

Quarterly Report

Quarter 1, Fiscal Year 2018



Texas Health and Human Services
Office of Inspector General



OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH & HUMAN SERVICES COMMISSION

SYLVIA HERNANDEZ KAUFFMAN
INSPECTOR GENERAL

I am pleased to submit the first quarterly report for fiscal year 2018 to Governor Greg Abbott, Executive Commissioner Charles Smith, the Texas Legislature, and the citizens of Texas.

The Office of Inspector General (OIG) demonstrated its commitment to Texas taxpayers by recovering nearly \$21 million in this quarter, and identifying \$28.7 million in questioned costs. The office will continue to shift resources and make internal process improvements as needed to sharpen the focus on protecting the integrity of the Texas Medicaid program. We continue to use data analytics to identify trends and patterns, to ensure our work is data-driven and focused on those areas most susceptible to fraud, waste, and abuse.

Our office is committed to transparency. We have redesigned this report to include identified trends, policy recommendations, and more detail on our activities with added performance measures. Our public website has a new look, with more space on our home page for news and other developments and more direct access to our reports. All reports issued by our Audit and Inspections divisions, along with our quarterly and other regular reports, are posted to the website.

The OIG staff dedicates its work toward the goal of protecting and promoting the fiscal integrity of HHS programs and the health and safety of those who use these services. Our commitment to seeing that taxpayer funds are used only for their intended purpose remains steadfast. I am pleased to report our office will continue to achieve positive and demonstrable results in detecting, preventing, and deterring fraud, waste, and abuse in the delivery of health and human services across Texas.

Respectfully,

Sylvia Hernandez Kauffman

Quarter 1 results

Dollars recovered

Audit

Audit collections (IG Audits, CMS Audits, and RAC Audits) \$6,683,327

Inspections

WIC collections (Civil monetary penalties) \$13,357
 Inspections collections \$990,060

Investigations

Client collections (SNAP, TANF, Medicaid, CHIP, WIC) \$4,123,328

Medicaid Program Integrity

Provider collections \$933,784

Medical Services

Acute care provider collections \$2,819,875
 Hospital collections \$4,278,938
 Nursing facility collections \$824,855
 Nursing facility UR settlements \$107,769
 Voluntary repayments and self-reports \$53,944

Total \$20,829,237

Dollars identified for recovery

Audit

Provider overpayments (IG Audits, CMS Audits, and RAC Audits) \$8,056,896

Inspections

WIC vendor monitoring \$665

Investigations

Client claims in process of recovery (SNAP, TANF, Medicaid, WIC) \$7,879,281

Medicaid Program Integrity

MCO identified overpayments \$2,102,801

Medical Services

Utilization review (acute care) \$241,227
 Utilization review (hospitals) \$10,459,095

Total \$28,739,965

Cost avoidance

Investigations

Client disqualifications and income eligibility matches \$1,729,135

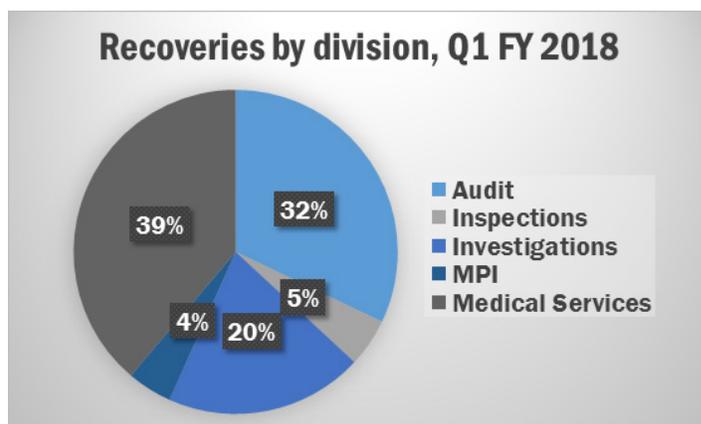
Medicaid Program Integrity

Medicaid excluded providers \$12,316,856

Medical Services

Pharmacy Lock-In \$16,692

Total \$14,062,683



How we measure results

An investigation, audit, inspection, or review that is performed, managed, or coordinated by the OIG can result in:

Dollars recovered: Dollars recovered are overpayments that have been collected based on the results of an investigation, audit, inspection, or review.

Dollars identified for recovery: Dollars identified include overpayments identified for recovery during an IG investigation, audit, inspection or review for: an alleged violation of a statute, law, regulation, rule, policy, or other authority governing the expenditure of funds or the provision of services; a finding that a cost is not supported by adequate documentation; or a finding that funds were not used for their intended purpose or were unnecessary, unreasonably spent, or wasteful.

Cost avoidance: Cost avoidance results in resources being used more efficiently; an increase in available resources from reductions in inefficient expenditures; or avoidance of unnecessary expenditure of funds for operational, medical, contract, or grant costs.

OIG peace officer recoveries

Dollars recovered \$13,434*

Dollars identified for recovery \$90,244

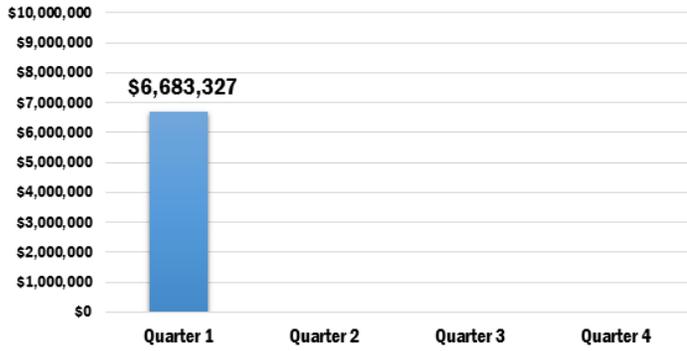
Cases involving OIG peace officers 197

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

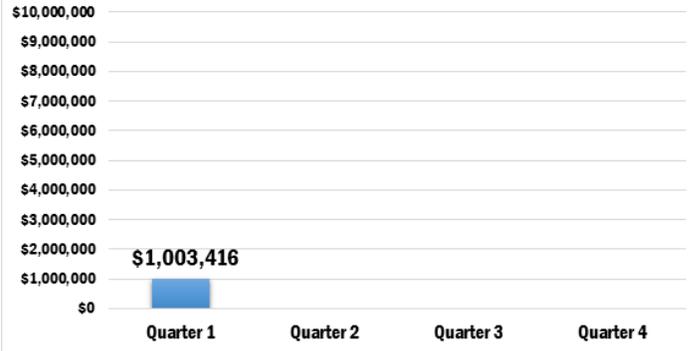
* Amount does not include a one-time settlement of \$296,587.

Fiscal year 2018 results to date

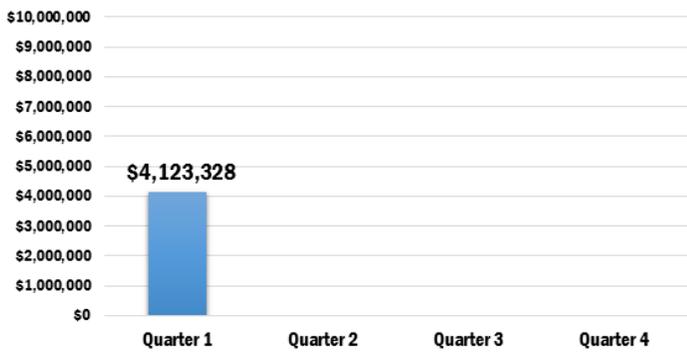
Audit recoveries FY 18



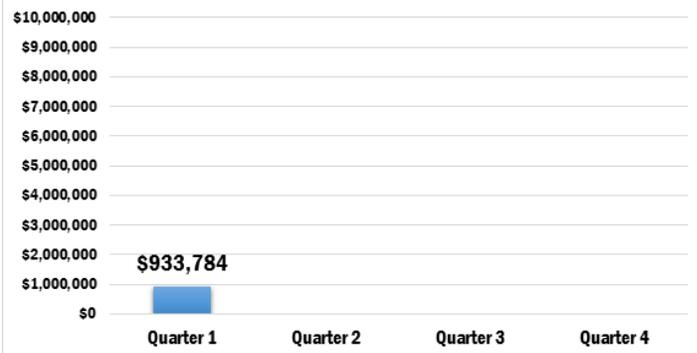
Inspections recoveries FY 18



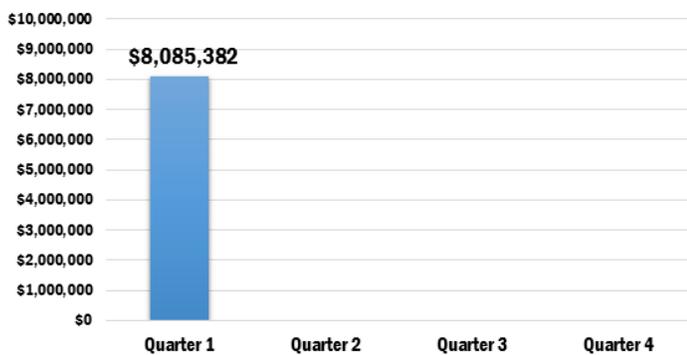
Investigations recoveries FY 18



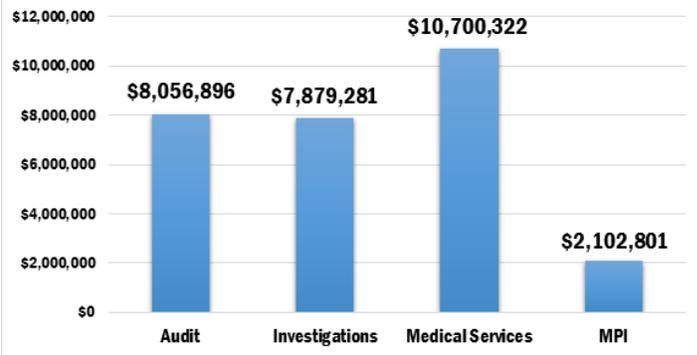
Medicaid Program Integrity recoveries FY 18



Medical Services recoveries FY 18



Dollars identified for recovery Q1, FY 18



Quarter 1 policy recommendations

Audit

Long-term care: Audit Division staff recommended that the HHSC Medicaid and CHIP Services Department form a workgroup to review potential policy and procedure changes to address wasteful therapy practices at the Sunny Springs Nursing and Rehabilitation Center. An audit of Sunny Springs found that its practice of clustering therapy services within look-back periods resulted in artificially higher Resource Utilization Group levels and therefore higher daily payments than would have been made based on a doctor's therapeutic prescription or the amount of therapy provided in the non-look-back periods. In 58 percent of resident files the IG Audit Division tested, the number of therapy days and minutes provided during the look-back period exceeded the number of days and minutes delivered during any week outside of the look-back period.

Eligibility: Audit Division staff recommended that HHSC Access and Eligibility Services (AES) strengthen the processes it uses to determine eligibility for SNAP, TANF, Medicaid, and CHIP. Audit proposed that AES develop policy, criteria, and guidelines to coordinate and develop multiregional and statewide corrective action plans and evaluate their effectiveness. AES must determine if the plans helped to reduce or prevent errors, and, if not, come up with new plans. Audit also recommended that information technology data integrity issues be addressed.

Inspections

Speech therapy: Inspections Division staff recommended that the HHSC Medicaid/CHIP Services Department collaborate with MCOs to make sure they understand Texas Medicaid Provider Procedures Manual (TMPPM) policy about speech therapy services and determine if more specific definitions of noncompliant attendance and progress plateau are needed. The TMPPM stipulates speech therapy services be discontinued when the client has plateaued in response to therapy goals or demonstrated noncompliance in attendance. However, definitions for the plateau and noncompliance in attendance criteria have not been specified in the TMPPM.

Treasury Offset Program: Inspections Division staff recommended that TIERS database functionality be enhanced to initiate recoupment for all eligible SNAP overpayment debts. Although FNS requires automatic collection of a validated SNAP overpayment debt, TIERS does not initiate recoupment if the primary responsible individual's SSN is not in TIERS. Inspections Division staff also recommended that HHSC Accounts Receivable should ensure all eligible responsible individuals are referred to TOP. FNS requires states to refer all SNAP debts that are delinquent for 180 days or more to TOP. Although Accounts Receivable submits an address request to FNS prior to debt submission to TOP, if ARTS does not contain an SSN for the primary responsible individual, an address request is not submitted for that debt, preventing a TOP referral for the additional responsible individuals.

Agency highlights

Disaster SNAP

Nearly 50 OIG investigators assisted HHSC Access and Eligibility System (AES) staff with screening clients, authenticating identification, and verifying applicants' information to help curb program fraud at 27 D-SNAP enrollment sites following Hurricane Harvey. These site operations ran from September 18 through October 20, 2017. Investigators were onsite to provide information about preventing fraud, answering fraud related questions from AES staff, and consulting with applicants as requested by AES.

D-SNAP fraud issues are the same as in SNAP. For beneficiaries, this includes clients who provide false information about their eligibility in order to receive benefits, or those who qualify but then sell or trade the benefits illegally. Retailer fraud includes retailers who illegally traffic benefits from beneficiaries, through actions such as buying the benefits from clients, or allowing the benefits to be used to purchase goods that are not allowed under program rules.

The OIG investigates D-SNAP fraud using the established processes for SNAP cases. This includes the use of data analytics and referrals to open cases. The IG works with federal agencies such as the United States Department of Agriculture (USDA) Office of Inspector General to leverage any fraud data that is identified at that level as well.

WIC inspections

The USDA halted Women, Infants and Children (WIC) Vendor Monitoring Unit compliance buys until October 1, 2017, in the wake of Hurricane Harvey to avoid further disruption to stressed grocery supply chains. The unit instead focused efforts on in-store evaluations, which evaluate a store's adherence to WIC policies including signage, pricing, and product stock. The unit closed 101 cases, 84 resulting from a USDA waiver due to the hurricane. The unit assessed civil monetary penalties on three vendors: One for \$11,000 resulting from an invoice audit, and two totaling \$884.82 for WIC product labeling violations. The unit also sent invoice audit notification letters to 25 vendors for a total of 32 outlets. The audits will begin in January, and vendors will have 60 days to respond.

Quarter 1 highlights

Audit reports issued	8
Audits in progress	22
Investigations completed	3,969
Inspections reports issued	2
Inspections in progress	7
Medicaid provider cases opened	377
Medicaid provider cases completed	
Preliminary	447
Full-scale	58
MPI cases transferred to full-scale investigation	62
MPI cases referred to Medicaid Fraud Control Unit	176
Hospital claims reviewed	14,603
Nursing facility reviews performed	40
Medicaid and CHIP high-risk provider enrollment screenings performed	6,325
Medicaid providers excluded	46
Fraud hotline calls answered	7,470

IG creates new Medicaid Program Integrity Division

The OIG established the Medicaid Program Integrity (MPI) Division in November 2017. By realigning resources into a separate division focused on Medicaid, the IG will develop a deeper expertise, concentrate resources on the largest area of health care expense, target resources to maintain the fiscal integrity of the Medicaid program, and ensure the health and safety of Texas Medicaid clients. To further this goal, the IG will continue to evaluate other IG units, divisions, or groups that perform Medicaid program integrity work for consolidation into the MPI Division. Consolidating Medicaid program integrity work into one division allows for better collaboration, more strategic oversight, efficient use of resources, and enhanced outcomes.

Currently, MPI's focus is on the investigation and review of providers who have been alleged to have committed fraud, waste, and/or abuse and may be subject to a range of administrative enforcement actions, including education,

Agency highlights

prepayment review of claims, penalties, required repayment of Medicaid overpayments, and/or exclusion from the Medicaid program.

MPI has staff at IG's Austin headquarters as well as in regional offices in Dallas, Houston, Pharr, and San Antonio.

General Investigations efficiencies

November 1, 2017, was the one year anniversary of the GI intake initiative, which focused on GI using its resources more efficiently.

In the 12-month period, GI completed 87 percent of its investigations within the required 180-day time frame; that's up from 72 percent in the previous 12 months. GI also saw an increase in its return on investment. From November 2016 to November 2017, GI had an average recovery of \$25.70 for every dollar spent, up from \$15 for every dollar spent the previous 12 months. Of the complaints deemed valid by intake, 61.6 percent resulted in an identified overpayment after the completion of the full-scale investigation.

GI intake investigators are assigned to review all incoming complaints and income data matches involving fraud, waste, and abuse in the SNAP, Medicaid, TANF and WIC programs. The review determines if the complaint is valid and should be progressed to a full -scale investigation and assigned to either a claims or field investigator.

Prior to GI intake, claims and field investigators spent a majority of their time screening every complaint they received. With intake program staff completing all screening work, claims and field investigators can now devote their time and resources to investigate valid referrals.

RAC program increases dollars identified for recovery using expanded claims review process

The Recovery Audit Contractor (RAC) program's use of expanded automated reviews in its claims review process has identified additional dollars identified for recovery of \$1.4 million this quarter. The RAC began using the new automated review process at the end of fiscal year 2017, based on Medicaid policy and rules, to determine whether a health care service claim was paid correctly or properly. The process also grew the number of reviews to more efficiently identify the amount of questioned costs starting in the first quarter of fiscal year 2018.

Concluding the first round of claims this quarter using this new process, the RAC completed 222 claims that resulted in \$1.4 million in questioned costs. Recoveries will be collected in subsequent quarters.

NHCAA annual training conference

OIG staff attended the National Health Care Anti-Fraud Association (NHCAA) 2017 Annual Training Conference in November. Staff learned about best practices from more than 60 anti-fraud solution organizations, health care fraud professionals, and law enforcement personnel.

OIG staff attended skills building sessions on new investigative strategies they can apply to their own cases, which include these common fraud schemes:

- Doctors over-prescribing pain medications and organized crime involved in recruiting patients to obtain pills to resell.
- Pharmacists compounding topical creams with more medication than prescribed.
- Medical staff billing for multiple, repeated lab testing and corresponding treatment plans.
- Medical staff billing for more hours than doctor spent with patients.
- Doctors recruiting patients.
- Medical staff falsifying professional licenses and credentials of personal care attendants.

Joint federal partnership

The Investigations Division's leadership met with the special agent-in-charge of the U.S. Social Security Administration (SSA) Office of Inspector General (OIG) in Dallas to discuss IG staff joining the Cooperative Disability Investigations (CDI) Program Unit task force. CDI is a joint effort among the SSA, SSA OIG, and states to investigate fraud in federal and state disability claims and social services programs such SNAP, TANF, Medicaid, and WIC.

During federal fiscal year 2016, CDI reported more than \$268 million in projected savings to SSA's disability programs.

The OIG also met with the special agent-in-charge of the U.S. Department of Agriculture (USDA) OIG to discuss ongoing joint investigations and future joint investigations regarding SNAP benefits trafficking by authorized retailers. The USDA OIG made a presentation to the OIG's SNAP

Agency highlights

Electronic Benefits Trafficking unit during training in Austin.

Texas Fraud Prevention Partnership

The OIG held three Texas Fraud Prevention Partnership (TFPP) meetings in the first quarter. During these meetings with MCOs and DMOs that serve Medicaid clients across Texas, TFPP Partners shared information about the fraud, waste, and abuse schemes and trends occurring in our state, and ways to improve prevention, detection, and recovery. Discussions held during these meetings have helped OIG improve its communication and collaboration with health and dental plans on individual investigations. Additionally, in September OIG completed its first Fraud Detection Operation (FDO) of fiscal year 2018 with a focus on Day Activity and Health Services in the Rio Grande Valley. During FDOs, OIG Medicaid Program Integrity Division collaborates with OIG Data and Technology Division in order to identify providers with billing and payment patterns that could signal potential fraud, waste, or abuse. Selected provider locations are then visited by the FDO teams, where interviews and records collection takes place. Depending on the subsequent findings, MPI may open a full-scale investigation; or it may make a referral to another division within OIG, to the Medicaid Fraud Control Unit, or to one or more licensing or regulatory boards. In some cases, providers receive education letters to encourage future compliance.

Completed reports

Audit

Wee-Care Pediatric Specialty Therapeutic: This audit evaluated whether Wee-Care complied with Texas Medicaid requirements for speech therapy claims billing; prior authorizations; appropriate discontinuation of therapy; and credentialing and supervision of speech language pathologist assistants and interns. For the claims tested, audit results indicated that Wee-Care complied with the selected Texas Medicaid requirements.

Children's Hope Residential Services, Inc.: This audit reviewed whether Children's Hope met contract requirements governing its treatment centers and child placing agency; whether state funds were used as intended for facility maintenance; and whether foster care payments were based on a documented service level per child.

Audit results indicated that while Children's Hope complied with certain requirements, it did not always meet the required child-to-caregiver ratio, made incorrect payments to foster parents, did not complete timely reviews and updates of service plans, and lacked a strong internal control environment. The IG recommended that Children's Hope address the issues identified in the audit.

Pharmacy Benefit Managers in Texas: This informational report describes how Pharmacy Benefit Managers (PBMs) are a central element within the complex system to deliver pharmacy services to Medicaid and CHIP clients, and details the oversight responsibilities shared between HHSC, Managed Care Organizations (MCOs), and PBMs.

As of September 2017, Texas contracted with 20 MCOs that subcontracted with 6 PBMs. The HHSC Medicaid and CHIP Services Department performs oversight of MCOs, and MCOs perform oversight of their subcontracted PBMs, including ensuring that PBMs follow all pharmacy-related contractual and statutory requirements.

HALO-Flight: This audit determined whether HALO-Flight billed fee-for-service claims for air ambulance services in accordance with state laws, regulations, and the Texas Medicaid Provider Procedures Manual. For the claims tested, audit results did not indicate any exceptions to Texas Medicaid billing requirements. In addition, audit results indicated that HALO-Flight's claim processing system had appropriate controls in place to secure protected health information.

HHSC Processes for Analyzing and Preventing Eligibility Determination Errors: This audit evaluated HHSC activities designed to analyze eligibility determination errors for HHSC benefit programs. Audit results indicated that HHSC Access and Eligibility Services (AES) processes for developing corrective action plans for the identified eligibility errors and evaluating the effectiveness of those plans could be improved. For example, AES did not always perform problem and root cause analysis; did not always evaluate the effectiveness of implemented corrective actions to reduce errors; and did not have in place processes and procedures to review errors across regions and determine when corrective actions at a multi-regional or statewide level should be developed. The IG recommended that AES strengthen processes to address these issues.

Homelife and Community Services, Inc.: This audit

Agency highlights

determined whether fee-for-service claims for residential support services submitted by and paid to Homelife, and authorizations for billed day habilitation services, were documented in accordance with applicable agreements, rules, and guidelines. Audit results indicated that service delivery logs and individual plans of care sometimes lacked required signatures or contained signature discrepancies, and that Homelife did not always adequately document services provided to clients. In addition, Homelife needed to improve written policies and procedures, staff training, and billing process oversight, and also implement a secure employee email service in order to avoid potential HIPAA violations.

The IG recommended that Homelife reimburse HHSC \$71,645 and address the issues identified in the audit.

Sunny Springs Nursing and Rehabilitation: This audit determined whether staff at Sunny Springs delivered therapy services consistent with physician orders and according to resident assessments and evaluations. Audit results indicated that Sunny Springs' clustering of therapy services during look-back periods led to higher Resource Utilization Group (RUG) levels than would have been made if RUG had been based on a doctor's therapeutic prescription or the amount of therapy provided in the non-look-back period, therefore increasing Medicaid payments by an estimated \$225,824. Policy allowed this practice, so the IG recommended that the HHSC Medicaid and CHIP Services Department make policy changes to reduce the waste of state funds.

Providence Memorial Hospital Cost Report Fiscal Year 2014: This audit determined whether the amounts in the capitalization and moveable equipment cost centers reported on the Providence Memorial Hospital fiscal year 2014 cost report were accurate, allowable, and adequately supported in accordance with CMS and state requirements. Audit results indicated that Providence did not always comply with American Hospital Association (AHA) guidelines for asset depreciation calculations. The IG will submit an adjustment to increase the reported expense by \$6,031 to TMHP, the Texas Medicaid fiscal intermediary, and recommended that Providence follow AHA guidelines when determining the useful lives of assets for cost reporting purposes.

Inspections

Treasury Offset Program: This report details the

inspection of procedures used to maximize recovery of SNAP overpayments through the Treasury Offset Program (TOP). Inspections determined that HHSC has effective policies, procedures, and practices in place to maximize the accuracy of data submissions as part of the TOP referral process. The inspection also found opportunities to improve some steps to increase recovery of SNAP overpayments. The IG recommended that Texas Integrated Eligibility Redesign System (TIERS) database functionality be enhanced to initiate recoupment for all eligible SNAP overpayment debts. Inspections also recommended that HHSC Accounts Receivable should ensure all eligible responsible individuals are referred to TOP.

Speech therapy: This report examines how Texas Medicaid speech therapy providers handle MCO controls for prior authorization and notable practices to strengthen controls, and how they determine medical necessity for authorization and speech therapy utilization rates across managed care service areas. The IG recommended that the HHSC Medicaid/CHIP Services Department collaborate with MCOs to make sure MCOs understand the current Texas Medicaid Provider Procedures Manual and to determine if more specific definitions of "noncompliant attendance" and "progress plateau" are needed.

Policy Issue Briefs

Value-based payments: This issue brief provides an overview of value-based payments, which are structured to incentivize providers to deliver quality care in the most cost-effective manner. This issue is important for the IG because new payment methods bring new opportunities for fraud, waste, and abuse.

Recovery of funds: This issue brief provides a look at new state and federal guidelines for Medicaid MCOs, about the recovery of improper payments, and how other states distribute recovered Medicaid funds. As the OIG works more in managed care, the way recoveries are collected may change.

Annual reports

The IG issued this quarter the following required annual reports for fiscal year 2017:

- Joint Annual Report on Fraud and Abuse in Medicaid, compiled by IG and the Attorney General's Medicaid Fraud Control Unit: a joint interagency report on the coordinated efforts

Agency highlights

- between the IG and OAG on fraud.
- Annual Report of State Hospital Investigations: a report on the number and types of investigations at state hospitals.
- Annual Report of State Supported Living Center Investigations: a report on the number and types of investigations at state supported living centers.
- Annual Report on Certain Fraud and Abuse recoveries by managed care organizations: a report on the amount of recoveries made by MCOs and DMOs not referred to the IG, or referred but returned to the MCO or DMO.
- Consolidated Senate Bill 30 Report: a report on eligibility and recoveries made through three programs: the Telephone Collection Program, Information Matching System Relating to Immigrants and Foreign Visitors, and Data Matching with Neighboring States and the Texas Department of Criminal Justice.

Stakeholder outreach

- Then-Principal Deputy Inspector General Sylvia Hernandez Kauffman gave presentations to

and met with several groups this quarter: Texas Medical Association on September 15, 2017; Texas Dental Association on September 29, 2017; Texas Pharmacy Association on October 27, 2017; and the Texas Association for Home Care & Hospice on November 11, 2017. Mrs. Kauffman discussed how OIG works to achieve its mission, and legislative actions that affected OIG.

- Division of Medical Services, and Medical and Social Services Division Medicaid and CHIP Services staff hosted the Nursing Facility Utilization Review Stakeholder Meeting in September to discuss and promote best practices in nursing facility utilization reviews. Representatives from the Texas Health Care Association, Leading Age, Texas Medicaid Coalition, and other nursing facility providers attended the meeting.
- Division of Medical Services staff hosted the Hospital Utilization Review Stakeholder Meeting in October to discuss and promote best practices in hospital utilization reviews. Representatives from hospital associations, health plan associations, and the Medical and Social Services Division Medicaid and CHIP Services attended the meeting.

Quarter 1 Trends

OIG allegations

Home health agencies: Reports of billing clients on a monthly basis for in-home, remotely monitored, vital sign monitoring systems that are not being provided.

Hospitals: Reports of improper billing of injections administered in an emergency room setting and using procedure codes that are not benefits of Texas Medicaid.

Client investigations: Reports of unreported income from employment, unreported household member with income, and unreported absent parent.

Internal Affairs: Complaints about falsification of a government record, abuse of official capacity, benefits fraud, confidentiality violations, perjury, policy and/or work rule violations, and theft.

Law enforcement: Reports from the EBT Trafficking Unit indicating exchanges of SNAP benefits for cash at

Complaints to MPI by provider type

Home health agency (long-term services)	43.78%
Physician (individual or group practice)	11.08%
Home health agency (personal care services)	9.19%
Dental	5.95%
Nursing facility	5.68%
Hospital	4.59%
Pharmacy	4.05%
Durable medical equipment	2.16%
Managed care organizations	2.16%
Psychiatry	1.89%

retail stores; creation of credit accounts at retail stores and use of SNAP benefits to pay the credit debt; and use of SNAP benefits to purchase non-authorized items.

Program Integrity Spotlight

Increasing program integrity in Medicaid: Personal Care Services

The Centers for Medicare & Medicaid Services (CMS) released a white paper, Vulnerabilities and Mitigation Strategies in Medicaid Personal Care Services, in fall 2017 detailing potential program integrity issues in Personal Care Services (PCS).

PCS are services provided by personal care attendants (PCAs) to elderly or disabled Medicaid beneficiaries in need of assistance with the activities of daily living (i.e. bathing, dressing) and instrumental activities of daily living (i.e. grocery shopping). By receiving PCS from a PCA, beneficiaries are able to enjoy greater independence by living in their homes instead of in a nursing facility or another institution. Providing Medicaid beneficiaries with PCS is cost effective because PCS can replace, prevent or delay the incursion of medical costs or placement in an institution.

Although PCS provides Medicaid beneficiaries' greater choice and independence, because PCAs provide services within the beneficiaries' home, there is typically limited, direct supervision of the caregiver. This lack of direct supervision exposes the state to the potential loss of program funds to fraud, waste, or abuse (FWA).

This CMS white paper provides recommendations for mitigating program risk in state Medicaid PCS programs. These recommendations were developed by experts from CMS, State Medicaid Agencies, state Medicaid Fraud Control Units, state Inspectors General, the Department of Justice, the Department of Health and Human Services Office of Inspector General (OIG).

Key findings and takeaways

- **Strengthen prevention activities so only screened and qualified providers provide PCS to Medicaid beneficiaries.** Recommendations include requiring both PCS agency staff and PCAs be screened using Fingerprint-based Criminal Background Checks, as well as through Adult Protective Services and Child Protective Services exclusion lists, require all PCAs to be registered and qualified by the state to provide PCS to Medicaid beneficiaries, and strengthen required qualifications, training and education for attendants and PCA staff.
- **Ensure claims for PCS should include detailed specifications regarding services received by beneficiaries, including the date of service and a unique, attendant identifier.** Recommendations include requiring verification data collected through Electronic Visit Verification (EVV) systems to produce data in a specified format compatible with the state's Medicaid Management Information System (MMIS), and that PCS claims should identify specific units of service for each date of service as a separate claim with an attendant identifier in order to ensure that the PCA had been cleared to provide PCS and to help detect improper payments.
- **Confirm that beneficiaries are receiving services in accordance with their plans of care.** Recommendations include requiring assessments and reassessments be conducted by a qualified independent agent using an independent assessment tool. Implement quality control checks of assessments by conducting follow-up visits with beneficiaries to detect fraud, waste and abuse. Additionally, follow-up visits should also ensure that beneficiaries are receiving the services described in their care plan from the PCA or PCS agency.
- **Optimize prepayment review to prevent improper payments.** Recommendations include prepayment edits and audits be able to cross-check against other available data systems, such as EVV systems, PCS assessment outcomes, service authorizations, and provider enrollment status. States should also establish daily caps for PCS billing to a maximum reasonable number of hours for a single PCA.
- **Expand post-payment reviews and sanction bad actors.** Recommendations included using data analytics to run algorithms that imitate prepayment edits and audits to identify cases where claims should not be paid or to identify potential targets to audit. States should also terminate or decline provider enrollment for bad actors and implement a "lock-in" program for clients that collude with providers.
- **States should implement parallel program integrity safeguards in managed care contracts to ensure MCOs are providing the same safe guards.**

Division performance

Investigations

The Investigations Division protects the integrity of HHS programs through investigations of employee misconduct involving fraud, waste, and abuse; to include, but not limited to bribery, theft, and investigations of SNAP retailer and client fraud, waste, and abuse. Cases are referred for Administrative Disqualification Hearings (ADH) and prosecution to appropriate state or federal regulatory and law enforcement authorities. Additionally, the Investigations Division conducts personnel investigations at the State Supported Living Centers and State Hospitals.

The Investigations Division includes:

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

Law Enforcement commissioned and non-commissioned investigators conduct criminal investigations of State Supported Living Centers and State Hospitals violations, and Electronic Benefits Transfers misuse. The two units in this directorate are the State Centers Investigative Team and the Electronic Benefit Transfer Trafficking Unit.

General Investigations performance

Overpayments recovered	\$3,813,307
Cases completed	3,696
Cases referred for prosecution	25
Cases referred for ADH	186

Law Enforcement performance

Overpayments recovered	\$310,021
Cases opened	260
Cases completed	182

Internal Affairs performance

Investigations completed	91
Cases with sustained allegations	19

Major Case Unit performance

Investigations completed	12
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Internal Affairs (IA) investigates employee misconduct that results in fraud, waste, and abuse within the HHS System.

Major Case Unit team conducts investigations involving sensitive and serious incidents that often involve high monetary value investigations and egregious situations.

Medicaid Program Integrity

The Medicaid Program Integrity Division investigates and reviews allegations of fraud, waste, and/or abuse committed by Medicaid providers, who may be subject to a range of administrative enforcement actions including education, prepayment review of claims, penalties, required repayment of Medicaid overpayments, and/or exclusion from the Medicaid program. Referrals are made to the Attorney General's Medicaid Fraud Control Unit when there are indications of criminal Medicaid fraud.

Medicaid Program Integrity performance

Preliminary investigations opened	377
Preliminary investigations completed	447
Full-scale investigations completed	58
Cases transferred to full-scale investigation	62
Cases referred to AG's Medicaid Fraud Control Unit	176
Open/active cases at end of quarter	153

Audit

The Audit Division conducts risk-based audits that examine the performance of contractors, providers, and HHS programs to reduce fraud, waste, and abuse throughout the HHS System, and provide independent assessments of HHS programs and operations.

Audit coordinates federal government audits, serves as the project lead for the Recovery Audit Contractor (RAC) contract, and is the single point of contact with the Centers for Medicare and Medicaid Services (CMS) for Medicaid

Audit reports issued

- Homelife and Community Services, Inc: A Texas Medicaid Home and Community-Based Services Program provider
- Children’s Hope Residential Services, Inc.: Residential Child-Care Contracts with the Texas Department of Family and Protective Services
- Wee-Care Pediatric Home Health, LLC: A Texas Medicaid Speech Therapy Provider
- HALO-Flight: A Texas Medicaid Air Ambulance Provider
- Pharmacy Benefit Managers in Texas: Informational Report on the Role of PBMs in Delivering Medicaid and CHIP Pharmacy Benefits to Managed Care Members
- HHSC Processes for Analyzing and Preventing Eligibility Determination Errors
- Providence Memorial Hospital Cost Report: Fiscal Year 2014
- Assessment and Evaluation Practices at Sunny Springs Nursing and Rehabilitation

Audit performance

Overpayments recovered	\$6,683,327
Overpayments identified	\$8,056,896
Audits completed	8

Integrity Contractor (MIC) audits and Payment Error Rate Measurement (PERM) activities.

Audits in progress

A list of audits in progress and audit topics the IG plans to initiate can be found in the two-year rolling audit plan located on the IG’s website.

- Pharmacy providers (6)
- Therapy services at long-term care nursing facilities (1)
- Durable medical equipment claims (2)
- IT security assessments (3)
- Residential child care services contractor (1)
- STAR+PLUS enrollment (1)
- MCO SIU performance (1)
- Managed care pharmacy benefits managers’ compliance (1)
- Medical Transportation Program vendor performance (1)
- Home and community-based services providers (2)
- Medicaid air ambulance providers (1)
- Third party recovery activities managed or performed by a claims administrator (1)
- Pharmacy inventory reconciliations (1)

Medical Services

The Division of Medical Services reviews a variety of health and human services claims and medical records, including acute care utilization, hospital utilization, nursing facility utilization, and pharmacy lock-in. The division provides clinical consultation to the Investigations, Audit, and Inspections divisions on dental, medical, nursing, and pharmacy services.

Medical Services is comprised of three units:

Clinical Subject Matter Expert (CSME) team includes a physician, dentist, dental hygienist, and pharmacist who provide clinical expertise to IG investigations, audits, inspections, special collaborative initiatives, and legal staff. The CSME team also communicates with MCO and Dental Management Organization (DMO) compliance departments to educate and clarify clinical documentation and medical/dental policy interpretation.

Acute Care Surveillance (ACS) team identifies patterns of aberrant billing, performs Surveillance Utilization Reviews required by the federal Centers for Medicare and Medicaid Services, develops and runs targeted data queries to identify acute care billing outliers, and collects Medicaid overpayments. The ACS team also performs medical record reviews as requested by IG Audit,

Medical Services performance

Acute Care provider recoveries	\$2,819,876
ACS identified MCO overpayments	\$241,227
Hospital UR recoveries	\$4,278,938
Hospital UR claims reviewed	14,603
Nursing Facility UR recoveries	\$824,855
Nursing Facility UR settlements	\$107,769
Nursing facility reviews initiated	40

Inspections, or Investigations divisions. When a case does not meet criteria for action by other divisions, it is referred to ACS team for record review and completion.

Quality Review team conducts retrospective utilization reviews of hospitals and nursing facilities, and administers the pharmacy Lock-in Program. The Utilization Review (UR) team performs on-site and desk reviews of hospital claims and nursing facility Minimum Data Set forms for appropriate billing. Lock-in Program staff work with MCOs to monitor client use of prescription medications and acute care services.

Inspections

The IG Inspections Division inspects HHS programs, systems, and functions for fraud, waste, abuse, and systemic issues in order to improve the HHS system. Inspections oversees the state's WIC Vendor Monitoring Unit. This unit conducts in-store evaluations, compliance buys, and invoice audits to monitor vendors participating in the WIC program.

Inspections reports issued

- Treasury Offset Program: Inspection of Procedures to Maximize Recovery of SNAP Overpayments
 - Speech Therapy: Managed Care Organization Controls for Prior Authorization, Medical Necessity Determination, and Utilization Processes
-

Inspections in progress

- Managed Care Duplicate Capitated Rate Payments
 - Access Eligibility Services Interstate and Income Eligibility & Verification System Alerts
 - Medicaid Payments for Deceased Clients
 - Electronic Visit Verification
 - Multiple Medicaid Identification Numbers
 - Long-term Services and Supports - Community Attendant Services
 - Suspense Account in the IG Medicaid Recovery Process
-

Chief Counsel

The Chief Counsel Division provides legal counsel to the IG and IG divisions: Audit, Inspections, Investigations, Medicaid Program Integrity, Medical Services, and Support Services, so that each division is best able to accomplish the IG mission. Chief Counsel processes all provider cash recoupments for the IG and produces a monthly report for each division so they can track recoveries.

Litigation

The Litigation section receives referrals from Investigations Division staff to determine the amount of any overpayments that may have been made to Medicaid providers and recommend whether any further sanctions should be pursued in a case.

Litigation handles the appeals of investigations and audits that have determined that providers received Medicaid funds to which they were not entitled. These investigation cases are settled by agreement or resolved by hearing before

a State Office of Administrative Hearings judge. Audit files are settled by agreement or resolved by hearing before an HHSC appeals judge.

Litigation terminates and excludes Medicaid provider enrollment for certain program violations and also works with providers who want to self-report a potential Medicaid violation.

General Law

The General Law section provides legal advice and support to all aspects of the IG's operations, including researching termination/exclusion issues, drafting policies and procedures related to the IG mission, determining federal share obligations, and proposing rule and statute changes. General Law is responsible for taking initial actions to terminate or exclude providers when a provider has been terminated or excluded from Medicare or another state Medicaid program.

Support Services

The Support Services divisions promote efficiency and effectiveness throughout the IG office.

Data and Technology

The Data and Technology Division (DAT) implements tools and innovative data analytic techniques that streamline IG operations and increases the identification of fraud, waste, and abuse in HHS programs. DAT uses data research, and data analytics to identify, monitor, and assess trends and patterns of behavior of providers, clients, and retailers participating in HHS programs. The division consists of five units: Fraud Analytics, Data Intelligence, Data Research, Statistical Analysis, and Data Operations.

Operations

The Operations Division is comprised of five core functions: the Integrity Line, which receives allegations of fraud, waste, and abuse and refers them for appropriate further investigation or action; the Program Integrity Research team, which completes the required state and federal disclosure and screening activities for high-risk providers seeking to enroll or re-enroll in Medicaid and other HHS programs; Business Operations and Operations Support, which is responsible for oversight of IG purchasing and contract management, acting as a liaison for facility support and handling OIG administrative services;

Operations performance

Provider enrollment inventory (applications and informal desk reviews) processed	6,325
Individual screenings processed	18,047
Fraud hotline calls answered	7,470

Strategic Operations and Professional Development, which promotes training services, internal policy development, and organizational support for all IG divisions; and Finance, which is responsible for overseeing the IG's budget and reporting Legislative Budget Board performance measures.

Policy and Publications

The Policy and Publications Division is comprised of three areas: Government Relations, Publications, and Policy. The division coordinates and ensures timely and effective external communication with a variety of stakeholders. It provides outreach and communication with legislators, consumers, family members, MCOs, other agencies within the HHS System, and the media, and is the primary division for managing government relations for the IG. The division analyzes legislation, conducts analysis of program policies, and handles all legislative and media inquiries.



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