OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

Seton Health Plan SIU
Activities, Resources, and Infrastructure

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HHSC IG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL

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Seton Health Plan SIU Activities, Resources, and Infrastructure

WHY IG DID THIS AUDIT

Seton is one of 22 managed care organizations (MCOs) contracted to provide Medicaid and CHIP health care services in Texas. Approximately 84 percent of individuals enrolled in Medicaid or CHIP are members of an MCO. At approximately $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. IG is responsible for approving SIU annual plans, and evaluating and sometimes investigating SIU referrals.

This is the first in 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 IG RECOMMENDS

IG recommends that HHSC require Seton to put corrective actions in place to strengthen Seton's fraud, waste, and abuse activities, and to strengthen Seton's resource and infrastructure commitment to its SIU function.

View **IG-16-011**
For more information, contact:
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WHAT IG FOUND

Though Seton Health Plan (Seton) maintains the contractually required annual SIU fraud, waste, and abuse plan, Seton has not effectively implemented the plan.

Seton received approximately $52.9 million in Medicaid and CHIP capitation and delivery supplemental payments in 2014, and $51.8 million in 2015, and paid approximately $88.3 million in medical claims dollars over those two years. During this two-year period, Seton's SIU did not open or conduct any investigations, recover any overpayments, or refer any fraud, waste, or abuse cases to IG or the Office of Attorney General.

Year	Medical Claims	Medical Claims $	# of Investigations	Amount of Recoveries	# of Referrals
2014	169,472	$ 42,708,580	0	$ 0	0
2015	196,734	$ 45,617,703	0	$ 0	0
Total	366,206	$ 88,326,283	0	$ 0	0

Although Seton's annual fraud, waste, and abuse plan outlined the essential activities needed for an effective SIU, Seton failed to perform these activities. Seton did not conduct recipient verifications to confirm that services billed by providers were delivered to the recipient, nor did it maintain a log of suspected fraud, waste, and abuse referrals. Seton's SIU also did not perform the prepayment or post-payment data analytics that would effectively detect potential fraud, waste, and abuse.

Personnel, policies and procedures, and training are essential foundations for the successful prevention, detection, investigation, and reporting of fraud, waste, and abuse. Seton's annual fraud, waste, and abuse plan indicated that Seton would deploy adequate resources and infrastructure for an effective SIU; however, Seton did not assign adequate personnel resources to effectively accomplish SIU activities, and no SIU policies or procedures were developed to provide specific guidance to staff in implementing the general requirements of the fraud, waste, and abuse plan. In addition, fraud, waste, and abuse training was not consistently provided to employees and subcontractors.

Until Seton increases its resources, infrastructure, and activities related to the SIU function, HHSC does not have assurance that Seton 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 Seton's development of a corrective action plan designed to improve Seton'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.

TABLE OF CONTENTS

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 the second in a series of reports on MCO SIUs. The first was an informational report that provided background, context, and a compilation of information provided by the 22 Texas Medicaid and CHIP MCOs[1]. This audit report is focused on SIU activities at Seton Health Plan (Seton). The IG Audit Division will continue to release audit reports for selected MCO SIUs as the audit proceeds.

Background

Seton is a licensed Texas MCO contracted to provide Medicaid and CHIP services through its network of providers. Seton coordinates health services for two managed care programs: the Children's Health Insurance Program (CHIP), and the Medicaid State Texas Access Reform (STAR) program for members[2] in Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson counties.

Seton 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, HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, and abuse by members and health care service providers.[3] An MCO may contract with an outside organization to perform all or part of the activities

[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.

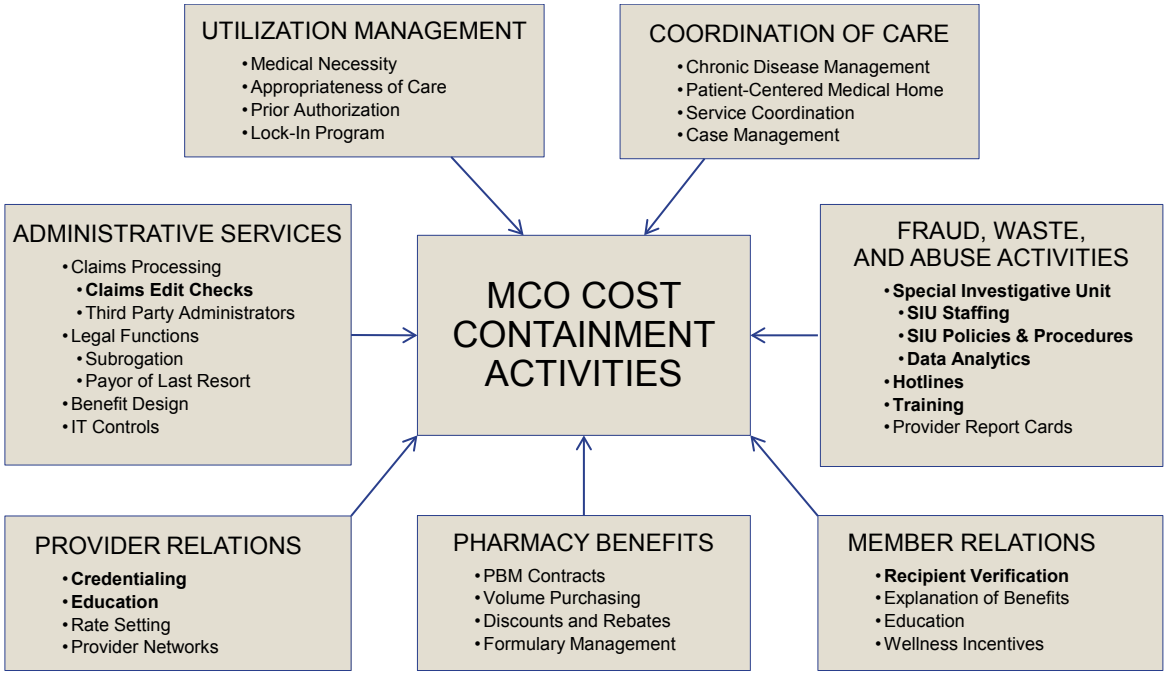
[2] MCOs refer to enrollees as "members." An "enrollee" is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

[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).

associated with the SIU. Seton 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 Seton 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 Seton'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 Seton. IG is responsible for approving Seton's annual fraud, waste, and abuse plan,[5] and evaluating and sometimes investigating any fraud referrals it receives from Seton. Seton is required by its contract to refer suspected fraud, waste, and abuse to IG. When IG determines it will not pursue an SIU referral, Seton is responsible for recovery of any Medicaid and CHIP 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. 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. Texas Medicaid provides services to some individuals through a traditional fee-for-service model[8], but most are enrolled through a managed care model[9]. For providing these services,

[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] Seton's contract with HHSC does not include the provision of disability or long-term support services.

[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

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 conducted this performance audit of Seton in accordance with *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 audit results, issues, and recommendations to the HHSC Medicaid/CHIP Division and to Seton Health Plan in a draft report dated April 14, 2016. Each was provided with the opportunity to study and comment on the report. HHSC Medicaid/CHIP Division management responses to the recommendations contained in the report are included in the report following each recommendation. Seton Health Plan comments are included in Appendix C. HHSC Medicaid/CHIP Division concurred with the IG Audit Division recommendations, and will facilitate Seton Health Plan's development of a corrective action plan designed to improve Seton's SIU function.

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

Seton maintains a fraud, waste, and abuse plan; the fundamental contractual and regulatory SIU requirement for MCOs. The plan describes ways Seton can strengthen program integrity by monitoring service providers, auditing claims, identifying overpayments, and educating members and providers about Medicaid program integrity. Though the fraud, waste, and abuse plan is in place, Seton has not effectively implemented the plan. As a result, weaknesses exist in the structure and function of Seton's SIU. During this audit, the IG Audit Division evaluated Seton's SIU and identified issues related to the:

- Number of fraud, waste, and abuse investigations and referrals; and the amount of recoveries.
- Verification of member services.
- Utilization of data analytics to detect potential fraud, waste, or abuse.
- Tracking of fraud referrals submitted through a fraud hotline or other source.
- Organizational structure and number of personnel committed to the SIU.
- Policies and procedures for executing its fraud, waste, and abuse plan.
- Delivery of fraud, waste, and abuse training to employees and subcontractors.

Seton received approximately $52.9 million in Medicaid and CHIP capitation and delivery supplemental payments[11] in 2014, and $51.8 million in 2015. Seton maintained an average monthly membership of 12,345 Medicaid members and 12,875 CHIP members during 2014, and 17,003 Medicaid members and 8,552 CHIP members during 2015. Table 1 shows the breakdown of capitation payments by program. Capitation payments include both medical and pharmacy payments.

Table 1: Seton Capitation and Delivery Supplemental Payments by Program

Program	2014	2015	Total
Medicaid	$ 32,459,705	$ 37,841,539	$ 70,301,244
CHIP	$ 20,442,720	$ 13,974,573	$ 34,417,293
Total	$ 52,902,425	$ 51,816,112	$ 104,718,537

Source: HHSC 2014 Year-End 334-Day FSR and 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.

Issue 1: SETON DID NOT PERFORM ACTIVITIES NEEDED TO IMPLEMENT ITS FRAUD, WASTE, AND ABUSE PLAN

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 detection, investigation, and reporting of fraud, waste, and abuse.

In 2014 and 2015, No Investigations Were Opened, Recoveries Pursued, or Referrals Made

Though Seton is maintaining an SIU function with a fraud, waste, and abuse plan, Seton's SIU did not identify any potential fraud, waste, or abuse in 2014 or 2015. Consequently, during the two-year period under review, Seton did not:

- Open or conduct any fraud, waste, or abuse investigations.
- Refer any substantiated cases to IG or to the Office of Attorney General's Medicaid Fraud Control Unit.
- Recover any Medicaid or CHIP overpayments that occurred due to health care provider fraud, waste, or abuse.

During the same two-year period, Seton's health care providers submitted 366,206 Medicaid and CHIP medical claims and were paid $88.3 million medical claims dollars[12]. Table 2 shows a breakdown of the number and amount of medical claims by year along with the number of investigations and referrals, and amounts recovered.

Table 2: Seton Medicaid and CHIP Medical Claims and SIU Performance Results

Year	Medical Claims	Medical Claims $	# of Investigations	Recoveries	# of Referrals
2014	169,472	$ 42,708,580	0	$ 0	0
2015	196,734	$ 45,617,703	0	$ 0	0
Total	366,206	$ 88,326,283	0	$ 0	0

Source: Seton All Claims Summary SFY 2014-2016; Seton 2014 Year-End 334-Day FSR and 2015 Year-End 90-Day FSR

[12] "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.

The IG Audit Division evaluated Seton SIU activities and identified issues related to performance of key SIU activities. One area that was not an issue related to provider credentialing. The IG Audit Division tested a sample of providers to determine whether Seton (a) completed the credentialing process prior to the addition of each provider to the Seton network, and (b) completed the re-credentialing process every three years thereafter. The IG Audit Division identified no exceptions. Other activities that the IG Audit Division tested with no exceptions included: the exclusion verification process, random payment reviews, and periodic provider audits.

The IG Audit Division identified the following issues related to SIU performance: Seton's SIU did not (a) perform verification of services, (b) utilize effective data analytics, or (c) maintain a log of fraud, waste, and abuse referrals.

Verification of Services Was Not Performed

Seton's SIU did not conduct recipient verifications to confirm that services billed by providers were delivered to the recipient. Seton's approved fraud, waste, and abuse plan states that the SIU will verify that recipients received billed services by regularly conducting activities including member interviews and member surveys. As indicated in its fraud, waste, and abuse plan, Seton "will regularly utilize methods to verify that recipients received billed services."[13]

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

Data Analytic Techniques Were Not Utilized to Detect Fraud, Waste, or Abuse

Seton's SIU prepayment activities are not focused on detecting fraud, waste, and abuse. During the audit period, Seton engaged a third-party administrator that provides routine prepayment edit checks of claims, and detection of potential issues related to duplicate payments, incorrect coding, and rate errors. In addition, Seton employed two claims processors who performed manual reviews of provider claims, such as verifying the accuracy of claims exceeding $10,000, prior to processing the claims. These two individuals manually processed an average of 1,187 claims per week.[14] These reviews performed by Seton prior to processing claims are standard business practice, but do not constitute prepayment analysis for fraud, waste, and abuse detection.

Seton's SIU also did not apply post-payment data analytics, including algorithms and other techniques that are effective for detecting potential fraud, waste, and abuse. Seton's SIU did

[13] Seton Health Plan, Inc. Fraud, Waste, and Abuse Compliance Plan, CHIP and STAR Programs (2014, 2015).

[14] This average was calculated on a calendar year basis for 2015.

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 Seton 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."[15] 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.

A Log of Fraud Referrals Was Not Maintained

Seton did not maintain a log of all instances of suspected fraud, waste, and abuse received by the MCO. Seton may receive potential fraud, waste, and abuse referrals from several sources, including:

- IG
- Provider services
- A member services hotline
- A fraud, waste, and abuse hotline

However, any referrals received from these sources were not recorded on a log. Texas Administrative Code states that each MCO keep a "log of all incidences of suspected waste, abuse and fraud received by the MCO regardless of the source. The log must contain the subject of the complaint, the source, the allegation, the date the allegation was received, the recipient's or provider's Medicaid number, and the status of the investigation."[16]

Responsible management at Seton indicated that in the two-year period under review, no referrals were received from either members or providers, and that only one referral was received from IG. This referral from IG was not recorded on a log, but was recalled by Seton management during interviews with the IG Audit Division. Without a referral log, Seton cannot ensure that referrals are monitored and addressed appropriately and in a timely manner.

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

[16] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(d)(2) (March 1, 2012).

Recommendation 1

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Seton 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.
- Maintaining referral logs to record and track referrals of suspected fraud, waste, and abuse received from IG, providers, and Seton fraud hotlines.

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

HHSC Medicaid/CHIP Division Management Response

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

- *Recipient verifications to confirm that services billed by providers were delivered to the recipient.*
- *Data analytic techniques to identify unusual trends and anomalies in provider claims, and applying data analytics to effectively detect fraud, waste, and abuse.*
- *Referral logs to record and track referrals of suspected fraud, waste, and abuse received from IG, providers, and Seton fraud hotlines.*

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 Seton. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Seton 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.

Seton has indicated it will transition its SIU responsibilities to a third party in December 2016. The Medicaid/CHIP Division will request the new fraud, waste, and abuse plan under the third party to be reviewed and approved by the IG Investigations Division prior to the December transition.

Responsible Individual: Deputy Director, MCD Contract and Performance Management

Target Implementation Date: August 2016

Issue 2: SETON DID NOT DEPLOY RESOURCES AND INFRASTRUCTURE NECESSARY FOR AN EFFECTIVE SIU

As specified by contract and regulations, MCOs are required to maintain adequate staff and resources needed for an effective SIU function. Personnel, policies and procedures, and training are essential foundations for the successful prevention, detection, investigation, and reporting of fraud, waste, and abuse.

During fieldwork, the IG Audit Division evaluated Seton SIU personnel resources and infrastructure and identified several issues related to key SIU requirements. These issues include the following: Seton (a) did not have adequate personnel assigned to the SIU, (b) had not developed policies and procedures to support the SIU, and (c) did not provide adequate fraud, waste, and abuse training.

Adequate Personnel Resources Were Not Dedicated to the SIU

Seton has no personnel whose primary function is to prevent, detect, and investigate potential fraud, waste, and abuse. In consultation with Seton's Executive Director, the Senior Director of Corporate Responsibility and HIPAA Privacy Officer at Seton Healthcare Family oversees Seton's SIU. This assigned officer is responsible for leading the corporate responsibility program across all Seton sites, coordinating compliance training, and identifying and investigating high-risk business areas, along with overseeing operation of the SIU.

In addition to the assigned officer, Seton has appointed seven members to an SIU committee. This committee is predominantly composed of management, and includes representatives of the Contracting, Operations, Claims, and Medical Departments. The SIU committee is chartered to meet once a month to address potential fraud, waste, and abuse within the Seton system, but there are no personnel primarily focused on completing SIU functions and activities. This does not constitute sufficient personnel resources to effectively prevent, detect, and investigate potential fraud, waste, and abuse.

The IG Audit Division recognizes the importance of management participating in, and creating an organizational culture that values the prevention and detection of fraud, waste, and abuse. However, a committee of managers and directors does not supersede the need for trained professionals in data analytics, investigations, and medical analysis, whose primary focus is combatting fraud, waste, and abuse.

According to responsible management, Seton's commitment to the SIU function is appropriate given the size of the organization. However, safeguarding the integrity of the Medicaid program encompasses a broad spectrum of cooperative activities. It relies upon sophisticated analysis of claims and utilization data and a skilled and dedicated staff. Seton’s

contract states that "the SIU must have adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases…"[17] Seton does not have adequate personnel to accomplish SIU activities.

Policies and Procedures to Guide SIU Activities Did Not Exist

Seton has not developed policies and procedures to guide the execution of the fraud, waste, and abuse plan. Although a fraud, waste, and abuse plan provides a general approach for an SIU function, detailed policies and procedures are necessary to provide specific guidance for SIU personnel on:

- Detecting potential fraud, waste, and abuse.
- Conducting preliminary investigations to determine whether fraud is substantiated.
- Recovering Medicaid and CHIP funds.
- Referring cases to IG and to the Office of Attorney General Medicaid Fraud Control Unit.

For example, Seton's approved fraud, waste, and abuse plan states that "the SIU will follow the process as outlined in the Seton Health Plan Policies and Procedures to conduct its investigation."[18] However, Seton personnel have no detailed procedures, checklists, documentation templates, or other tools to direct them in conducting an investigation, because there is no Seton Health Plan Policies and Procedures manual or guidance. Detailed policies and procedures would help ensure SIU activities are consistently performed and meet management expectations for quality and timeliness, and they are essential to effectively operating the SIU function.

Fraud, Waste, and Abuse Training Was Not Consistently Provided

Seton employees and subcontractors did not consistently receive annual fraud, waste, and abuse awareness training, as required by Texas regulations. The IG Audit Division selected a sample of employees and subcontractors to confirm whether each had received required training. In 2014, 15 of 21 employees received annual fraud, waste, and abuse training, and 8 of 21 employees received training in 2015.

The IG Audit Division reviewed fraud, waste, and abuse training data submitted by Seton for its two subcontractors. MediView, a third-party administrator, stated that 61 of its employees completed the required training in 2014, but evidence of training was provided for only 4 employees. For 2015, MediView stated that all employees involved in Medicaid attended

[17] 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).

[18] Seton Health Plan, Inc. Fraud, Waste, and Abuse Compliance Plan, CHIP and STAR Programs (2014, 2015).

fraud, waste, and abuse training, but no evidence of training attendance was provided. Navitus Health Solutions, a pharmacy benefits manager, stated that its employees completed the training for 2014, but had not yet completed the training for 2015. Navitus did not provide any further evidence of training attendance for 2014 or 2015.

Texas Administrative Code requires MCOs to provide fraud, waste, and abuse training to all employees and subcontractors. It states: "On an annual basis, the MCO must ensure that waste, abuse, and fraud training is provided to each employee and subcontractor who is directly involved in any aspect of Medicaid."[19] Regulations also require that the training be targeted for the particular roles and responsibilities of the employee or subcontractor. Texas Administrative Code states: "The training must be specific to the area of responsibility for the MCO and subcontractor staff receiving the training and contain examples of waste, abuse, or fraud in their particular area of interest."[20]

Without annual training, Seton's employees and subcontractors lack the knowledge and awareness needed to prevent, detect, and report suspected fraud, waste, and abuse to the SIU.

Recommendation 2

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Seton to strengthen its resource and infrastructure commitment to its SIU function by:

- Ensuring that adequate personnel resources are assigned to the SIU to perform all tasks required of the SIU function.
- Developing and implementing internal policies and procedures for executing the fraud, waste, and abuse plan. These must include detailed guidance for (a) detecting and investigating potential fraud, (b) referring substantiated cases to IG and the Office of Attorney General's Medicaid Fraud Control Unit, and (c) recovering Medicaid and CHIP funds lost to fraud, waste, or abuse.
- Ensuring that employees and subcontractors receive fraud awareness training on an annual basis that is appropriate for their roles and responsibilities.

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

[19] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c)6 (March 1, 2012).

[20] Ibid.

HHSC Medicaid/CHIP Division Management Response

The Medicaid/CHIP Division is in agreement with the recommendations and will allow Seton ten days from receipt of the final audit report to submit a corrective action plan (CAP) that includes:

- *Ensuring that adequate personnel resources are assigned to the SIU to perform all tasks required of the SIU function.*
- *Development and implementation of internal policies and procedures for executing the fraud, waste, and abuse plan that include detailed guidance for (a) detecting and investigating potential fraud, (b) referring substantiated cases to IG and the Office of Attorney General's Medicaid Fraud Control Unit, and (c) recovering Medicaid and CHIP funds lost to fraud, waste, or abuse.*
- *Ensuring that employees and subcontractors receive fraud awareness training on an annual basis that is appropriate for their roles and responsibilities.*

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 Seton. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Seton 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.

Seton has indicated it will transition its SIU responsibilities to a third party in December 2016. The Medicaid/CHIP Division will request the new fraud, waste, and abuse plan under the third party to be reviewed and approved by the IG Investigations Division prior to the December transition.

Responsible Individual: Deputy Director, MCD Division Contract and Performance Management

Target Implementation Date: August 2016

CONCLUSION

The IG Audit Division completed an audit of Seton SIU performance. The audit included an evaluation of policies and practices associated with preventing, detecting, and investigating fraud, waste, and abuse. The IG Audit Division conducted a site visit from February 22, 2016 through February 25, 2016 at a Seton facility in Austin, Texas.

HHSC and Seton share accountability for ensuring that state and federal dollars are used to deliver cost-effective health care services to eligible Medicaid and CHIP members. 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 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 and CHIP accurately reflect the cost of providing health care services to eligible beneficiaries.

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

- Seton SIU resources, infrastructure, and activities designed to detect potential fraud, waste, and abuse in the Medicaid and CHIP managed care programs were not effective.
- Policies and procedures that should provide guidance to SIU members in executing the fraud, waste, and abuse plan have not been developed, and the SIU function has not performed many activities required by Texas Administrative Code.
- Adequate personnel have not been assigned to perform required SIU activities.
- Fraud awareness training was not delivered to a majority of Seton employees and subcontractors.

Until Seton increases its resources, infrastructure, and activities related to the SIU function, HHSC does not have assurance that Seton is maintaining an effective SIU that successfully guards against losses due to fraud, waste, and abuse. The IG Audit Division offered recommendations to the HHSC Medicaid/CHIP Division which, if implemented, will:

- Increase the time allocated to SIU activities, providing greater opportunity to successfully prevent, detect, and investigate fraud, waste, and abuse.
- Increase employee and subcontractor knowledge and awareness of fraud, waste, and abuse to improve the frequency of prevention and detection.
- Produce robust data and information activities that support timely prevention and detection of fraud, waste, and abuse.

- Introduce key activities designed to prevent and detect fraud, waste, and abuse, and track and recover losses due to fraud, waste, and abuse.
- Provide standardized, consistent policies and procedures that will strengthen prevention, detection, investigation and recovery efforts.

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

Appendix A: SCOPE AND METHODOLOGY

Scope

The scope of the performance audit of the Seton SIU included the period of September 2013 through August 2015 as well as review of relevant SIU activities through the end of fieldwork in March 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, 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 Seton, and through request and review of the following information from Seton:

- 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 Seton providing information about the upcoming SIU audit, and conducted fieldwork at Seton's facility in Austin, Texas from February 22, 2016 through February 25, 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 Seton's facility, the IG Audit Division reviewed and copied documentation and records related to the SIU function. No original records were removed from Seton's premises. Upon request, Seton 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.

Seton did not provide sufficient and appropriate data relevant to the objectives of this audit. Therefore, for the purposes of this audit, the IG Audit Division did not assess or rely upon the completeness and accuracy of data provided by Seton.

The IG Audit Division used the following criteria to evaluate the information provided:

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

IG Audit Division analyzed information and documentation it collected to determine the effectiveness of the Seton SIU at (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC. Professional judgment was exercised in planning, executing, and reporting the results of this audit.

The IG Audit Division conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

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 Seton employees, subcontractors, and providers.

Seton Employee and Subcontractor Training

The IG Audit Division conducted sample testing in order to assess whether Seton employees had attended annual fraud, waste, and abuse training required by Texas Administrative Code. The IG Audit Division selected a simple random sample[21] using a random number generator. The sample size of employees included 25 employees from the total population of 61 Seton staff with SIU responsibilities who were employed at any time during the two-year audit period. Seton utilized two subcontractors during the audit period, and the IG Audit Division selected both subcontractors to review fraud, waste, and abuse training provided to subcontractor employees.

The IG Audit Division evaluated whether Seton employees in the samples received required annual fraud, waste, and abuse training 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 Seton relevant to fraud, waste, and abuse training provided to subcontractor employees.

Seton 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 3,609 unique STAR and CHIP providers enrolled with Seton during the two-year audit period.

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

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

Appendix C: SETON HEALTH PLAN COMMENTS

Seton Health Plan

A member of the Seton Healthcare Family

April 29, 2016

Via Electronic Delivery
Steve Sizemore, CIA, CISA, CGAP
Audit Director
Texas Health and Human Services Commission
Office of Inspector General
Mail Code 1326
P.O. Box 85200
Austin, Texas 78708-5200

Dear Mr. Sizemore:

In response to the April 14, 2016, IG Report No. IG-16-011, Seton Health Plan (Seton) is submitting the following comments in relation to Issue 2, *Fraud, Waste, and Abuse Training was not Consistently Provided.*

Seton and its subcontractors did consistently provide fraud, waste, and abuse training. However, as noted in the finding, documentation that each individual received the training (i.e. sign-in sheets, certificates of completion, or computer-based training reports) could not be produced for all of the employees selected for sampling by the auditors.

The gaps in documentation resulted, in part, due to a transition in personnel responsible for retaining records of training during the audit time frame. Seton will be taking steps to ensure complete documentation of the training provided, for Seton and its subcontractors.

Thank you for the opportunity to comment on the audit report.

Respectfully,

Wendy Smith
Executive Director
Seton Health Plan, Inc.

Appendix D: 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, Audit Project Manager
- Babatunde Sobanjo, Auditor
- Netza Gonzalez, CFE, IT Audit Project Manager
- Jude Ugwu, 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

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- Charles Smith, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Kara Crawford, Chief of Staff
- Gary Jessee, Associate Commissioner, Medicaid/CHIP Division
- Tony Owens, Deputy Director, Medicaid/CHIP Division Contract and Performance Management
- Nicole M. Guerrero, Director of Internal Audit

Seton Health Plan

- Jeff Cook, Chief Executive Officer, Seton Insurance Services Corporation
- Wendy Smith, Executive Director, Seton Health Plans
- Vickie Paterra, Assigned Officer of the SIU, Seton Health Plans

Appendix E: 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
- Patricia A. Vojack — Director, Government Relations and Public Affairs

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To Contact the Inspector General

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- Mail: Texas Health and Human Services Commission
  Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000