Quarterly Report

Quarter 2, 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 second 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) continued its work on behalf of Texas taxpayers by recovering more than $19 million this quarter, and identifying another nearly $29 million in funds to be recovered. These results reflect the effectiveness of the work of the OIG team in using all the tools at our disposal - including advanced data analytics - to find and get back funds that have been mistakenly paid.

As the health care environment continues to evolve, the OIG continues to step up to meet the challenge. We are realigning our resources to ensure this office is properly positioned to succeed in the managed care environment. We are boosting our deterrence efforts to stop fraud, waste, and abuse before it happens, which keeps taxpayer funds from being misused and reduces the need to pursue remedies after funds have been spent.

While the world of health care may be changing, the focus of the OIG mission does not waver. Our team remains dedicated to protecting and promoting the fiscal integrity of HHS programs to ensure that those who need those services get them, and that taxpayer funds are properly and efficiently used. We remain committed to detecting, preventing, and deterring fraud, waste, and abuse in the delivery of health and human services across Texas.

Respectfully,

Sylvia Hernandez Kauffman

Quarter 2 results

Dollars recovered

Audit

Audit collections (OIG Audits, CMS Audits, and RAC Audits)
$6,385,257

Inspections

WIC collections (Civil monetary penalties) $73

Investigations

Collections
(SNAP, TANF, Medicaid, CHIP, WIC) $3,242,575

Medicaid Program Integrity

Provider collections $832,475

Medical Reviews

Acute care provider collections $326,091

Hospital collections $8,454,211

Nursing facility collections $74,851

Voluntary repayments and self-reports $46,263

Total	**$19,361,796**

Dollars identified for recovery

Audit

Provider overpayments (OIG Audits, CMS Audits, and RAC Audits) $17,203,209

Investigations

Client claims in process of recovery
(SNAP, TANF, Medicaid, WIC) $7,930,109

Medicaid Program Integrity

MCO identified overpayments $6,280,594

Medical Reviews

Acute care $344,726

Hospitals $10,156,101

Total	**$41,914,739**

Cost avoidance

Investigations

Client disqualifications $1,336,781

Medicaid Program Integrity

Medicaid excluded providers $10,455,160

Medical Services

Pharmacy Lock-In $71,083

Total	**$11,863,024**

Recoveries by division, Q2 FY 2018

- Audit — 33%
- Inspections — 0%
- Investigations — 17%
- MPI — 4%
- Medical Services — 46%
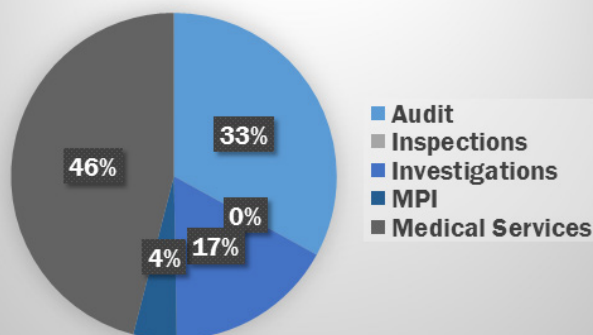
How we measure results

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

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

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

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

OIG peace officer recoveries

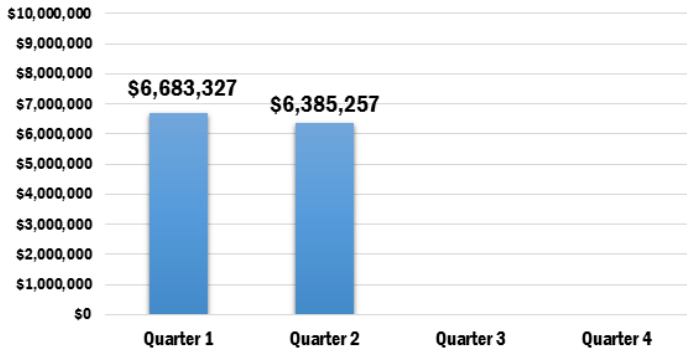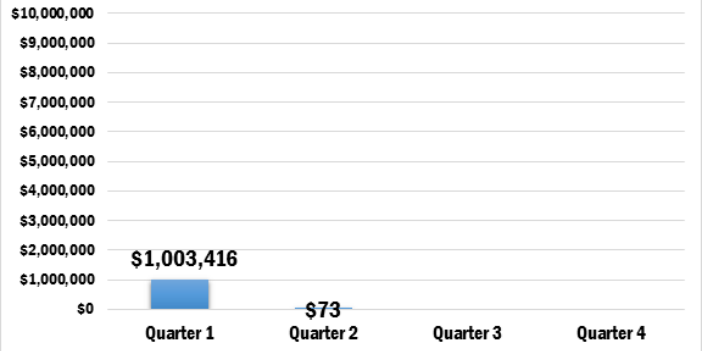|	
Dollars recovered	$13,366
Dollars identified for recovery	$198,529
Cases involving OIG peace officers	213

HB 2523 passed in the 85th Texas Legislature requires the OIG to report the portion of funds recovered from investigations involving OIG peace officers.
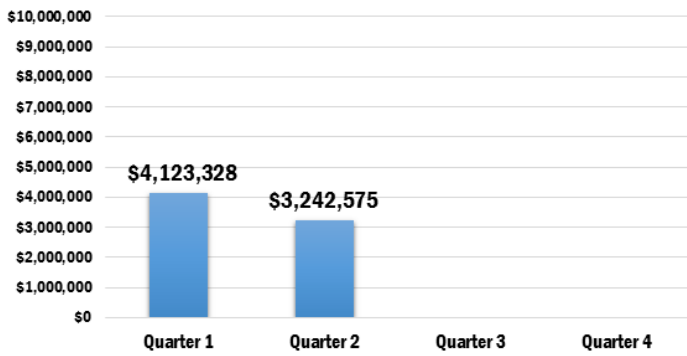
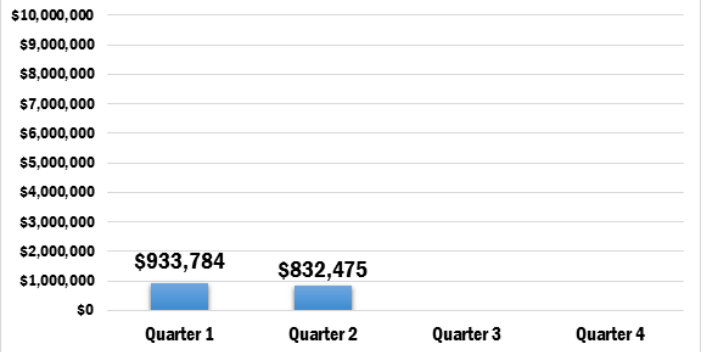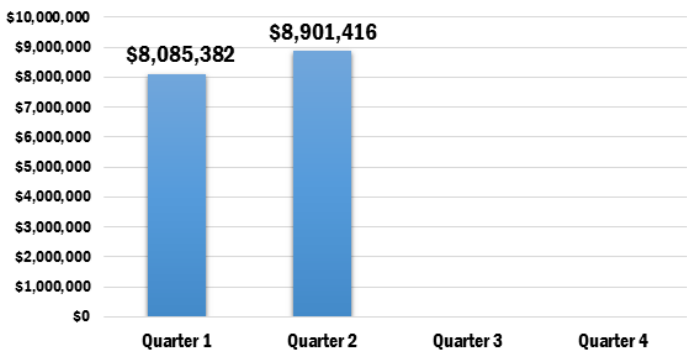# Fiscal year 2018 results to date

Audit recoveries FY 18

Quarter 1	$6,683,327
Quarter 2	$6,385,257
Quarter 3	
Quarter 4	

Inspections recoveries FY 18

Quarter 1	$1,003,416
Quarter 2	$73
Quarter 3	
Quarter 4	

Investigations recoveries FY 18

Quarter 1	$4,123,328
Quarter 2	$3,242,575
Quarter 3	
Quarter 4	

Medicaid Program Integrity recoveries FY 18

Quarter 1	$933,784
Quarter 2	$832,475
Quarter 3	
Quarter 4	

Medical Services recoveries FY 18

Quarter 1	$8,085,382
Quarter 2	$8,901,416
Quarter 3	
Quarter 4	

Dollars identified for recovery Q2, FY 18

Audit	$17,203,209
Investigations	$7,930,109
Medical Services	$10,500,827
MPI	$6,280,594
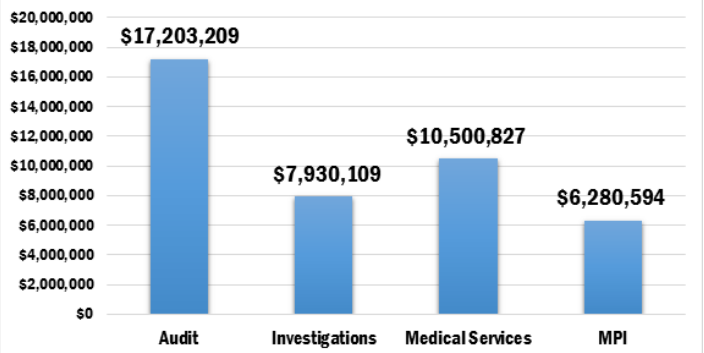
Quarter 2 policy recommendations

Audit

Security controls: Audit Division staff recommended that HHSC Medicaid and CHIP Services (MCS) coordinate with HHS Information Security Office to establish formal roles, responsibilities, and processes for the review and approval of system security plans submitted by contractors, which should help ensure the plans are timely received and reviewed by all applicable parties.

The recommendation follows an audit of MAXIMUS, which contracts with the state to perform Medicaid and CHIP enrollment broker services. MAXIMUS uses personally identifiable information to enroll qualified people into Medicaid and CHIP MCOs. MAXIMUS stores that information and transmits the confidential information across multiple networks.

To ensure confidentiality is not compromised, Audit also recommended that MCS require MAXIMUS to prioritize and remediate identified security weaknesses; develop system maintenance processes that include updating system security documents; and obtain information and documentation from its subcontractors to enable evaluation of subcontractor performance.

MCS agreed with OIG's recommendation.

Quarter 2 trends

OIG allegations

Client Investigations: Reports of clients not reporting income from employment and not reporting a household member with income when applying for Medicaid program benefits.

Internal Affairs: Complaints alleging policy and/or work rule violations; theft and fraud of time and leave; falsification of government records, including tampering with Family and Medical Leave Act paperwork, changing doctors' excuses, and entering false information into the Texas Department of Family and Protective Services' IMPACT system; and birth certificate fraud, using false information to obtain a U.S. birth record, generally done by paying a midwife to fill out a birth record attesting the birth took place in the United States.

Home health agencies: Complaints alleging an attendant falsified timesheets by not working the hours reported, or falsified timesheets and split the paycheck with a client.

Hospitals: Reports of isolated incidents regarding the quality of care, or a client questioning what was billed to Medicaid.

Acute care services: Reports of inappropriate billing for after-hour visit codes during routine clinic hours in fee-for-service.

Complaints received by MPI

Home health agency (long-term care services)	44.18%
Home health agency (personal care services)	7.60%
Hospital	7.13%
Physician (individual or group practice)	6.89%
Dental	6.18%
Nursing facility	4.75%
Pharmacy	4.28%
Managed care organizations	2.85%
Durable medical equipment	2.14%
Adult day cares	2.14%

Case highlight

The OIG Electronic Benefits Transfer Trafficking Unit completed its investigation of a former HHSC employee who fraudulently created and recertified SNAP profiles to illegally obtain $29,892 in state and federal funds to which he/she was not entitled. From February 2013 through November 2016, this former employee authorized and collected $29,892 in illegal benefits.

The OIG referred this case to the local district attorney for prosecution.

Agency highlights

Appointment of Inspector General Sylvia Hernandez Kauffman

Governor Greg Abbott appointed Sylvia Hernandez Kauffman as the Inspector General (IG) for the Texas Health and Human Services Commission on January 11, 2018, for a term expiring on February 1, 2018. Governor Abbott re-appointed Ms. Kauffman on February 1, 2018, to serve a full year term expiring on February 1, 2019.

Ms. Kauffman served as the Principal Deputy Inspector General for Health and Human Services since early 2016. Previously, she served in strategic leadership roles at the OIG and at the Texas Health and Human Services Commission. Ms. Kauffman received a Bachelor of Science in computer science from Stanford University and a Master in Public Policy from Harvard University.

Ms. Kauffman will continue working with the OIG to preserve and protect the integrity of the health and human services programs and the health and safety of program clients.

Increased collaboration streamlines fraud detection operations

The Medicaid Program Integrity Division (MPI) conducted a fraud detection operation (FDO) in January that focused on behavioral health providers.

The providers investigated included a group practice providing behavioral health services, individual psychologists, and licensed professional counselors located in Houston, San Antonio, and McAllen.

Evidence collected on three of the four providers selected by the OIG substantiated the data analytics that flagged these providers' billing behaviors. These cases may be recommended for full scale investigation and referred to the Office of Attorney General's Medicaid Fraud Control Unit.

Staff's planning and research, and the creation of standardized record-review tools for investigators, allowed investigators to report preliminary results in about a week; that's down from an average of three weeks in prior operations. Also new to this operation was a daily debrief from the field to the data analytics team, resulting in an enhanced operation, and which will serve to improve future

Quarter 2 highlights

Audit reports issued	3
Audits in progress	24
Investigations completed	4,028
Inspections in progress	8
Medicaid provider cases completed	
Preliminary	357
Full-scale	34
MPI cases transferred to full-scale investigation	69
MPI cases referred to Medicaid Fraud Control Unit	161
Hospital claims reviewed	8,262
Nursing facility reviews performed	142
Medicaid and CHIP high-risk provider enrollment screenings performed	5,556
Medicaid providers excluded	71
Fraud hotline calls answered	6,720

operations and data research.

Data analytics gave investigators providers whose billings suggested that they were an outlier for specific measures as compared to their peers. Investigators conducted interviews with providers, staff, and recipients or their caregivers, and performed records reviews.

MPI focuses on generating initiatives

To proactively tackle fraud, waste, and abuse, MPI expanded a position in the Administrative Investigative Services directorate that now coordinates, creates, and documents methodologies, strategies, and initiatives that enable investigators to isolate providers who appear to be high risk for potential fraud, waste, and abuse. The initiatives are based on a combination of investigative experience, collaborative discussion, and research.

The first initiative focused on durable medical equipment (DME) providers' questionable billing for incontinence supplies. An OIG field investigator noticed DME providers who were repeatedly billing the maximum allowable quantities for incontinence supplies. The investigator sent letters to clients to verify whether the providers delivered the

supplies as billed and if not, the investigator worked with OIG Litigation to develop the cases and get settlements. So far, MPI has transferred three full-scale cases to the OIG Chief Counsel for administrative enforcement action. Administrative Investigative Services has developed the DME initiative for use by other investigators across the state. Other initiatives under development involve excluded providers and pharmacies.

Electronic Benefit Transfer 99 Project investigations

OIG General Investigations (GI) completed investigations of 20 Electronic Benefit Transfer (EBT) 99 Project cases in the Rio Grande Valley. These 99 cases involve clients who receive or have received benefits from the Supplemental Nutrition Assistance Program (SNAP) while owning or operating a business that accepts SNAP benefits through EBT cards.

OIG identified 10 cases of EBT trafficking fraud using a common scheme - SNAP clients purchased items using their EBT card, then resold the items. The 10 cases resulted in 12-month disqualifications for the clients and identified funds totaling $82,613.

Four of the 20 cases determined the clients committed fraud by under-reporting self-employment income in their benefit applications. One case resulted in a 12-month disqualification and restitution of $7,929. OIG is preparing the other three cases for prosecution; they involve $100,000 identified in fraudulently obtained benefits, including SNAP and Medicaid.

Six of the 20 EBT 99 cases had no evidence of fraud or program violations.

In these ongoing EBT 99 investigations, OIG gathers evidence such as audio recordings, written statements, bank records, and business data. The OIG works closely with the U.S. Department of Agriculture's Food and Nutrition Services and local law enforcement in these efforts to combat fraud, waste, and abuse.

Peace officer recoveries

HB 2523 authorized the OIG, in June 2017, to employ and commission peace officers to fulfill its federally mandated responsibility as the state law enforcement bureau for SNAP and TANF investigative purposes. Peace officers can obtain and execute search and arrest warrants as needed,

Peace officer identified EBT recoveries

	FY 2017	FY 2018
Quarter 1	$15,167	$90,244
Quarter 2	$83,046	$198,529

can access law enforcement sensitive information and law enforcement databases, receive specialized training, use grant funding programs, and participate in federal task force operations.

This new authority helps the OIG investigate and complete more cases and increase recoveries. In the first half of fiscal year 2018, peace officers working within the EBT Unit identified for recovery $288,773, nearly three times the amount identified in the first half of fiscal year 2017 - $98,213. Identified recoveries are significant as actual recoveries are often made by clients with repayment obligations in payment plans.

The investigations this quarter involved alleged trafficking or misuse of SNAP benefits on the Lone Star EBT card at authorized SNAP retailers. These investigations are authorized by an agreement with United States Department of Agriculture and are often conducted alongside local, state, and federal law enforcement agencies.

Inspector certification program

The Inspections Division is helping to create a certification for inspectors nationwide, similar to certifications offered for inspectors general, investigators, and auditors. The Association of Inspectors General (AIG), with the help of the Texas OIG, began developing a curriculum this quarter to certify inspectors with skills necessary to perform their jobs.

The curriculum includes: Principles and Standards for Offices of Inspector General; Inspections & Evaluations (I & E) Policies and Procedures; Types of I&Es; Factors in Selecting I&E Projects/Areas; Evidence Collection and Analysis; Ethics; and Interviewing Techniques.

Similar to the other certification processes, inspectors nationwide would participate in a weeklong certification study program with a test of core competencies at the end of the week. The first inspector certification will be available at the AIG Winter Institute (February or March 2019) in Jacksonville, Florida.

Agency highlights

▌ WIC invoice audits

The WIC Vendor Monitoring Unit (VMU) used a new source to identify vendors for invoice audits. In addition to using WIC's high-risk vendors list, the VMU used a list of vendors identified through data analytics. Using data analysis of vendors' sales records, the VMU focused invoice audits on purchases of specific food items and redemption rates. This shortened the time needed to complete the audits, allowing more time to conduct invoice audits and other compliance activities on a larger number of vendors.

This quarter, the VMU completed five invoice audits in which it found the vendors to be in compliance; the VMU substantiated all paid claims by inventory. Preliminary findings in three invoice audits indicated disallowances (the claims were not substantiated by inventory). The VMU sent these vendors 20-day notices, as required by the state WIC vendor agreement policy, to produce additional invoices.

▌ New hospital admissions review application

The OIG this quarter began developing an application to review managed care hospital inpatient admissions as Texas Medicaid moves away from fee-for-service. The new application will allow review of inpatient admissions in managed care and maximize recoveries.

▌ Utilization Review process enhancements

DMS staff attended a Theory of Constraints workshop to determine how it can adjust the flow and accelerate nursing facility and hospital utilization to streamline the document review processes for the OIG. Strategies to be implemented include establishing SharePoint access for physician consultants and hospitals for reviews, and developing better training for coding specialists.

▌ Estimating damage to the state

In February 2018, the OIG completed a pharmacy audit using the OIG's revised extrapolation methodology, incorporating a statistical software program called RAT (Regional Advanced Techniques)-STATS. The U.S. Department of Health & Human Services Office of Inspector General (HHS OIG) created RAT-STATS; it is the primary statistical tool used for the HHS OIG's Office of Audit Services. RAT-STATS was developed in the late 1970s and has been used effectively to estimate overpayments.

Extrapolation is a rigorous mathematical method in which test results for a sample of claims are estimated (extrapolated) to all claims within a defined audit population. This allows the OIG to calculate an overpayment estimate for a large volume of claims that the state does not have enough resources to audit.

To ensure that pharmacy audits adhere to statistically valid methods for projecting overpayments, an OIG statistician analyzes data associated with claims submitted for reimbursement within the defined period of time (audit scope). The statistician stratifies the data defined in the scope of the audit, which could be classified by factors such as the strength of the prescription or the dollar amount of the claims, and enters the related statistical values into RAT-STATS to generate a statistically valid random sample. The statistician then evaluates the sample to determine if it was statistically representative of all claims in the audit scope. After completing the first analysis, an external statistician independently validates the sampling methodology and replicates the sampling process to ensure the same results could be generated.

After reviewing audit exceptions and extrapolating to all claims in the audit scope, the OIG determines the total dollar amount owed to the state, using the lower amount identified in the estimate. If a pharmacy provider disagrees with the audit findings, the HHSC Appeals Division provides an informal hearing if the provider submits a request for an appeal within specified timeframes.

▌ Completed reports

Audit

Audit of Southside Pharmacy: A Texas Vendor Drug Program Provider: The audit determined whether Southside Pharmacy properly billed the Texas Vendor Drug Program (VDP) and complied with contractual and Texas Administrative Code (TAC) requirements. The audit also evaluated IT general controls to determine whether data used for audit testing was reliable. The OIG found that Southside Pharmacy did not bill VDP properly, or comply with other contractual or TAC requirements, for 15 of 133 claims tested. The 15 claims resulted in $8,817.40 reimbursed in error, which extrapolates to more than $81,000 owed to the state.

Agency highlights

The Audit Division tested Southside Pharmacy's compliance with contractual and TAC requirements in seven areas: (a) claims validity, represented by claims documentation maintained by the provider, (b) National Drug Code (NDC) usage, (c) quantity, (d) refills, (e) controlled substances, (f) warehouse billing, and (g) acquisition cost.

Audit results indicated that there were exceptions related to claims validity, NDC usage, quantity, and controlled substances. There were no exceptions related to refills, warehouse billing, or acquisition cost, and IT general controls were sufficiently reliable for the purposes of the audit.

Audit of Security Controls Over Confidential HHS System Information: MAXIMUS Enrollment Broker: The audit evaluated MAXIMUS, which contracts with the state of Texas to provide Medicaid and CHIP enrollment broker services. MAXIMUS is required to protect and secure confidential HHS System information and follow HHS Information Security Standards and Guidelines. MAXIMUS uses personally identifiable information to enroll qualified individuals into Medicaid and CHIP MCOs, stores confidential information for Medicaid and CHIP applicants and enrollees, and transmits confidential information to MCOs and other entities across multiple networks.

The OIG found that MAXIMUS had an adequate physical security environment in its primary data center to protect confidential information, and processes to monitor information systems activities were sufficient to identify and prevent harmful activities such as viruses on the network. The OIG did recommend that HHSC Medicaid and CHIP Services should coordinate with HHS IT to ensure MAXIMUS system security plans are timely reviewed, and should require MAXIMUS to, among other things, improve access controls for systems containing confidential HHS System information and strengthen account management practices and password configurations.

Audit of Gaddy Enterprises, Inc.: A Durable Medical Equipment Provider: The audit determined whether Gaddy Enterprises properly billed Medicaid for fee-for-service claims durable medical equipment (DME) incontinence supplies according to state laws, regulations, and program requirements.

The Audit Division tested Title XIX DME/Medical Supplies Physician Order forms for 45 clients to determine whether the forms were current and complete. Audit also tested DME Certification and Receipt forms for 50 clients to evaluate the existence and support of paid claims for the audit period. Test results did not identify any exceptions to Texas Medicaid billing requirements. In addition, results of controls testing indicated that Gaddy Enterprises' claim processing system, Mediware, had appropriate controls in place to protect health information.

Legislative reports

Rider 153: The OIG completed and submitted to the Legislative Budget Board on February 1, 2018, Rider 153, Recoveries Accountability Report. The report outlined the methodology the OIG uses to collect and validate funds recovered through investigations, audits, utilization reviews, and inspections, which offset funds which would otherwise be expended by the state. This report contained supporting details of the methodology used to confirm the reported Dollars Recovered (OP-5), a key OIG performance measure.

Rider 151: The OIG completed and submitted to the Legislative Budget Board on March 1, 2018, Rider 151, Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities Report. The report outlined OIG's review of cost avoidance and waste prevention activities employed by managed care organizations. Details of the Rider 151 report are in the Program Integrity Spotlight on page 9.

Stakeholder outreach

IG presentations: Inspector General Sylvia Hernandez Kauffman spoke to the Association of Governmental Accountants in February on the importance of accurate accounting and record keeping. Ms. Kauffman also presented to the Texas Association of Home Care & Hospice in February on what to expect in an OIG audit, investigation, or review.

Disaster SNAP testimony: The Inspector General's office testified on Disaster-SNAP (D-SNAP) fraud efforts at the House General Investigating & Ethics Committee Hearing in Houston in January. OIG provided testimony on the office's efforts to prevent, detect, and investigate fraud within the D-SNAP program in the wake of Hurricane Harvey.

Internal Affairs meeting: Deputy Inspector General

for Investigations Roland D. Luna, Sr. and Assistant Deputy Inspector General for Internal Affairs Kevin Hoskins presented on Internal Affairs at the All HHSC Regional Attorneys Quarterly Meeting in January. The meeting focused on fostering better communication between the regional attorneys and Internal Affairs.

DPS training: OIG Investigations Lieutenant Lesley Malinak assisted with Crisis Intervention Training for the Texas Department of Public Safety (DPS) Trooper Trainee Academy at DPS headquarters in Austin in February. The OIG has about 30 full-time peace officers who are required to participate in continuing education to stay in compliance with OIG police certification. The OIG partners with DPS to assist with the training provided by DPS.

The 40-hour training curriculum includes de-escalation techniques designed to help interaction with mentally ill people. Mentally ill individuals transported to one of the state hospitals may pose a threat to themselves or others and have to be taken into protective custody by law enforcement..

Quarterly meeting: OIG staff met with State Supported Living Center (SSLC) Leadership, State Hospital (SH) Leadership, and Legal Services in January to discuss incident protocol on priority investigations.

DMS meetings: OIG staff held its hospital utilization review quarterly meeting in January. Attendees discussed how providers may submit medical records for review via SharePoint and where to send information for an appeal of an adverse finding.

DMS held its quarterly stakeholders' meeting with nursing facilities in December. Attendees discussed nursing facility rules and reviews as well as correcting ADL (activities of daily living) coding.

Dental presentation: OIG staff presented "Update for Dental Health Professionals: Deterring Fraud, Waste, and Abuse" to dental hygiene students and instructors at Concorde College in Dallas in January. The presentation was part of the OIG's efforts to provide training and technical assistance to future medical staff, external partners, and other agencies.

Lock-in Program training: OIG staff held a webinar for new managed care organization (MCO) pharmacy staff in December. The training outlined the criteria staff should use to determine whether a client needs to be locked in to a specific pharmacy. The training also included how the program's referral process works using the WAFER system to complete the referral. MCOs ask for this training as they strive to improve cost avoidance in this area and improve their reporting of the program's success.

Program Integrity Spotlight

Managed Care Organizations' Cost Avoidance and Waste Prevention Activities

The OIG submitted the Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities Report in compliance with the 2018-2019 General Appropriations Act, Senate Bill 1, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission, Rider 151.)

The rider required the OIG to conduct a review of cost avoidance and waste prevention activities employed by managed care organizations (MCOs) throughout the state. The rider also required the OIG to consider the effectiveness of cost avoidance strategies employed by the MCOs to prevent waste and the adequacy of current cost avoidance functions. And, finally, the OIG was to scrutinize performance measures related to cost avoidance and waste prevention activities employed by MCOs.

The OIG conducted research on this topic, including distributing a 26-question survey to 22 Texas Medicaid and Children's Health Insurance Program (CHIP) MCOs and dental maintenance organizations (DMOs), conducting follow-up interviews with several MCOs, and undertaking a comprehensive review of the literature in this area.

Key findings and takeaways

The OIG found that 18 MCOs selected prepayment activities as one of the most effective cost avoidance and waste prevention strategies, which includes fraud, waste, and abuse activities such as front-end claim edits and prior authorization programs. Almost the same number identified post payment reviews as one of the most effective methods to reduce costs through cost avoidance and waste prevention, especially data mining.

Additionally, the OIG found that most MCOs also performed audits and internal monitoring to address cost avoidance and waste prevention. And while most MCOs do not consider reducing potentially preventable events (PPEs) to be a program integrity activity, 16 MCOs reported that they most frequently used client case management as a strategy to help reduce PPEs.

In this survey and through research, the OIG also found that definitions of cost avoidance activities and methodologies for calculating cost avoidance activities varied significantly. Texas MCOs currently do not use a uniform definition of cost avoidance or a standard methodology to measure the effectiveness of their cost avoidance activities. Federal government and other states' reporting on fraud, waste, and abuse cost avoidance indicated that there was no standardized definition, methodology, or industry standard for calculating fraud, waste, and abuse cost avoidance in Medicaid and CHIP.

Despite the variation in how Medicare and other states calculate their cost avoidance performance measures, Medicare and other states report their cost avoidance by identifying the dollar value of costs avoided. Sixteen MCOs also reported using, or recommended using, the dollar value of costs avoided as a cost avoidance performance measure. Federal government and other states' reporting on fraud, waste, and abuse cost avoidance and the healthcare industry research indicated that there was no standardized definition, methodology, or industry standard for calculating fraud, waste, and abuse cost avoidance in Medicaid and CHIP.

OIG recommendations

From these findings and observations, the OIG has made several recommendations:

Recommendation 1: Require Medicaid and CHIP MCOs and DMOs to report performance measures based on the dollar value of costs avoided and the value of costs avoided as a percent of total paid claims.

Recommendation 2: Require Medicaid and CHIP MCOs and DMOs to use standard methodologies to calculate and evaluate their cost avoidance related to fraud, waste, and abuse prevention activities.

Recommendation 3: Establish a workgroup with stakeholders to develop standardized methodologies for performance measure reporting to the state by Medicaid and CHIP MCOs and DMOs.

Once a standard definition and methodology for calculating the dollar value of MCO fraud, waste, and abuse cost avoidance is finalized, a baseline of current MCO and DMO cost avoidance activities can be established. Then, the state can assess the adequacy and effectiveness of MCO and DMO cost avoidance and waste prevention activities.

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.

General Investigations performance

Overpayments recovered	$3,229,209
Cases completed	3,720
Cases referred for prosecution	34
Cases referred for ADH	180

Law Enforcement performance

Overpayments recovered (EBT trafficking)	$13,366
Cases opened	208
Cases completed	215

Internal Affairs performance

Investigations completed	93
Cases with sustained allegations	26

The two units in this directorate are the State Centers Investigative Team and the Electronic Benefit Transfer Trafficking Unit.

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

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	438
Preliminary investigations completed	357
Full-scale investigations completed	34
Cases transferred to full-scale investigation	69
Cases referred to AG's Medicaid Fraud Control Unit	161
Open/active full-scale cases at end of quarter	190

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

Audit performance

Overpayments recovered	$6,385,257
Overpayments identified	$17,203,209
Audits completed	3

Audit reports issued

- Audit of Southside Pharmacy: A Texas Vendor Drug Program Provider
- Audit of Security Controls Over Confidential HHS System Information: Maximus Enrollment Broker
- Audit of Gaddy Enterprises, Inc.: A Durable Medical Equipment Provider

Audits in progress

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

- STAR+PLUS performance (1)
- DME claims (2)
- Pharmacy providers (5)
- Managed care pharmacy benefit managers' compliance (1)
- Therapy services at long-term care nursing facilities (1)
- MCO SIU performance (1)
- Third party recovery activities managed or performed by a claims administrator (1)
- IT security assessments (2)
- Residential child care services contractor (1)
- Speech Therapy (1)
- Home and community-based services providers (2)
- Medicaid air ambulance providers (1)
- Pharmacy Inventory Reconciliations (1)
- Medical transportation program vendor performance (4)

Inspections

The OIG 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 in progress

- Long-term Services and Supports Community Attendant Services
- Suspense Account
- Electronic Visit Verification
- Medicaid Payments for Deceased Recipients
- Managed Care Duplicate Capitated Rate Payments
- Multiple Medicaid Identification Numbers
- Access and Eligibility Services Interstate and Income Eligibility Verification System Alerts
- Durable Medical Equipment Motorized Wheelchairs Inspection

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 OIG 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 OIG Audit,

Medical Services performance

Acute Care provider recoveries	$326,091
ACS identified MCO overpayments	$344,726
Hospital UR recoveries	$8,454,211
Hospital UR claims reviewed	8,262
Nursing Facility UR recoveries	$74,851
Nursing facility reviews initiated	142

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.

Chief Counsel

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

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 OIG's operations, including researching termination/exclusion issues, drafting policies and procedures related to the OIG 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 OIG office.

Data and Technology

The Data and Technology Division (DAT) implements tools and innovative data analytic techniques that streamline OIG 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 OIG purchasing and contract management, acting as a liaison for facility support and handling OIG administrative services; Strategic Operations and Professional Development, which promotes training services, internal policy development, and organizational support for all OIG divisions; and Finance, which is responsible for overseeing the OIG's budget and

Operations performance

Provider enrollment inventory (applications and informal desk reviews) processed	5,556
Individual screenings processed	16,568
Fraud hotline calls answered	6,720

Data and Technology performance

Data requests received	137
Outliers identified through data analytics in Behavioral Health Fraud Detection Operation (FDO)	56
Outliers selected by MPI for FDO	6

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 OIG. The division analyzes legislation, conducts analysis of program policies, and handles all legislative and media inquiries.