

Quarterly Report

Quarter 4, 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 present the fourth quarterly report for fiscal year 2018, summarizing our work during this period, as well as the complete year, to Governor Greg Abbott, acting Executive Commissioner Cecile Young, the Texas Legislature, and the citizens of Texas.

It was another strong year for this office. We exceeded our performance goals thanks to the outstanding effort by our OIG team. Our recoveries total nearly \$115.5 million, a 17.5 percent increase from fiscal year 2017. In addition, another \$291 million was identified for future recovery, and \$39 million was saved in cost avoidance — money that was prevented from being spent.

As we head into a new fiscal year, we will be focused on continuing to further redefine our oversight and program integrity strategy to continue to work in a managed care environment. We will assess business process improvements, train our staff, and seek out best practices from other states to ensure we are even better well-positioned to continue improving how this office operates.

The OIG has an important duty: detect, prevent, and deter fraud, waste, and abuse in the delivery of all health and human services in Texas. We work to protect the integrity of those programs: making sure that taxpayer funds dedicated to providing services to those who need them are spent only for their intended purpose. Our team abides by our core values: Accountability; Integrity; Collaboration; and Excellence. We are committed to ensuring Texas taxpayers are properly served and that the people who need these services get them in a timely and efficient way. I'm honored to serve with the OIG team as we work to achieve that mission every day.

Respectfully,

Sylvia Hernandez Kauffman

Fiscal year 2018 results

Dollars recovered

Audit

Collections (OIG Audits, UPIC Audits, RAC Audits and OIG contracted audits) \$32,730,936

Inspections

Inspections collections \$3,040,478
WIC collections \$23,382

General Investigations

Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC) \$33,478,651

Peace Officers

EBT Trafficking team \$119,660
State Centers Investigative Team \$301,561

Medicaid Program Integrity

Provider collections \$5,905,098

Medical Reviews

Acute care provider collections \$6,138,856
Hospital collections \$32,384,518
Nursing facility collections \$1,114,612
Voluntary repayments and self-reports \$230,961

Total \$115,468,713

Dollars identified for recovery

Audit

Provider overpayments (OIG Audits, UPIC Audits, RAC Audits and OIG contracted audits) \$35,628,926

Inspections

Identified in completed inspections \$168,260,611
WIC vendor monitoring \$665

General Investigations

Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC) \$32,629,135

Peace Officers

EBT trafficking \$1,054,927

Medicaid Program Integrity

MCO identified overpayments \$14,130,512

Medical Reviews

Acute care providers \$2,813,845
Hospitals \$36,642,172

Total \$291,160,793

Cost avoidance

Inspections

Vendor disqualifications \$437,878

General Investigations

Client disqualifications \$5,697,493

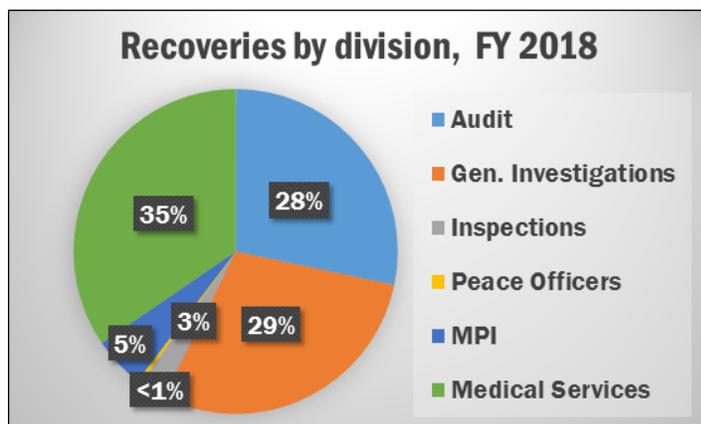
Medicaid Program Integrity

Medicaid provider exclusions \$31,044,959

Medical Services

Pharmacy Lock-In \$1,881,581

Total \$39,061,911



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

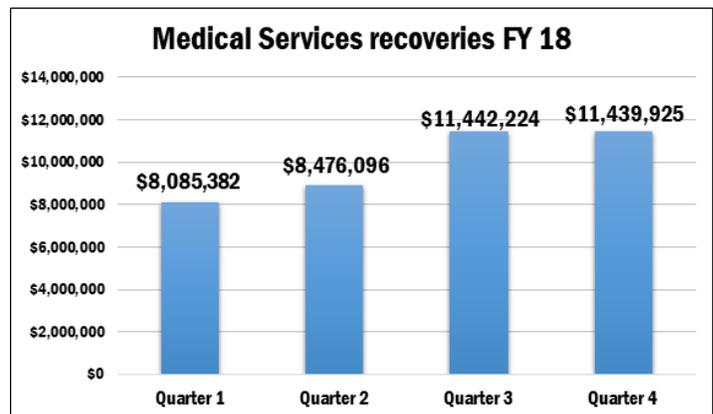
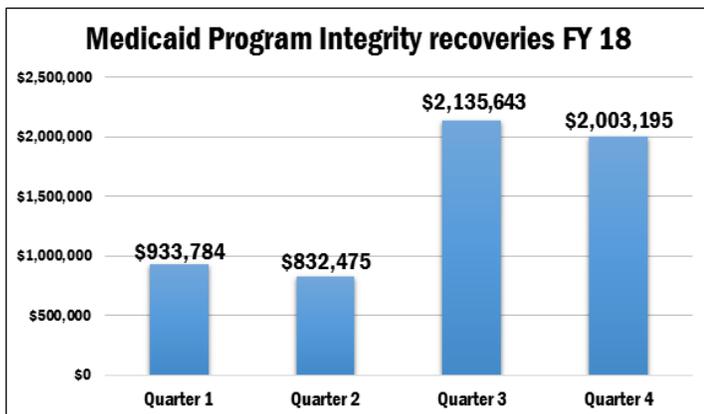
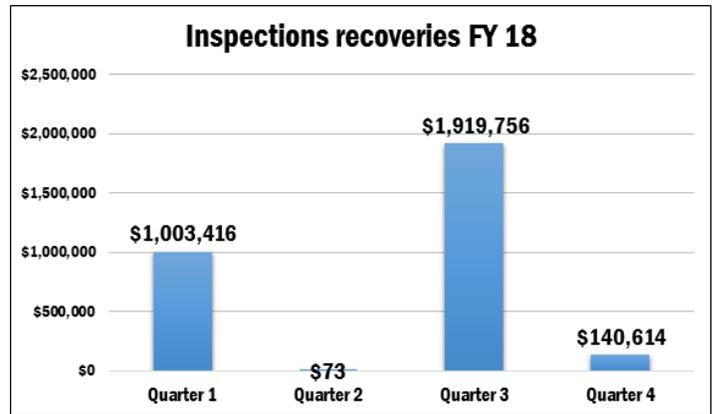
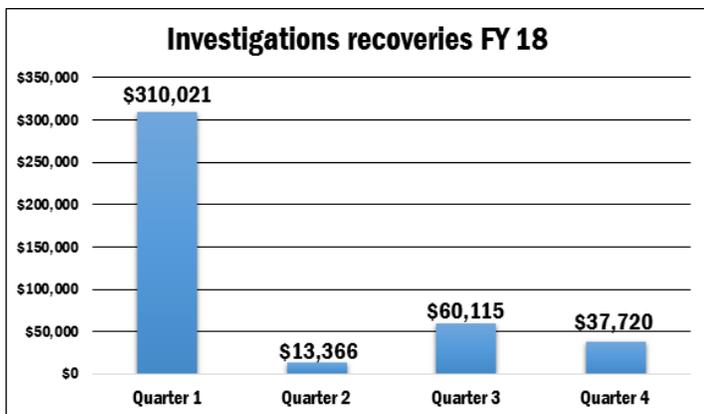
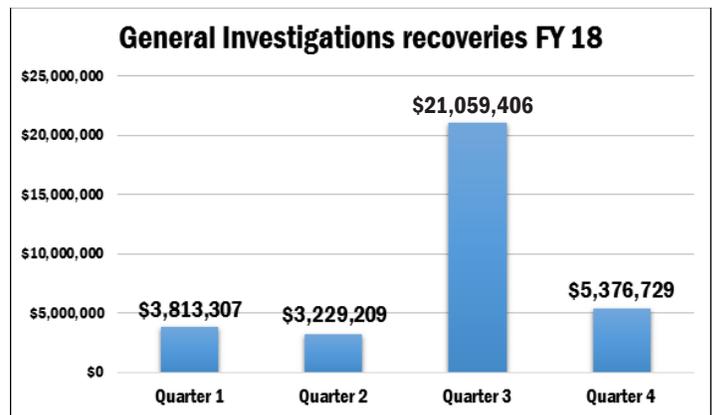
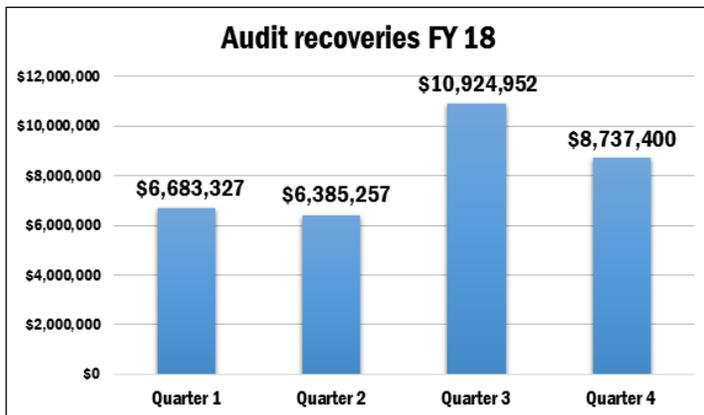
Dollars recovered \$421,221

Dollars identified for recovery \$1,054,927

Cases involving OIG peace officers 1,048

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 by quarter



Fiscal year 2018 overview

Fiscal year 2018 recoveries increase

In fiscal year 2018, a sharp focus on audits and reviews enabled the OIG to increase its recoveries to more than \$115 million, compared to \$98 million in fiscal year 2017. That's a 17.5 percent increase over fiscal year 2017.

The Audit Division recovered \$32.7 million, which was 28 percent of OIG recoveries and a 41 percent increase over fiscal year 2017. General Investigations recovered \$33.5 million, which was 29 percent of OIG recoveries and a 3 percent increase over fiscal year 2017. The Division of Medical Services completed 39,041 hospital claim reviews and performed 581 nursing facility reviews in fiscal year 2018 and recovered \$39.9 million, which was 34.5 percent of OIG recoveries and a 6 percent increase over fiscal year 2017. The Medicaid Program Integrity Division recovered nearly \$6 million, which was 5 percent of OIG recoveries and a 21 percent increase over fiscal year 2017.

Organizational realignments

In November 2017, the OIG created the Medicaid Program Integrity (MPI) Division, formerly the Medicaid Provider Integrity directorate. The restructure gives the OIG a deeper expertise in combatting fraud, waste, and abuse of Medicaid services by concentrating investigative and nurse resources on the largest area of health care expense, targeting resources to maintain the fiscal integrity of Medicaid, and ensuring the health and safety of Texas Medicaid clients.

The OIG combined the Law Enforcement and Inspections divisions into the Inspections and Investigations Division. These changes will help the OIG continue its collaborative efforts to improve program integrity across the HHS System.

Internal Affairs was moved to the Chief Counsel Division, allowing for better communication with the IG and creating a streamlined Internal Affairs reporting process that is more responsive in its investigative scope.

The OIG combined the Policy & Publications and the Data and Technology divisions into the Chief Strategy Office. Responsibilities were expanded to include strategy and innovation, with additional subject matter experts and staff to assist with the continued transition to managed care. Data is key to developing strategy for the OIG and this realignment is designed to bring those resources together.

Fiscal year 2018 highlights

Audit reports issued	40
Inspections reports issued	8
Investigations completed (GI, IA, Peace Officer)	15,447
Medicaid provider investigations completed	
Preliminary	2,036
Full-scale	230
MPI cases transferred to full-scale investigation	218
MPI cases referred to Medicaid Fraud Control Unit	517
Hospital claims reviewed	39,041
Nursing facility reviews conducted	581
Medicaid and CHIP high-risk provider enrollment screenings performed	70,800
Medicaid providers excluded	257
Fraud hotline calls answered	27,283

Record number of provider investigations transferred to Litigation

A record number of investigations, 117, were transferred to the OIG's Litigation team for potential administrative enforcement action. By comparison, 34 investigations were transferred in fiscal year 2017. The increase comes from working more closely with enforcement attorneys, more and better training for investigators, initiating more cases, and closely following investigative timelines.

The increase also results from a streamlined and updated sampling and extrapolation process to better define the information on which the investigators will focus.

Advancing OIG business modifications in managed care

The OIG increased staff experienced in Texas Medicaid and related programs to guide OIG business areas' further transition into working in Medicaid managed care. This team will complete an internal assessment of OIG activities in managed care, seek feedback from stakeholders related to key program integrity considerations in managed care, review trends in program integrity in other states,

Fiscal year 2018 highlights

and develop a plan to guide the OIG's further transition operating in a managed care environment.

Initiating new work products

Staff has produced new work products, such as issue and data briefs, on matters that may merit further OIG review. These documents serve to summarize policy or data information on select topics that the OIG may need to monitor to improve business operations; further explore a policy issue, which may be susceptible to fraud, waste, or abuse; and highlight key data facts.

Focusing on data-driven priorities

The OIG completed more than 700 data requests, which included algorithm development, lead identification, sampling and extrapolation, MCO paid claims data analysis, data research, and technical support. This work allows the OIG to continue focusing on data-driven priorities.

Assessing attendant care services

Given the number of allegations the OIG receives related to fraud, waste, and abuse in attendant care services, the OIG is collaborating across the HHS System with staff from Medicaid and CHIP Services and HHS Regulatory Services to examine program integrity issues in this Medicaid service. The staff will explore data and institutional insight across departments to identify opportunities to strengthen program integrity, develop data-driven recommendations, and identify opportunities for the OIG and the other HHS System staff to work to address risks and threats cooperatively and independently.

Analyzing dental services

Given the number of allegations the OIG receives related to fraud, waste, and abuse in dental services and the feedback the OIG and the Texas Medicaid and CHIP Services have received from dental stakeholders, the OIG and the Medicaid staff are working together to analyze the dental claims data in Medicaid to assess the type and breadth of program integrity issues in dental services provided. The staff will assess the dental claims data, develop data-driven recommendations, and identify opportunities for Texas Medicaid staff or the OIG to take action to address program integrity issues.

Inspections boosts recoveries and published reports

The Inspections Division identified \$168 million in recoveries and had eight published inspection reports in fiscal year 2018. The eight inspections reports are available on the OIG website (oig.hhsc.texas.gov):

- Duplicate Capitation Payments to Managed Care Organizations
- Access and Eligibility Services: Interstate and Income Match Action Alerts
- Community Attendant Services
- Multiple Medicaid Identification Numbers
- Medicaid Payments for Deceased Clients
- Electronic Visit Verification System
- Treasury Offset Program
- Speech Therapy

Record TOP recoveries

The OIG posted record Treasury Offset Program (TOP) recoveries in fiscal year 2018. The \$18.9 million in recoveries resulted from higher repayments from delinquent SNAP recipients and better enforcement. The total surpassed the OIG's TOP recoveries for fiscal year 2017 by approximately \$1 million.

TOP is a fully automated program that captures federal payments to collect delinquent debts owed to federal and state agencies. In Texas, when a SNAP client is more than 120 days delinquent in their repayment of an overpayment, HHSC sends the client's information to TOP, which will then stop any federal payment, such as a tax refund, to the client in order to pay down the client's debt.

SNAP provides benefits to an average of 1.6 million Texas households per month, with an annual expenditure of over \$5 billion.

Fiscal year 2018 highlights

Recoveries resulting from RAC audits

	Overpayment recovered
FY 2016	\$14,500,288
FY 2017	\$20,538,888
FY 2018	\$26,816,310
Total	\$61,855,486

Increased RAC reviews and utilization

The work performed and recoveries resulting from the federally required Recovery Audit Contractor (RAC) reviews have increased significantly this year.

The RAC conducts complex reviews that typically require review of medical documentation supporting the service by qualified clinical staff such as physicians, registered nurses, and certified coding specialists. The RAC also conducts automated reviews that analyze Medicaid claims data using algorithms to identify claims with a high probability of an overpayment occurring. The automated reviews resulted in recoveries totaling \$3.06 million in fiscal year 2018.

Prior to fiscal year 2018, the RAC primarily conducted two complex reviews — newborn upcoding reviews and inpatient hospital short stay reviews. At the end of fiscal year 2018, the RAC conducted, or was approved to conduct, four complex reviews and 18 automated reviews.

EBT trafficking team boosts identified recoveries

The Electronic Benefits Transfer Trafficking team identified \$1,054,927 for recovery, compared to \$357,764 in fiscal year 2017. This increase is a result of efficiencies gained through a renewed focus on timely case completion, and aided by HB 2523, which allows the OIG to use its peace officers to fulfill its federally mandated Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) investigative duties.

Peace officers can obtain and execute search and arrest warrants as needed, 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 with no additional cost to the state.

Increased use of technology in WIC compliance activities

The Women, Infants, and Children Vendor Monitoring Unit (WIC VMU) transitioned from using paper forms to electronic forms that can be filled out and signed using an iPhone and a secure server. This change has significantly reduced the amount of time needed to notify vendors about compliance buy activity and to conduct in-store compliance activities.

The use of iPhone technology enables inspectors to document violations directly into inspection forms during a compliance buy (eliminating the need to bring a laptop, printer, and case files to the compliance activity) while still appearing to be a typical, nondescript grocery shopper. This adds efficiency and accuracy to the compliance buy process.

Initiating provider enrollment screenings in CHIP

The OIG enrolled CHIP providers who had not previously been required to be registered through the state, based on the federal 21st Century Cures Act, which required all managed care providers to enroll with the state by January 2018. Previously, CHIP providers only had to be credentialed through their respective managed care organizations (MCOs). The OIG processed 441 CHIP applications with 1,148 associated screenings, including criminal history background checks and license verification.

New enhancements in the pharmacy Lock-in program

The Lock-in Program restricts Medicaid recipients to a single designated provider or pharmacy for their prescriptions when they have demonstrated use of Medicaid services, including drugs, at a frequency or amount that is excessive, contraindicated, or duplicative, or if it finds that the member's actions indicate abuse, misuse, or fraud.

OIG Lock-in Program staff works closely with MCOs to identify and place members who meet specific criteria in the Lock-in Program, in addition to referrals from the public and health care providers. If criteria is met, the recipient may be locked.

A Lock-in survey was sent to MCOs in the fall of fiscal year 2017. Based on those results, in April 2017, OIG Lock-in Program staff implemented revised criteria and lowered

Fiscal year 2018 highlights

the threshold for referral to the Lock-in Program from 10 or more overlapping controlled substances from 2 or more prescribers in a 90-day period, to 7 or more overlapping controlled substances from 2 or more prescribers. Staff added criteria such as morphine equivalent dosing that exceeds therapeutic levels, drug combinations with abuse potential, and expanded diagnoses that could indicate conflicting use or abuse to include recreational or illegal drug use. As a result of the revised criteria, staff saw a 30 percent increase in clients locked-in as of April 2017 compared to April 2016.

The Lock-in Program conducted another survey in May 2018. The Lock-in Program collaborated with MCOs to evaluate changes since the last survey to further increase Lock-in participation. The results were compiled and discussed with the MCOs. Based on MCO feedback, modifications to the current criteria for the Lock-in Program are being finalized.

The following criteria updates for locking in a member to the program are planned:

- Lower thresholds for the number of controlled substance prescriptions within 90 days from seven to five overlapping or duplicative prescriptions from

two or more prescribers.

- An additional medication was added to the list of drug combinations with abuse potential to include stimulants such as amphetamines.
- Instructions added to the 24-month criteria to clarify that overdose diagnoses should reflect intentional self-harm or suicide attempt.

Stakeholder outreach

The OIG made presentations at numerous regional meetings and conferences on best practices to protect the fiscal, operational, and program integrity of Medicaid programs; assist states in preventing, detecting, and investigating SNAP fraud; have successful inspections of systemic issues which directly or indirectly impact the Medicaid system; and monitor trends in Medicaid policy that affect the use of Medicaid services. The OIG met with more than 15 provider associations in 2018 to discuss specific areas of interest in program integrity as well as partnering on education and outreach. The OIG began writing quarterly articles for the Texas Dental Association and Texas Pharmaceutical Association with information on ways to prevent fraud, waste, and abuse, how to prepare for an audit, and dental solicitation of Medicaid clients.

Quarter 4 results

Dollars recovered

Audit

Audit collections (OIG Audits, UPIC Audits, RAC Audits and OIG contracted audits) \$8,737,400

Inspections

Inspections collections \$136,719
WIC collections \$3,895

General Investigations

Client collections (SNAP, TANF, Medicaid, CHIP, WIC) \$5,376,729

Peace Officers

EBT trafficking \$37,720

Medicaid Program Integrity

Provider collections \$2,003,195

Medical Reviews

Acute care provider collections \$316,625
Hospital collections \$11,073,470
Nursing facility collections \$683
Voluntary repayments and self-reports \$49,147

Total **\$27,735,583**

Dollars identified for recovery

Audit

Provider overpayments (OIG Audits, UPIC Audits, RAC Audits and OIG contracted audits) \$9,965,536

Inspections

Identified in completed inspections \$47,085,099

General Investigations

Client claims in process of recovery (SNAP, TANF, Medicaid, WIC) \$9,228,975

Peace Officers

EBT trafficking \$489,431

Medicaid Program Integrity

MCO identified overpayments \$1,312,347

Medical Reviews

Acute care \$1,288,856
Hospitals \$6,002,659

Total **\$75,372,903**

Cost avoidance

Inspections

WIC disqualifications \$437,878

General Investigations

Client disqualifications \$1,296,190

Medicaid Program Integrity

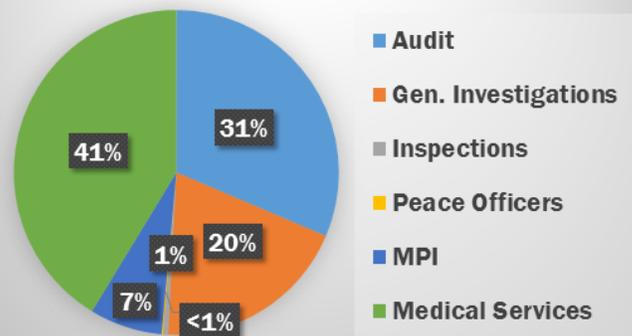
Medicaid provider exclusions \$8,242,413

Medical Services

Pharmacy Lock-in Program \$955,936

Total **\$10,932,417**

Recoveries by division, Q4 FY 2018



How we measure results

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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 \$37,720

Dollars identified for recovery \$489,431

Cases involving OIG peace officers 296

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

Quarter 4 trends

MPI full-scale cases opened

MPI opened 56 full-scale cases involving 12 Medicaid provider types, employees of providers, and managed care organizations:

- Dental
- Attendant care
- Home health agency
- Physician
- Therapy (physical, occupational, or speech)
- Therapy (counseling)
- Pharmacy
- Adult day care
- Laboratory
- Durable medical equipment supplier
- Hospital
- Managed care organization

Trends in allegations across the OIG: The majority of the full-scale cases opened during the fourth quarter involve dental providers and include allegations related to solicitation; poor quality of care; and billing for services not necessary, not rendered, or not covered by Texas Medicaid. New allegations include home health agencies submitting improper claims for telemonitoring services.

Ninety percent of client investigations were unreported income or household compensation complaints. There was also a decrease in dual issuance referrals. OIG staff is able to work the investigations quickly, closing the benefit case so that the client does not again appear in the following quarter's match report.

Internal Affairs has seen an increase in complex investigations involving HHS contracts and the procurement of those contracts. A common theme in the investigations is the lack of consistent process, limited quality assurance, lack of quality control, and communication challenges between divisions in the approval, processing, and monitoring of contracts.

Case highlights

WIC invoice audit

The OIG conducted a Women, Infants, and Children (WIC) program invoice audit on a WIC vendor this quarter, comparing the vendor's available inventory to claims paid

Type of complaints received by MPI

Personal care attendant fraud, waste, or abuse	46.54%
Home health agency	11.42%
Dental	9.52%
Physician (individual, clinic, or group practice)	8.48%
Nursing facility	3.63%
Pharmacy	2.77%
Hospital	2.25%
Therapy (physical, occupational, or speech)	1.90%
Adult day care	1.90%
Durable medical equipment	1.73%

Trends

Attendant care: The OIG continues to receive complaints alleging fraud, waste, and abuse by attendants who are clocking in but not appearing at a client's home.

Dental: A common complaint against dental providers is that billing for services such as restorations or extractions is not supported by the patient's record.

by the WIC program. The audit found that the vendor had been paid \$588,000, but had inventory that totaled \$38,397 less. The vendor is pending disqualification from the WIC program and has requested a fair hearing to appeal this recommendation. If the findings are upheld, the vendor will be disqualified from the program for three years. In the meantime, the OIG has recovered the \$38,397 disallowance through withholding of subsequent claim payments.

DME settlement

The OIG reached a settlement in August with a durable medical equipment (DME) provider for \$250,000 after an investigation determined that the provider billed Medicaid for larger-sized personal care products than were ordered, failed to maintain Title XIX forms, which provide physician authorization for the DME service, and delivery slips, and permitted an employee to bill for items the DME did not provide.

Quarter 4 policy recommendations

Audit

The OIG conducted an audit of Community First Health Plans (Community First) to assess the design and effectiveness of selected security controls over confidential HHS System information stored and processed by Community First. Community First is a licensed MCO that contracts with the State of Texas to provide Medicaid and CHIP services through its network of providers. Community First processes and pays medical provider claims, which contain protected health information and other confidential information. Community First is required to protect and secure confidential HHS System claims data according to criteria established in the Uniform Managed Care Contract.

The OIG recommended that HHSC Medicaid and CHIP Services (MCS) and HHSC Information Technology (IT) review Community First's system security plans, address deficiencies, and approve the plans. The OIG also suggested that formal protocols be established to ensure timely and effective reviews of Community First's security and risk management plans.

The OIG suggested that MCS require Community First to update its risk management plan and strengthen user account controls. The OIG recommended that MCS require Community First to document and maintain baseline configurations, conduct disaster recovery training, improve its incident response plan and associated training and testing, and update IT security policies and procedures consistent with its system security plan.

Inspections

The OIG made several recommendations to HHSC after performing an inspection to determine if Texas Medicaid made multiple capitation payments for clients with multiple Medicaid identification numbers (IDs). The OIG analyzed whether the Texas Medicaid system identifies and prevents the creation of multiple Medicaid ID numbers for clients, and recovers unallowable capitation payments associated with multiple Medicaid ID numbers.

The OIG recommended that HHSC develop a policy and train Texas Works Advisors (TWAs) on standardized naming conventions in the Medicaid application process, such as blending the names together without a space, hyphenating the dual surnames, and adding suffixes at the end of the last name without a space. The OIG recommended that HHSC develop a Texas Integrated Eligibility Redesign System (TIERS) program edit to prevent a Social Security number (SSN) from being used more than once. TIERS has no restriction on how many Medicaid IDs can be created based on a single valid SSN already in use. Inquiries using the SSN will provide the TWA with all cases in TIERS associated with that SSN and prevent the creation of multiple Medicaid IDs. The OIG recommended that HHSC revise policy to require TWAs to search using the SSN on all initial applicants prior to any other program searches. The OIG recommended that MCS provide direction to HHSC Social Services Applications to merge existing Medicaid IDs with CHIP, as appropriate, and develop policy for future merges to be completed within the 24-month period.

Agency highlights

Collaboration on DMO audits

The OIG collaborated with the U.S. Department of Health and Human Services Office of Inspector General (DHHS OIG) on OIG audits of DentaQuest and MCNA, Texas Medicaid's dental maintenance organizations (DMOs). The OIG is conducting the audits to evaluate the effectiveness of the DMOs' performance in complying with selected contract requirements, achieving contract-related outcomes, and reporting financial and performance results to HHSC.

DHHS OIG participated in the OIG audit onsite review at DentaQuest in June, attending interviews and, when appropriate, providing input into site visit activities. DHHS OIG plans to conduct audits in other states where DentaQuest provides Medicare/Medicaid services and will leverage the approach taken by the OIG audit team. DHHS OIG staff participated in the MCNA onsite review in July and primarily focused on the financial components of the audit.

OIG will issue reports on both of these DMO audits in fiscal year 2019. DHHS OIG will provide available information on DentaQuest and MCNA operations in other states for comparison and analysis purposes.

Dental fraud detection operation

The OIG conducted a data-driven fraud detection operation (FDO) in July, which focused on four dental providers in the Houston area. This FDO is the second operation to focus on dental providers and, unlike FDOs that focus on other provider types, July's operation included onsite clinical examinations of Medicaid recipient volunteers by the OIG's chief dental officer. The OIG conducted interviews with providers, staff, and clients or their caregivers.

The OIG dental team is now conducting records reviews to determine whether or not there is evidence of program violations, or potential fraud, waste, or abuse. The previous dental FDO, which took place in Dallas in June 2017, resulted in the OIG opening four full-scale investigations and four referrals to the Texas Office of Attorney General's Medicaid Fraud Control Unit. This is the 15th FDO since August 2016.

USDA/OIG conducts SNAP audit

The U.S. Department of Agriculture Food and Nutrition

Quarter 4 highlights

Audit reports issued	5
Audits in progress	31
Inspections reports issued	3
Inspections in progress	8
Investigations completed (GI, IA, Peace Officer)	3,679
Investigations opened	4,409
Medicaid provider investigations completed	
Preliminary	542
Full-scale	89
MPI cases transferred to full-scale investigation	56
MPI cases referred to Medicaid Fraud Control Unit	58
Hospital claims reviewed	6,138
Nursing facility reviews conducted	512
Medicaid and CHIP high-risk provider enrollment screenings performed	6,723
Medicaid providers excluded	51
Fraud hotline calls answered	6,617

Services (FNS) performed its annual audit of the Texas SNAP program in August. FNS and OIG staff reviewed prosecution cases claims, Treasury Offset Program hearings, and the Electronic Benefits Transfer program. Audit results will be available in the first quarter of fiscal year 2019.

Select RUG payments to nursing facilities assessed

In July 2018, the OIG initiated a statewide assessment on the financial impact of long-term care nursing facility therapy practices on Resource Utilization Group (RUG) payments because of the findings and practices identified in prior audits of assessment and evaluation practices at two nursing facilities. Specifically, the nursing facilities' practice of clustering therapy sessions during look-back periods led to assigning higher RUG levels, therefore increasing Medicaid payments by an estimated \$918,776. The statewide assessment will examine a sample of 154 assessments at approximately 135 nursing facilities across the state.

Agency highlights

Proposed rule amendments modernize OIG processes

HB 2379

The OIG is reviewing proposed changes to rules related to HB 2379, which passed in 2017 and instituted changes to the MCO recovery process, due to provider overpayments.

The proposed amendments would align the rules with HB 2379 and update changes to MCO referral procedures.

Nursing facility utilization review rule

The proposed amendment replaces the requirement that the OIG conduct onsite utilization reviews of every nursing facility at least every 15 months with a process whereby the OIG conducts a comprehensive annual review of all nursing facilities by considering factors such as length of time since the last review, previous review results, complaints, and referrals. The OIG uses the results of that review to prioritize nursing facilities for onsite utilization reviews.

Completed reports

Audit

Audit of Amber Pharmacy: A Texas Vendor Drug Program Provider: The OIG conducted an audit of Amber Pharmacy to determine whether it properly billed the Texas Vendor Drug Program (VDP) for Medicaid claims submitted and if it complied with selected contractual and Texas Administrative Code (TAC) requirements.

The OIG recommended that Amber Pharmacy ensure that all prescriptions are signed by the prescriber prior to dispensing medication and that all claims submitted contain the correct National Drug Code. The OIG also recommended that Amber Pharmacy maintain all records related to prescription services. Amber Pharmacy owes the state of Texas \$59,231 for these exceptions.

Audit of Premier Care Pharmacy Services: A Texas Vendor Drug Program Provider: The OIG conducted an audit of Premier Care Pharmacy Services (Premier Care) to determine whether it properly billed the Vendor Drug Program for Medicaid claims submitted and complied with selected contractual and Texas Administrative Code requirements.

The OIG found that Premier Care did not bill VDP properly, or comply with other contractual or TAC requirements, for 9 of 86 claims tested.

The OIG recommended that Premier Care obtain the prescriber's authorization for any changes in the quantity of a prescription dispensed from the quantity prescribed. The OIG determined that Premier Care owes the state of Texas \$10,497.

Security Controls Over Confidential HHS System Information: Community First Health Plans:

The OIG conducted an audit of Community First Health Plans (Community First) to assess the design and effectiveness of selected security controls over confidential HHS System information stored and processed by Community First. Community First is required to protect and secure confidential HHS System claims data according to criteria established in the Uniform Managed Care Contract (UMCC).

The OIG found that the Community First risk management plan had a risk assessment that had not been updated for six years to reflect changes to its IT environment. Community First used a secondary application to access and change claims information, and did not adequately control access to the application or monitor changes made to claims using the secondary application.

Community First did not adequately manage user access to systems storing confidential HHS System information or have documented server configuration settings that met required security standards. The OIG found that Community First did not conduct disaster recovery training or have an effective incident response plan. Community First's security policy and procedures were inconsistent with the system security plan submitted to HHSC.

The OIG recommended that HHSC Medicaid and CHIP Services coordinate with HHSC IT to review Community First's system security plans, address deficiencies, and approve the plans. The OIG recommended that formal protocols should be established to ensure timely and effective reviews of both the MCO's security and risk management plans.

The OIG recommended that MCS require Community First to update its risk management plan, improve controls over the secondary application, and strengthen user account controls. The OIG recommended that Medicaid and CHIP Services require Community First to document and maintain baseline configurations, conduct disaster recovery training, improve its incident response plan and associated training and testing, and update IT security policies and

Agency highlights

procedures consistent with its system security plan.

Audit of Himmel Home Health: A Medicaid Speech Therapy Provider:

The OIG conducted an audit of Himmel Home Health, LLC (Himmel) in New Braunfels, Texas, on speech therapy claims submitted and paid under an Ancillary Provider Agreement as a network provider for Community First Health Plan (CFHP), a Texas Medicaid MCO.

The OIG analyzed whether Himmel complied with Texas Medicaid requirements for speech therapy initial authorizations and re-authorizations, discontinuation of the therapy treatments, and the associated claims billed to CFHP; licensure, certification, and supervision of speech therapists; and medical necessity of speech therapy treatments.

The audit results indicated that Himmel complied with these Texas Medicaid requirements.

Audit of Pharmacy Inventory Controls: Richard's Pharmacy:

The OIG conducted an audit of Richard's Pharmacy in Edinburg, Texas, on the inventory of selected attention deficit/hyperactivity disorder (ADHD) drugs and determine whether Richard's Pharmacy correctly billed Medicaid, complied with TAC requirements, and maintained sound controls over its IT systems related to inventory controls.

OIG test results indicated inventory records for the selected drugs were accurate, and test results did not identify any exceptions to Texas billing requirements or noncompliance with TAC requirements. In addition, the results of IT controls testing indicated that computerized data used during the audit was reliable and IT system controls related to inventory controls were sufficient.

Inspections

Multiple Medicaid Identification Numbers: Inspection of Multiple Medicaid IDs and the Texas Medicaid System:

The OIG conducted an inspection to determine if Texas Medicaid made multiple capitation payments for clients with multiple Medicaid identification (ID) numbers. The OIG wanted to determine if the Texas Medicaid system identifies and prevents the creation of multiple Medicaid ID numbers for clients, and recovers unallowable capitation payments associated with multiple Medicaid ID numbers.

A federal audit report identified concerns about more than one Medicaid ID number assigned to a client and improperly paid capitation payments. HHSC requested a follow-up inspection to the federal audit to determine potential causes of multiple Medicaid IDs and whether improperly paid managed care payments are recovered.

The OIG identified capitation payments totaling \$4.4 million made for 2,965 multiple Medicaid ID numbers. The OIG supplied HHSC with a list of multiple Medicaid IDs, which resulted in recovery of \$1,119,617.

The OIG recommended that HHSC develop a policy and train Texas Works Advisors (TWAs) on standardized naming conventions in the application process. The OIG also recommended that HHSC develop a Texas Integrated Eligibility Redesign System (TIERS) program edit to prevent a Social Security number from being used more than once. The OIG also recommended that HHSC revise policy to require TWAs to query using the Social Security number on all initial applicants prior to any other inquiries. And the OIG recommended that Medicaid and CHIP Services provide direction to HHSC to merge existing Medicaid IDs with CHIP, as appropriate, and develop policy for future merges to be completed within the 24-month period.

Inspection of Community Attendant Services: The OIG conducted an inspection to determine if Community Attendant Services (CAS) are billed to Medicaid and rendered to clients according to program requirements. CAS is a medically related personal care service available to eligible adults and children whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner's statement of medical need. The inspection focused on how HHSC Community Supports provides oversight of the CAS program to ensure services are being rendered and properly billed, and whether home health providers are effectively monitoring that community attendant services billed are actually provided to clients.

The OIG found that HHSC has an eligibility and authorization process for CAS. However, several required forms of documentation were missing from the home health provider's client files and the Service Authorization System Online (SASO), an online application used to create the authorizations for all Medicaid long-term services and supports.

Agency highlights

The OIG identified potentially erroneous overpayments for CAS in fiscal year 2016, Region 6 - Gulf Coast. The final estimated improper overpayment amount to CAS providers in Region 6 for the missing Practitioner's Statement of Medical Need form was \$14,368,240. The final estimated improper overpayment amount for all four missing forms required by the home health provider was \$37,231,477.

In fiscal year 2016, Texas Medicaid paid \$146,971,836 for 16,413 CAS clients in Region 6 - Gulf Coast, which is approximately \$8,954 per client.

Interstate and Income Match Action Alerts - Preventing and Recovering Benefit Overpayments:

The OIG conducted an inspection to determine whether HHSC responses to OIG match action alerts prevent Supplemental Nutrition Assistance Program (SNAP) and Medicaid overpayments. The inspection focused on whether HHSC accurately processes all required changes to client benefits in response to Public Assistance Reporting Information System (PARIS), a federal-state partnership that allows states to exchange eligibility files to identify clients receiving benefits in multiple states, and Income and Eligibility Verification System (IEVS) match action alerts, a system that identifies a change in a recipient's income that may affect their benefits, and whether HHSC processes all necessary changes within timeline requirements.

The OIG found that HHSC accurately processed changes in response to income match action alerts. However, it was noted that action taken in response to interstate match action alerts could lead to recoupment of overpayments for Medicaid recipients who have applied for and are receiving Medicaid benefits in other states.

Medicaid capitation payments to MCOs may continue for several months after PARIS determines the client received Medicaid benefits in two or more states simultaneously. There are several reasons for this, including time delays inherent in the PARIS notification process and delays due to customer care center backlogs.

Recovery of Medicaid capitation overpayments made to MCOs in fiscal year 2017 for clients receiving Medicaid in other states and had no Medicaid services provided in Texas would result in estimated recoveries of \$9,853,622. If the volume of interstate and income alerts is consistent with fiscal year 2017, the change in policy could result in recoveries estimated at \$8,908,989 annually.

OIG Review of the HHS Procurement Process: 2013 - 2018

Texas HHS manages the daily operations that ensure the delivery of all health and human services in the state, and currently oversees approximately 108,500 contracts estimated at \$60.2 billion in associated spending. Effective policies and procedures are key to assuring overall program integrity and preventing fraud, waste, and abuse in the procurement process.

During the last five years, however, HHS has seen lapses in the evaluation, scoring, and awarding processes for several major procurements and contracts, the most recent of which was with the contract for the Children's Health Insurance Program (CHIP) services in the Hidalgo and rural service areas (RSA).

On April 6, 2018, Governor Greg Abbott requested that the OIG investigate the HHS procurement process to "... uncover any and all errors with this system." The OIG's investigation confirmed that errors occurred, but found no evidence to suggest intentional manipulation of the procurement evaluation tool. However, the investigation found several issues with the CHIP RSA procurement process that led to these errors.

The type of issues identified are not unique to this procurement and echoed systemic issues previously identified in prior audits and reviews. Therefore, the OIG also conducted a review of previously published reports, audits, and investigations of HHS procurements. The review included reports published from 2013-2018 and were authored by the OIG, state agencies, and the federal government to determine if there was a pattern of inconsistencies or weaknesses in the procurement process. Based on this review, the OIG identified the following observations:

Observation 1: Procurement and Contracting Services (PCS) Lacks Necessary Procurement Policies and Procedures.

Opportunity 1.1: Perform a Gap Analysis to Establish Clear Processes, Procedures, Roles and Responsibilities.

PCS must have procurement policies and procedures with clearly defined roles and responsibilities that are regularly maintained and communicated, and that staff are trained to follow. All staff involved in the procurement process need clear and reliable expectations, defined

Agency highlights

requirements, continual communication and collaboration throughout the procurement lifecycle.

Observation 2: PCS Needs A Stronger Evaluation and Scoring Process To Ensure Adequate Oversight, Consistency, And Transparency.

Opportunity 2.1.: Strengthen the Evaluation and Scoring Process.

Opportunity 2.2: Standardize and Protect Evaluation and Scoring Tools.

Lack of oversight and control in the PCS evaluation and scoring process has resulted in a variety of errors, ranging from a lack of documentation to inconsistently following processes to scoring errors. Particular attention should be given to the evaluation. HHS could explore ways to make the tool less susceptible to error.

Observation 3: Thorough and Accurate Documentation Must Be Completed and Retained.

Opportunity 3.1: Clarify and Ensure Appropriate Documentation.

PCS had inadequate or missing documentation related to HHS procurement decisions. Failure to document appropriately can lead to perceptions of unfair or biased procurement actions. HHS should give attention to policies and procedures specific to procurement documentation and retention.

Observation 4: PCS Has Not Consistently Required Disclosures Of Conflicts Of Interest.

Opportunity 4.1: Obtain Appropriate Attestations.

PCS has not consistently nor adequately worked with HHS program areas to identify and document potential conflict of interest during a procurement, even after adopting processes and developing disclosure forms pursuant to legislation enacted to safeguard the state from such improprieties. It is critical that policies and procedures clearly define when and how conflicts of interest attestations must be disclosed.

Observation 5: PCS Should Seek Opportunities To Increase Fair and Open Competition In Purchasing Activities Whenever Possible.

Opportunity 5.1.: Promote Competitive Procurements.

It was noted that PCS could have strengthened processes or chosen another procurement method to increase the level of open and fair market competition. HHS should seek opportunities to increase fair and open competition

in purchasing activities whenever possible and consider how to improve advanced procurement planning and balance resources to build expertise in writing solicitation requirements and conducting evaluations appropriately.

Adoption of sound policies and procedures provides organizations with a solid foundation for proper oversight, consistency, fairness, and transparency in their procurement processes. While HHS needs to ensure it rectifies the immediate issues identified with the CHIP RSA procurement, recognizing and addressing the common systemic issues that have impacted the HHS procurement process over the past five years sets a foundation upon which change can be built. Risk to the HHS system can be reduced and these types of procurement issues may be prevented.

Stakeholder outreach

Legislative

OIG staff provided testimony at the House General Investigating & Ethics and House Appropriations Subcommittee hearing on the agencies and programs under the committees' jurisdictions and the implementation of relevant legislation passed by the 85th Legislature. Staff spoke on the status of the STAR Kids/Health audit and highlighted the OIG's mission and work in program integrity.

IG Kauffman presented at the HHS Quarterly Legislative Staff Briefing at the Capitol. She highlighted the OIG's fraud detection operations and work in attendant care services and Medicaid eligibility.

The OIG participated in a panel discussion on Medicaid managed care before the House Committee on Human Services.

IG Kauffman met with a number of state legislators this quarter to discuss program integrity issues. They included:

- Sen. Paul Bettencourt
- Rep. James Frank
- Rep. Stephanie Klick
- Sen. Eddie Lucio, Jr.
- Sen. Jose Menendez
- Sen. Kel Seliger
- Rep. Gene Wu

Agency highlights

Regional meetings

IG Kauffman traveled to OIG regional offices this quarter to talk with staff and visit with area legislators and stakeholders to discuss Medicaid program integrity issues. In June in San Antonio, the IG met with Sen. Jose Menendez, as well as staff from the University Health System (San Antonio Hospital District), Community First Health Plans, and Davila Pharmacy. In July in Houston, the IG met with Sen. Paul Bettencourt, as well as staff from Texas Children's Hospital, Texas Children's Health Plan, and The Harris Center for Mental Health and IDD.

Conferences/Training

IG Kauffman attended the Centers for Medicare and Medicaid Services 2018 Program Integrity Conference in Baltimore, Md. Discussion included the Quality Payment Program and modernization of fee-for-service, data storage, and delivery of services.

The IG gave a welcome address to members to the annual National Association for Medicaid Program Integrity conference in Austin in August. Representatives from all 50 states gathered to discuss best practices to protect the fiscal, operational, and program integrity of Medicaid programs, and monitor trends in Medicaid policy that affect the use of Medicaid services. The OIG Inspections Directorate presented at the conference, giving an overview of two specific inspections which included Long-Term Services and Supports: Inspection of Community Attendant Services and Inspection of Electronic Visit Verification System. The presentation provided details of the inspections and the respective impact to the HHSC system identifying potential fraud, waste, and abuse.

OIG and HHSC staff attended the Medicaid Integrity Institute's Program Integrity Partnership in Managed Care Symposium in Columbia, S.C., to learn new skills, insights, and specific goals to combat waste, fraud, and abuse in the Medicaid managed care environment and to serve Medicaid clients. The workshops included managed care payment risks, vulnerabilities, and oversight activities, as well as information on tools for auditing and diminishing fraud in managed care.

Staff presented on the OIG prosecution process at the USDA Food and Nutrition Services (FNS) Regional Training conference. Staff attended the FNS Southwest Regional Office SNAP Recipient Integrity Meeting, sharing

strategies and best practices that help states prevent, detect, and investigate SNAP fraud. The meeting provided information on recipient integrity policies and practices that enhance program compliance, promote fiscal management, and boost efforts to lessen fraud activity of SNAP participants.

OIG staff presented an agency overview at the Texas Attorney General's Medicaid Fraud Control Unit's annual investigator training.

OIG staff attended the Homeland Security Investigations Identity and Benefit Fraud Training Program at the Federal Law Enforcement Training Center.

Medical association meetings

OIG staff met with representatives of the HHSC Medical and Social Services Division's Medicaid and CHIP Services, Texas Health Care Association, Leading Age, Texas Medicaid Coalition, and nursing facility providers at its quarterly Nursing Facility Utilization Review (NFUR) Stakeholders meeting in June. They discussed telephone exit surveys, quality assurance reviews, Potentially Preventable Events reviews, and an NFUR proposed rule change.

OIG staff met with representatives of the HHSC Medical and Social Services Division's Medicaid and CHIP Services, hospital associations, and health plan associations at its quarterly Hospital Utilization Review Stakeholders meeting. They discussed managed care reviews, hospital trends, and a change in federal coding in re-review guidelines.

OIG staff met with the following health associations during the quarter to discuss partnering on program integrity issues:

- Texas Association of Health Plans
- Texas Nurses Association
- Texas Nurse Practitioners
- Texas Organization of Rural and Community Hospitals
- National Alliance for the Mentally Ill Texas
- Texas Association of Community Health Centers
- Texas Physical Therapy Association
- Texas Dental Association
- Texas Medical Association
- Texas Psychological Association

Agency highlights

Managed care-related meetings

OIG staff met with more than 50 representatives from MCOs, the Texas Association of Health Plans, and Texas Association of Community Health Plans to discuss implementation of HB 2379, which mandates that one-half of fraud and abuse recoveries by MCOs from providers be remitted to the state, and sets up a new system for division of recoveries collected by the OIG. HB 2379 also outlines a deconfliction process in which the OIG coordinates

with MCOs to avoid both entities from starting payment recovery efforts for the same case of fraud, waste, or abuse.

The OIG met with MCO representatives at its quarterly MCO-SIU (special investigative unit) meeting. They discussed a recent Lock-in Program survey, updates to the Uniform Managed Care Manual, MCO referrals for the third quarter, and recent therapy provider fraud and pharmacy schemes.

Program Integrity Spotlight

At-home care services

The OIG reviewed at-home care-related services and monitoring system funded by HHSC during the past several months. These services are delivered through several different programs.

Texas Medicaid and Attendant Care Services

One of the at-home care-related services available in Texas Medicaid is attendant care services, which can reduce Medicaid costs by providing services to people over the age of 65 and those with disabilities in their home or community instead of in a long-term care facility such as a nursing facility or other institution. These services may include assistance with activities of daily living, instrumental activities of daily living, and health maintenance activities. Attendant care services provide Medicaid clients services that are typically personal care services provided by unlicensed attendants and differ from healthcare services that require a licensed medical professional, such as a nurse or home health aide, to administer the service within a client's home.

Eligible clients may receive attendant care services if they have a functional limitation with at least one personal care task. Federal law establishes broad eligibility requirements for who may receive these services. States have the option to provide these services to additional populations through its state plan or waivers upon approval from the Centers for Medicare & Medicaid Services. During federal fiscal year 2016, Texas spent \$1.4 billion in General Revenue (\$3.3 billion All Funds) on attendant care services.

Fraud, Waste, and Abuse in Attendant Care Services

The OIG is responsible for the prevention, detection, and investigation of fraud, waste, and abuse in the delivery of all health and human services in Texas. The OIG's Medicaid Program Integrity (MPI) division investigates allegations of fraud, waste, and abuse by Medicaid providers and receives, tracks, and reports on provider complaints. Ensuring program integrity for attendant care services takes on added importance because attendants provide care in a person's home and clients may be at risk of unintentional harm or potential neglect and exploitation. During the second quarter of fiscal year 2018, 38 percent of MPI complaints received across all provider types were

allegations of fraud, waste, and abuse specific to attendants.

While cost-effective and beneficial for clients, receiving attendant care services may pose unique risks to clients' health and safety because services are not delivered in a traditional medical setting and may be provided without supervision. Verifying that attendant care services are delivered is a long-standing concern of federal and state governments. According to the Government Accountability Office, attendant care services have a high rate of improper payments. Part of the state's responsibility is to ensure the health and safety of Medicaid clients by ensuring that the agencies that hire attendants adhere to their licensing requirements and that Medicaid managed care organizations (MCOs) adhere to program integrity requirements.

Long-term Services and Supports: Community Attendant Services

One of the programs that provide attendant care services is Community Attendant Services (CAS). CAS is a medically related personal care service available to eligible adults and children whose health problems cause them to be functionally limited in performing activities of daily living according to a practitioner's statement of medical need. The OIG conducted an inspection to determine if CAS claims are billed to Medicaid and rendered to clients according to program requirements. The inspection focused on how the HHSC Community Supports section of Access and Eligibility Services provides oversight of the CAS program to ensure services are being rendered and properly billed, and whether home health providers are effectively monitoring that community attendant services billed are actually provided to clients.

The OIG found that the HHSC Community Supports section has an eligibility and authorization process for CAS. However, several required forms of documentation are missing from the home health provider's client files and the Service Authorization System Online (SASO). SASO is an online application used to create the authorizations for all Medicaid long-term services and supports.

The OIG determined that at least four types of required documentation were missing from the inspected home health provider's client files and SASO.

The OIG identified potentially erroneous overpayments for CAS during fiscal year 2016, Region 6 - Gulf Coast.

Program Integrity Spotlight

The final estimated overpayment amount for the missing Practitioner's Statement of Medical Need form was \$14,368,240. The final estimated overpayment amount for all four missing forms required by the home health provider was \$37,231,477.

Electronic Visit Verification System

One of the tools used to monitor these at-home care services is the Electronic Visit Verification (EVV) system. The OIG conducted an inspection to determine how effective the EVV system is at verifying home service visits for Medicaid clients occurred and confirming that home services were provided. The OIG wanted to determine the percentage of Medicaid claim details that matched with EVV data and the effectiveness of the HHSC EVV Provider Compliance Plan.

The EVV system was designed to deter fraud, waste, and abuse in attendant care services in Texas Medicaid. Those services, performed by home health attendants who are not required to be licensed or certified, are provided in client homes to assist vulnerable, medically fragile clients to

continue to live in the community. When used as intended, claim details matched to an EVV transaction can provide reasonable assurance that an attendant was present to provide services. In state fiscal year 2017, services that require matching EVV transaction data totaled nearly \$2.6 billion in paid claims.

The OIG recommended that Medicaid and CHIP Services (MCS) should comply with the Texas Administrative Code (TAC) and, where appropriate, recover dollars paid without an EVV match. Based on the data available to the OIG, in fiscal year 2017, HHSC paid more than \$117 million for claims without a matching EVV transaction, in violation of TAC.

The OIG also recommended that MCS require a prospective matching process and ensure that claims without a matching EVV are not paid; allow providers to only submit claims with a single date-of-service per detail for claims requiring EVV; require vendors to develop and implement EVV edits and audits to help enforce reason code policy; and establish a standard for percentage of auto-verified EVV transactions that providers must achieve.

Division performance

Investigations

Investigations is comprised of the State Centers Investigative Team and the Electronic Benefit Transfer (EBT) Trafficking Unit. The division protects the integrity of HHS programs through investigations of employee misconduct involving abuse, neglect and exploitation in State Supported Living Centers and State Hospitals as well as vendor and recipient EBT trafficking.

Cases are referred for Administrative Disqualification Hearings (ADH) and prosecution to appropriate state or federal regulatory and law enforcement authorities. Commissioned Peace Officers in the division conduct criminal investigations of allegations of abuse, neglect, and exploitation in State Supported Living Centers and State Hospitals, and EBT trafficking.

EBT Trafficking Unit performance

Overpayments recovered	\$37,720
Cases opened	33
Cases completed	42

State Centers Team performance

Overpayments identified (EBT trafficking)	\$233,116
Cases opened	196
Cases completed	238

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 reports issued

- Multiple Medicaid Identification Numbers: Inspection of Multiple Medicaid IDs and the Texas Medicaid System
- Long-Term Services and Supports (LTSS): Inspection of Community Attendant Services
- Access and Eligibility Services: Interstate and Income Match Alerts- Preventing and Recovering Benefit Overpayments

Inspections performance

Overpayments recovered	\$140,614
Overpayments identified	\$47,085,099

Inspections in progress

- Duplicate Capitation Payments to Managed Care: Inspection of Duplicate Capitation and the Texas Medicaid System
- Durable Medical Equipment: Inspection of Power Wheelchairs
- Ineligible Enrollment: Process for Addressing Non-Validated Social Security Numbers for Texas Medicaid Clients
- Managed Care Organizations Complaints Inspection (Series 1)
- Personal Care Services Background Checks Inspection (Series 1)
- Pharmacy Benefits Manager: Inspection of Program Integrity Activities PBMs Use to Detect Fraud, Waste, and Abuse of Medicaid-Funded Prescriptions
- Value-Based Purchasing (Series 1)
- Network adequacy and Access to Care

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 Unified Program Integrity Contractors (UPIC) audits and Payment Error Rate Measurement (PERM) activities.

Audit performance

Overpayments recovered	\$8,733,400
Overpayments identified	\$9,965,536
Audit reports issued	5

Audit reports issued

- Audit of Amber Pharmacy: A Texas Vendor Drug Program Provider
- Audit of Premier Care Pharmacy Services: A Texas Vendor Drug Program Provider
- Security Controls Over Confidential HHS System Information: Community First Health Plans
- Audit of Himmel Home Health: A Medicaid Speech Therapy Provider
- Audit of Pharmacy Inventory Controls: Richard's Pharmacy

Audits in progress

The Audit Division had 31 audits in progress this quarter on the topics listed below. A list of audits in progress and audit topics the OIG plans to initiate can be found in the two-year rolling audit plan located on the OIG's website.

- STAR+PLUS enrollment
- DME claims
- Pharmacy providers
- Managed care pharmacy benefit managers' compliance
- MCO SIU performance
- Third-party recovery activities managed or performed by a claims administrator
- IT security assessments
- IT security and business continuity and disaster recovery planning assessment
- Residential child care services contractor
- Speech therapy providers
- Home and community-based services providers
- Medicaid air ambulance providers
- Medical transportation program vendor performance
- Medically dependent children's program
- Dental maintenance organization performance
- MCO STAR+PLUS Waiver Program
- MCO Service Coordination
- Statewide Nursing Facility Therapy Service Analysis
- DFPS Child-Specific Contract Payments

General Investigations

The General Investigations Division 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. Clients can be disqualified from a program, denied benefits, and/or ordered to repay all benefits fraudulently received.

General Investigations performance

Overpayments recovered	\$5,376,729
Cases completed	3,327
Cases opened	4,180
Cases referred for prosecution	33
Cases referred for Administrative Disqualification Hearings	168

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 includes:

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 Services performance

Acute Care provider recoveries	\$316,625
ACS identified MCO overpayments	\$1,288,856
Hospital UR recoveries	\$11,073,470
Hospital UR claims reviewed	6,138
Nursing facility UR recoveries	\$683
Nursing facility reviews conducted	512

medical record reviews as requested by OIG Audit, 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.

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	578
Preliminary investigations completed	542
Full-scale investigations completed	89
Cases transferred to full-scale investigation	56
Cases referred to AG's Medicaid Fraud Control Unit	59
Open/active full-scale cases at end of quarter	128

Chief Counsel

The Chief Counsel Division provides legal counsel to the OIG and all OIG divisions, 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 includes:

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

Internal Affairs performance

Investigations completed	56
Cases with sustained allegations	19

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.

Internal Affairs: The Internal Affairs section investigates employee misconduct as it relates to the delivery of health and human services, and contract fraud within the HHS System.

Office of Strategic Initiatives : The Office of Strategic Initiatives (OSI) develops and implements IG-wide related initiatives and special projects, and coordinates and performs complex research concerning program integrity activities related to Texas Health and Human Services programs. OSI also provides expert assistance and advice on coordinating and implementing IG cross-functional projects and strategic initiatives.

Support Services

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

Operations

The Operations Division includes: the Fraud Hotline, 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 reporting Legislative Budget Board performance measures.

Chief Strategy Office

The Chief Strategy Office includes Government Relations, Public Affairs and Publications, Policy, and Data and Technology. 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

Operations performance

Provider enrollment inventory (applications and informal desk reviews) processed	6,723
Individual screenings processed	18,638
Fraud hotline calls answered	6,617

Data and Technology performance

Data requests received	179
Outliers identified through data analytics for the Pharmacy Fraud Detection Operation (FDO)	110
Outliers selected by MPI for FDO	4
Algorithms run	24
New algorithms developed	1

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.

The Data and Technology group 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.

Produced by OIG Chief Strategy Office

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