appendix A: OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to evaluate the effectiveness of Cigna's SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

Scope

The scope of the performance audit of the Cigna SIU included the period of September 2013 through August 2015 as well as review of relevant SIU activities through February 2016. The scope of this audit included review of:

- Contractor and subcontractor processes and activities that support SIU fraud, waste, and abuse plans.
- Policies and practices supporting the prevention, detection, investigation, and recovery activities of the SIU.
- Policies and practices supporting the reporting of SIU activities and results to HHSC.
- Data and information technology systems that support SIU processes and reporting.

Methodology

To accomplish its objective, the IG Audit Division collected information for this audit through discussions and interviews with responsible management at Cigna, and through request and review of the following information from Cigna:

- A description of the SIU function and organizational structure.
- A list of SIU employees, including their names, titles, and a description of their qualifications.
- Policies and practices associated with prevention and detection of fraud, waste, and abuse.
- Data related to SIU performance, including investigations, recoveries, and referrals in 2014 and 2015.
- A description and flowchart of the SIU investigation process.
- Data and information systems that support the SIU activities and data processing necessary to produce reports for submission to HHSC.
- A list and a description of each automated process or control in place to detect fraud, waste, and abuse.

The IG Audit Division issued an engagement letter to Cigna providing information about the upcoming SIU audit, and conducted fieldwork at Cigna's facility in Bedford, Texas from

March 7, 2016 through March 10, 2016. While on-site, the IG Audit Division interviewed responsible SIU personnel, evaluated policies and practices relevant to the SIU function, and reviewed relevant SIU activities, including those related to prevention, detection, investigation, disposition, and reporting.

While at Cigna's facility, the IG Audit Division reviewed and copied documentation and records related to the SIU function. No original records were removed from Cigna's premises. Upon request, Cigna sent additional documents that were requested during the audit, but were not available during the on-site review, to the IG Audit Division offices for review.

Professional judgment was exercised in planning, executing, and reporting the results of this audit. The IG Audit Division used the following criteria to evaluate the information provided:

- Cigna Fraud, Waste, and Abuse Compliance Plan
- Cigna SIU Policies and Procedures
- Uniform Managed Care Manual
- Uniform Managed Care Contract Terms and Conditions
- Texas Administrative Code
- Texas Government Code
- Code of Federal Regulations

The IG Audit Division reviewed the SIU data and reports produced by the claims management system at Cigna. The IG Audit Division determined the data was sufficiently reliable for the purposes of the audit. In order to make this determination, the IG Audit Division:

- Interviewed MCO officials knowledgeable about the data.
- Validated that the queries and parameters used to produce SIU reports were appropriately modified.
- Reviewed the access management process for appropriateness.
- Reconciled potential fraud, waste, and abuse claims reports to source documents.

The IG Audit Division conducted the audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that auditors plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on audit objectives. The IG Audit Division believes that the evidence obtained provides a reasonable basis for the issues and conclusions based on audit objectives.

Appendix B: SAMPLING METHODOLOGY

The IG Audit Division examined SIU activities for the period from September 2013 through August 2015. After an initial assessment of risk across SIU activities and contractor performance outcomes, the IG Audit Division performed testing from the population of Cigna employees, subcontractors, and providers.

Cigna Employee and Subcontractor Training

The IG Audit Division conducted sample testing in order to assess whether Cigna employees had received annual ethics and fraud, waste, and abuse trainings required by Texas Administrative Code. The IG Audit Division selected a simple random sample³⁰ using a random number generator. The sample size included 50 employees from the total population of 368 Cigna staff who were employed at any time during the two-year audit period. Cigna utilized 20 subcontractors during the audit period, and the IG Audit Division selected 100 percent of subcontractors to review whether fraud, waste, and abuse training was provided.

The IG Audit Division evaluated whether Cigna employees received required ethics and fraud, waste, and abuse trainings by comparing whether the employees in the sample had signed a fraud, waste, and abuse training sign-in sheet to indicate attendance. For subcontractors, the IG Audit Division evaluated documentation submitted by Cigna related to subcontractor fraud, waste, and abuse training.

Cigna Provider Credentialing

The IG Audit Division conducted sample testing to assess whether the provider credentialing process was conducted on a timely basis. The IG Audit Division selected a simple random sample using a random number generator. The sample size included 50 providers from the total population of 14,400 unique STAR+PLUS providers enrolled with Cigna during the two-year audit period.

The IG Audit Division assessed whether the provider credentialing process was conducted on a timely basis by reviewing the sampled providers' credentialing files to verify that the credentialing process was completed prior to their addition to the Cigna network, and that re-credentialing was completed at least once every three years thereafter.

³⁰ Random sampling is a method by which every element in the population has an equal chance of being selected.

The IG Audit Division requested schedules of the total population for the audit period and selected a judgmental sample³¹ of 20 percent of the population with a minimum sample size of 25 and a maximum of 50. Where the total population was 30 or less, the IG Audit Division tested 100 percent of the population. Samples reflected a 50:50 ratio between 2014 and 2015. This methodology provided sufficient and appropriate evidence to make determinations regarding the test objectives.

Cigna SIU Investigations

The IG Audit Division conducted sample testing to assess whether SIU investigations were conducted according to statutory and fraud, waste, and abuse plan requirements, and on a timely basis. During the audit period and through February 2016, 128 cases of suspected fraud, waste, and abuse were opened by Cigna's SIU. Of the 128 cases, 112 were investigated and closed, and 16 cases remained open.

The IG Audit Division selected a judgmental sample of 20 percent of the population of investigations opened during the audit period for a total of 26. This methodology provided sufficient and appropriate evidence to make determinations regarding the test objectives.

The IG Audit Division assessed whether investigations were conducted on a timely basis by determining whether investigations met the time frames required by Texas Administrative Code. The IG Audit Division also assessed whether appropriate records were requested and reviewed, and where applicable, whether overpayments were recovered.

³¹ Judgmental sampling is a non-probability sampling method where the auditor selects the sample based on certain characteristics, such as dollar amount, timeframe, or type of transaction.

Appendix C: REPORT TEAM AND REPORT DISTRIBUTION

Report Team

The IG staff members who contributed to this audit report include:

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Hilary Evbayiro, CPA, Audit Manager
- Jeff Jones, CPA, CIGA, Audit Project Manager
- Babatunde Sobanjo, PhD, Auditor
- Netza Gonzalez, MBA, MSM, CISA, CFE, IT Audit Project Manager
- Jude Ugwu, MBA, CFE, CRMA, Auditor
- JoNell Abrams, Auditor
- Angelica Villafuerte, Auditor
- Sarah Warfel, IT Auditor
- Lorraine Chavana, Quality Assurance Reviewer
- Collette Antoine, MBA, MPH, Senior Audit Operations Analyst

Report Distribution

Health and Human Services Commission

- Charles Smith, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Kara Crawford, Chief of Staff
- Gary Jessee, Deputy Executive Commissioner for Medical and Social Services
- Tony Owens, Deputy Director, Medicaid/CHIP Division Contract and Performance Management
- Karin Hill, Director of Internal Audit

Cigna-HealthSpring

- Jay Hurt, President and Chief Executive Officer
- Pamela Daniels, Medicaid Compliance Officer
- John Wentz, Business Integrity Unit Manager

Appendix D: IG MISSION AND CONTACT INFORMATION

Inspector General Mission

The mission of the IG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of IG's mission and statutory responsibility includes:

- Stuart W. Bowen, Jr. Inspector General
- Sylvia Hernandez Kauffman Principal Deputy IG
- Christine Maldonado Chief of Staff and Deputy IG for Operations
- Frank Bryan Counselor to the IG
- Quinton Arnold Senior Advisor and
Deputy IG for Inspections and Evaluations
- David Griffith Deputy IG for Audit
- James Crowley Deputy IG for Investigations
- Cynthia Reyna Chief Counsel

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- Phone: 1-800-436-6184

To Contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
Inspector General
P.O. Box 85200
Austin, Texas 78708-5200
- Phone: 512-491-2000