

TEXAS HEALTH AND HUMAN SERVICES COMMISSION
OFFICE OF INSPECTOR GENERAL

**AUDIT OF MEDICAID AND CHIP MCO
SPECIAL INVESTIGATIVE UNITS**

Driscoll Health Plan



April 3, 2018
OIG Report No. AUD-18-012



HHSC OIG

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WHY THE OIG CONDUCTED THIS AUDIT

Driscoll Health Plan (Driscoll) is one of 21 managed care organizations (MCOs) contracted to provide Medicaid and Children’s Health Insurance Program (CHIP) health care services in Texas. Approximately 87 percent of Medicaid and CHIP enrollees are members of an MCO. At nearly \$29.4 billion a year, the Medicaid and CHIP programs constitute over 28.6 percent of the total Texas budget.

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

The Texas Health and Human Services Commission (HHSC) is responsible for oversight of MCO contracts. The Office of Inspector General (OIG) is responsible for approving SIU annual plans, and evaluating and sometimes investigating SIU referrals.

The objective of this audit is to evaluate the effectiveness of Driscoll’s SIU at (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries.

WHAT THE OIG RECOMMENDS

HHSC should require Driscoll to implement corrective actions to achieve full compliance and strengthen Driscoll’s SIU fraud, waste, and abuse detection, investigation, recovery, and reporting activities.

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

WHAT THE OIG FOUND

Driscoll maintains a contractually required annual SIU fraud, waste, and abuse plan, but needs to improve its SIU function in order to comply with the plan and effectively detect and investigate fraud, waste, and abuse, report reliable information on SIU activities to the OIG, and recover identified overpayments.

Driscoll received approximately \$471 million in Medicaid and CHIP capitation and delivery supplemental payments in 2016, and \$315 million in the first half of 2017, and paid approximately \$692 million in medical claims dollars over those 18 months. During the year-and-a-half period, Driscoll opened 35 SIU cases, recovered \$168,785 in overpayments, and referred one case of potential fraud, waste, and abuse to the OIG.

Year	Medical Claims	# of SIU Investigations	SIU Recoveries	# of Referrals to OIG
2016	\$ 419,892,812	35	\$ 167,785	1
2017	272,543,700	0	1,000	0
Total	\$ 692,436,513	35	\$ 168,785	1

Although Driscoll’s annual fraud, waste, and abuse plan outlined the essential activities needed for an effective SIU, some SIU activities necessary to detect and investigate fraud, waste, and abuse were not performed. Driscoll’s SIU employs two full-time staff, but the two staff spent only 30 percent of their time on SIU activities. As a result, from May 2016 through May 2017 Driscoll did not investigate any new referrals of suspected fraud, waste, or abuse.

Driscoll’s SIU investigation activities were also limited. It did not perform preliminary and full-scale investigations within timeframes specified by the Texas Administrative Code. Additionally, during full-scale investigations, Driscoll’s SIU did not meet minimum sampling requirements.

Driscoll did not collect all of the overpayments it identified, and overstated some of the collections and underreported the number of investigations it performed in monthly reports to the OIG. In addition, it did not refer all possible acts of fraud, waste, and abuse to the OIG as required.

Driscoll’s SIU did not adequately utilize automated standardized queries to analyze post-payment data and detect potential fraud, waste, and abuse. Driscoll also did not establish application parameters that would identify and report suspected fraud and other abnormal claims to the SIU for further research.

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

HHSC Medicaid and CHIP Services concurred with the OIG Audit Division recommendations outlined in this report, and will facilitate Driscoll’s development of corrective action plans designed to improve Driscoll’s SIU function.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Office of Inspector General (OIG) Audit Division is conducting an audit of Medicaid and Children’s Health Insurance Program (CHIP) managed care organization¹ (MCO) special investigative units (SIUs). This audit report is focused on SIU activities at Driscoll Health Plan (Driscoll).

HHSC publishes a report² of general statistical information pertaining to the administration of public benefits in Texas. Unless otherwise noted, all statistical references in this report may be attributed to the HHSC report. Unless otherwise described, any year that is referenced is the state fiscal year, which covers the period from September 1 through August 31.

Objective and Scope

The objective of the audit is to evaluate the effectiveness of MCO SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse in Texas Medicaid and CHIP and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

The audit scope includes 2016 and the first half of 2017, which in total covers the period from September 2015 through February 2017, and includes a review of relevant SIU activities through the end of fieldwork in October 2017.

Background

Driscoll is a licensed Texas MCO contracted to provide Medicaid and CHIP services through its network of providers. Driscoll coordinates health services in Hidalgo and Nueces managed care service delivery areas for members³ enrolled in the Medicaid State of Texas Access Reform (STAR) program, STAR Kids program, or in CHIP.

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

² Texas Medicaid and CHIP in Perspective, 11th ed., Texas Health and Human Services Commission (Feb. 2017).

³ MCOs refer to enrollees as “members.” An “enrollee” is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

Driscoll received approximately \$471 million in Medicaid and CHIP capitation and delivery supplemental payments⁴ in 2016, and \$315 million in the first half of 2017. Driscoll maintained an average monthly membership of 142,693 Medicaid members and 6,759 CHIP members during 2016, and 161,113 Medicaid members and 7,073 CHIP members during the first half of 2017. Table 1 shows capitation and delivery supplemental payments by program.

Table 1: Driscoll Capitation and Delivery Supplemental Payments by Program

Program	2016	2017 ⁵	Total
Medicaid	\$ 456,545,653	\$ 306,482,327	\$ 763,027,980
CHIP	14,161,584	8,380,723	22,542,307
Total	\$ 470,707,237	\$ 314,863,050	\$ 785,570,287

Source: HHSC 2016 Year-End 334-Day FSR and 2017 Q4 FSR

Driscoll is one of 21 contracted MCOs responsible for administering, on behalf of the State of Texas, \$17.4 billion⁶ of Medicaid and CHIP health care services in 2016 through its health plans. By contract, HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, and abuse by members and health care service providers.⁷ An MCO may contract with an outside organization to perform all or part of the activities associated with the SIU. Driscoll previously contracted SIU activities to Health Management Systems (HMS), but as of November 2015 Driscoll performs all SIU activities internally.

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

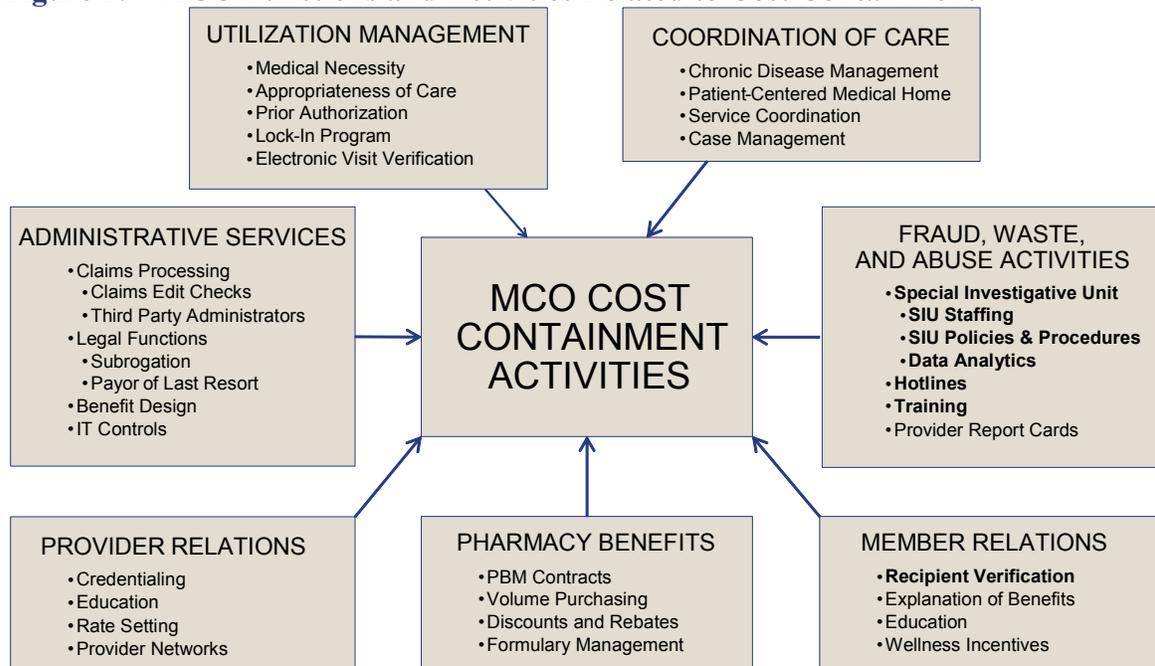
⁴ A “delivery supplemental payment” is a one-time payment per pregnancy to STAR, CHIP, and CHIP Perinatal MCOs for the delivery of live or still births.

⁵ 2017 figures include the first two quarters, or September 2016 through February 2017.

⁶ HHSC 2016 Year-End 334-Day MCO Financial Summary.

⁷ Uniform Managed Care Contract, Attachment B-1, Special Investigative Units, § 8.1.19.1, v. 2.16 (Sept. 1, 2015) through v. 2.21 (Feb. 1, 2017).

Figure 1: MCO Functions and Activities Related to Cost Containment



Source: *OIG Audit Division*

The activities in bold in Figure 1, under “Fraud, Waste, and Abuse Activities” and “Member Relations,” designate some of the areas of focus of this audit. This audit evaluated Driscoll’s SIU efforts related to:

- Prevention processes, such as the organizational code of ethics and fraud, waste, and abuse training.
- Detection activities, such as complex data analysis, periodic provider audits, intake of fraud referrals, and verification that recipients received billed services.
- Investigation efforts, such as conducting preliminary investigations and SIU case management.
- Disposition of fraud, waste, and abuse investigations, including referrals to the OIG, corrective action plans, and monetary recovery.

Texas Health and Human Services (HHS) agencies administer public health programs for the State of Texas. Within HHS, Medicaid and CHIP Services (MCS) oversees Medicaid and CHIP, which are jointly funded state-federal programs that

provide medical coverage to eligible individuals. In 2016, there were approximately 4.4 million individuals⁸ enrolled in Medicaid or CHIP.⁹

MCS is responsible for overall management and monitoring of the contract with Driscoll. The OIG is responsible for approving Driscoll's annual fraud, waste, and abuse plan, as well as evaluating any fraud referrals it receives from Driscoll. Driscoll is required to refer suspected fraud, waste, and abuse to the OIG.¹⁰ When the OIG determines it will not pursue an SIU referral, Driscoll is responsible for conducting the preliminary or full-scale investigation.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 or older, and adults and children with disabilities. Through the STAR program, Medicaid provides health services for pregnant women, newborns, and children. STAR Kids, which began in November 2016, provides services to disabled children and young adults who are 20 or younger. CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid. In federal fiscal year 2015, Texas spent \$29.4 billion on Medicaid. This represented approximately 28.6 percent of the 2015 Texas state budget.¹¹

Medicaid and CHIP programs deliver health care services (including medical, dental, prescription drug, disability, behavioral health, and long-term support services) to eligible individuals. CHIP provides services to individuals in Texas through a managed care model. Texas Medicaid provides services to some individuals through a traditional fee-for-service model,¹² but most are enrolled through a managed care model.¹³ For providing these services, MCOs receive capitation payments, which are monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to

⁸ Texas HHS Health Care Statistics, Medicaid Enrollment by Month (Sept. 2011 – Aug. 2016), <https://hhs.texas.gov/about-hhs/records-statistics/data-statistics/healthcare-statistics> (accessed Oct. 18, 2017).

⁹ This is the 2016 average monthly number of enrollees in Medicaid and CHIP.

¹⁰ 1 Tex. Admin. Code § 353.502(c)(5)(D) (Mar. 1, 2012).

¹¹ Texas Medicaid and CHIP expenditures in 2015 are "all funds" (which include federal and state dollars), but excludes Medicaid funding for Disproportionate Share Hospital, Upper Payment Limit, Uncompensated Care, and Delivery System Reform Incentive Payment funds. Medicaid and CHIP amounts are for the federal fiscal year, and the state budget reflects the state fiscal year which begins one month prior to the federal fiscal year.

¹² Medicaid fee-for-service was the original service delivery model for Texas Medicaid introduced in 1967. In this model, enrolled Medicaid providers are reimbursed retrospectively for a Medicaid eligible health care service or services provided to a Medicaid eligible patient.

¹³ Medicaid managed care was first introduced in pilot programs in Texas in 1993. In this model, the state contracts with MCOs who contract with Medicaid providers for the delivery of health care services to Medicaid enrollees. MCOs must provide the same services under managed care as provided under the traditional fee-for-service model.

MCOs at fixed, per member, per month, rates based on members' associated risk groups.¹⁴ These payments include federal and state funds.

In 2015, 100 percent of CHIP enrollees (approximately 340,000) were in managed care. Approximately 86 percent (3.5 million of 4.06 million) of Medicaid enrollees were managed care members.

The OIG Audit Division presented audit results, issues, and recommendations to MCS and to Driscoll in a draft report dated February 28, 2018. Each was provided with the opportunity to study and comment on the report. MCS management responses to the recommendations contained in the report are included in the report following each recommendation. Driscoll's responses are included in Appendix C. MCS concurred with the OIG Audit Division recommendations, and will facilitate Driscoll's development of a corrective action plan designed to improve Driscoll's SIU efforts.

¹⁴ A "risk group" is a group of MCO members that have a similar health status and are expected to have a similar Medicaid or CHIP spending pattern. HHSC applies an acuity risk adjustment to capitation rates to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. Final capitation payments are based on this acuity risk-adjusted premium for each combination of service area and risk group.

AUDIT RESULTS

Driscoll maintains a fraud, waste, and abuse plan in accordance with contractual and regulatory SIU requirements for MCOs. The plan describes ways Driscoll can strengthen program integrity by monitoring service providers, auditing claims, identifying overpayments, and educating members and providers.

Although the fraud, waste, and abuse plan is in place and Driscoll's SIU is performing in accordance with the plan in some areas, audit results indicated that, overall, Driscoll has not effectively implemented its plan.

The OIG Audit Division tested compliance with plan elements and identified no reportable issues with recipient verification practices, hotline requirements, SIU policies and procedures, and fraud, waste, and abuse training of SIU staff. The OIG Audit Division tested performance in additional areas, and results indicated that weaknesses exist in the structure and function of Driscoll's SIU for the following:

- Allocation of resources to the SIU.
- Consistent detection and investigation of potential fraud, waste, and abuse.
- Completion of preliminary and full-scale investigations within mandated timeframes and using required sample sizes.
- Recovery and reporting of identified overpayments.
- Referral of possible fraud, waste, and abuse to the OIG.
- Consistent utilization of automated data analytics to detect potential fraud, waste, and abuse.

As specified by contract and regulations, SIU fraud, waste, and abuse plans define the essential activities of the SIU. At a minimum, the plan must describe Driscoll's procedures for performing investigations, referring potential fraud, waste, and abuse to the OIG, and pursuing recovery of identified overpayments.¹⁵ Performance of these activities is critical for successful prevention, detection, investigation, and reporting of fraud, waste, and abuse. Driscoll maintained an OIG-approved SIU fraud, waste, and abuse plan, but the scope of activities it performed to implement the plan was limited.

¹⁵ 1 Tex. Admin. Code § 353.501 through § 353.505 (Mar. 1, 2012).

DRISCOLL COMMITTED LIMITED RESOURCES TO SIU ACTIVITIES

The OIG Audit Division evaluated Driscoll's resource commitment to the SIU and concluded that insufficient personnel resources hindered the operating effectiveness of the SIU.

Issue 1: Driscoll Did Not Dedicate Adequate Personnel Resources to the SIU

Though Driscoll maintained an SIU, it allocated limited staff to support SIU functions. Driscoll's SIU consisted of two staff who spent approximately one third of their time performing Texas Medicaid SIU activities:

- The SIU Manager (30 percent of time dedicated to SIU functions)
- The SIU Analyst (30 percent of time dedicated to SIU functions)

The UMCC requires Driscoll's SIU to "have adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases."¹⁶ Driscoll did not have adequate personnel to effectively accomplish all SIU activities because Driscoll management directed SIU staff to perform other Medicaid program integrity functions, such as assisting in the implementation of electronic visit verifications and expansion of the lock-in program. While these efforts represent controls to reduce fraud, waste, and abuse, they do not constitute SIU activities as defined by Texas Administrative Code (TAC).

By not committing adequate personnel and resources, Driscoll hindered its ability to detect, investigate, recover, and refer instances of fraud, waste, and abuse.

Recommendation 1

MCS, through its contract oversight responsibility, should require Driscoll to strengthen its resource commitment to its SIU function by ensuring that adequate personnel resources are assigned to the SIU to perform all tasks required of the SIU function.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to adequately staff its SIU function.

¹⁶ Uniform Managed Care Contract, Attachment B-1, Special Investigative Units, § 8.1.19.1, v. 2.16 (Sept. 1, 2015) through v. 2.21 (Feb. 1, 2017).

Management Response

Action Plan

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that identifies the specific steps that Driscoll will take to ensure that adequate personnel resources are assigned to the SIU to perform all tasks required of the SIU function.

MCS expects Driscoll to take immediate corrective action under the CAP and will allow 90 calendar days to implement all actions within the CAP. MCS will require Driscoll to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, MCS will request the OIG Medicaid Program Integrity Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

DRISCOLL PERFORMED LIMITED INVESTIGATION AND RECOVERY ACTIVITIES

The OIG Audit Division evaluated Driscoll's investigation and recovery processes and identified issues in which Driscoll's SIU:

- Did not continuously initiate investigations of fraud, waste, and abuse
- Did not conduct investigations within required timeframes
- Limited the sample sizes used in investigations
- Did not fully recover identified overpayment amounts

Driscoll identified a limited number of cases¹⁷ and recovery amounts of potential fraud, waste, and abuse in 2016 and 2017. During the 18-month period under review, Driscoll:

- Opened a total of 35 fraud, waste, and abuse investigations.¹⁸
- Recovered \$168,785 in Medicaid overpayments that occurred due to health care provider fraud, waste, and abuse, which represents 0.02 percent of Driscoll's total medical claim dollars.
- Referred one case to the OIG.

During the same 18-month period, Driscoll's health care providers were paid \$692 million in medical claims dollars.¹⁹ Table 2 shows medical claims for 2016 and the first half of 2017 along with the numbers of investigations, referrals, and dollars recovered.

¹⁷ SIU investigations are also referred to as "cases."

¹⁸ SIU investigations include both preliminary and full-scale investigations. A preliminary investigation may be closed without becoming a full-scale investigation.

¹⁹ "Medical claims dollars" are the total amounts submitted to MCOs by health care providers as payment requests for medical services performed. MCOs pay these medical claims as expenses for delivering covered health care services to members. Medical claims dollars include claims with a date of service that falls within the referenced year, and may or may not have been paid during the referenced year. Medical claims dollars for 2016 and 2017 include both medical and pharmacy amounts, but do not include MCO administrative costs.

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

Year	Medical Claims Dollars	# of SIU Investigations ²⁰	SIU Recoveries	# of Referrals to OIG
2016	\$ 419,892,812	35	\$ 167,785	1
2017	272,543,700	0	1,000	0
Total	\$ 692,436,512	35	\$ 168,785	1

Source: HHSC 2016 Year-End 334-Day FSR and 2017 Q4 FSR, OIG Investigations Referral Data, and Driscoll Investigation and Recoupment Logs

Issue 2.1: Driscoll Did Not Initiate Any New Investigations During a 13-Month Period

Driscoll did not open any new investigations for 10 of the 18 months audited. While Driscoll opened 35 investigations between September 2015 and April 2016, the SIU did not initiate another investigation during the scope of the audit, September 2015 through February 2017.

Driscoll commenced new investigations again in June 2017,²¹ ending the 13-month period in which no new investigations were started. Driscoll management indicated that the 13-month period was used to pursue recoveries from HMS investigations that had occurred in prior years.

MCOs are required to establish and maintain SIUs to investigate potential fraud, waste, and abuse by members and health care service providers.²² By not initiating new investigations, Driscoll limited its ability to effectively identify, recover, or refer fraud, waste, and abuse.

Recommendation 2.1

MCS, through its contract oversight responsibility, should require Driscoll to continuously initiate and conduct investigations of potential fraud, waste, and abuse.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to initiate and investigate all potential fraud, waste, and abuse on an ongoing basis.

²⁰ This includes the number of new investigations opened during the referenced year, regardless of whether they resulted in recoveries during the current or future years.

²¹ The three additional months are outside of the scope of the audit, but were reviewed as a part of relevant SIU activities through the end of fieldwork in October 2017.

²² Uniform Managed Care Contract, Special Investigative Units, Attachment B-1, § 8.1.19.1, v. 2.16 (Sept. 1, 2015) through v. 2.21 (Feb. 1, 2017); Tex. Gov. Code § 531.113 (Sept. 1, 2003) through (Sept. 1, 2015). See also 1 Tex. Admin. Code § 353.502 (b) and § 370.502 (b) (Mar. 1, 2012).

Management Response

Action Plan

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a CAP that identifies the specific steps that Driscoll will take to ensure that Driscoll continuously initiates and conducts investigations of potential fraud, waste, and abuse.

MCS expects Driscoll to take immediate corrective action under the CAP and will allow 90 calendar days to implement all actions within the CAP. MCS will require Driscoll to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, MCS will request the OIG Medicaid Program Integrity Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

Issue 2.2: Driscoll Did Not Conduct Investigations Within Required Timeframes

Driscoll did not perform preliminary or full-scale investigations within timeframes specified by TAC and Driscoll's fraud, waste, and abuse plan. SIU investigation logs and support documentation did not substantiate completion of preliminary investigations within 15 days or record reviews within 45 days of receipt.

TAC requires SIUs to "conduct a preliminary investigation within 15 working days of the identification or reporting of suspected or potential waste, abuse, or fraud."²³ The OIG Audit Division selected a judgmental sample²⁴ of 15 cases from the 35 investigations initiated during the audit review period. The OIG Audit Division determined the case tracking information for the 15 cases reviewed was inadequate to provide the assurance that preliminary investigation were completed within 15 days.

²³ 1 Tex. Admin. Code § 353.502(c)(2)(A) (Mar. 1, 2012).

²⁴ "Judgmental sampling" is a non-probability sampling method where the auditor selects the sample based on certain characteristics, such as dollar amount, timeframe, or type of transaction.

During full-scale investigations, Driscoll did not complete its records review within 45 days of receipt, as required by TAC.²⁵ Driscoll did not review received records for three investigations for over a year after receipt. Driscoll's case tracking system indicated that Driscoll only requested records from providers for 21 of the 35 investigations conducted. The case tracking system was inadequate to provide assurance that records for the remaining 18 cases were reviewed within required timeframes.

Driscoll's SIU staff used a spreadsheet as a case management tracking tool. The spreadsheet was found to contain inaccurate and incomplete information. Driscoll's SIU case management method lacked appropriate controls to ensure data integrity and contributed to the inability to demonstrate timeliness requirements were met.

By not conducting preliminary and full-scale investigations within required timeframes, Driscoll failed to comply with TAC requirements and its own fraud, waste, and abuse plan.

Recommendation 2.2

MCS, through its contract oversight responsibility, should require Driscoll to initiate and conduct preliminary and full-scale investigations of suspected fraud, waste, and abuse in accordance with TAC timeliness requirements.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to conduct SIU investigation activities within required timeframes.

Management Response

Action Plan

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that identifies the specific steps that Driscoll will take to ensure that Driscoll performs preliminary or full-scale investigations within timeframes specified by TAC and Driscoll's fraud, waste, and abuse plan.

MCS expects Driscoll to take immediate corrective action under the CAP and will allow 90 calendar days to implement all actions within the CAP. MCS will require Driscoll to submit monthly updates detailing the status of each milestone. Prior to approving actions within the CAP, MCS will request the OIG Medicaid Program Integrity Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

²⁵ 1 Tex. Admin. Code § 353.502(c)(2)(C)(ii) (Mar. 1, 2012).

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

Issue 2.3: Driscoll Did Not Meet Minimum Sample Size Requirements

Driscoll did not request and review samples of at least 50 recipients for any investigation.²⁶ During 2016, Driscoll requested records for 21 of its 35 investigations. All 21 record requests were for fewer than 50 recipients or 15 percent of claims. The number of records requested for the 21 cases ranged from 3 to 20 records.

TAC requires SIU samples to “consist of a minimum of 50 recipients or 15% of a provider’s claims related to the suspected waste, abuse, and fraud; provided, however, that if the MCO selects a sample based upon 15% of the claims, the sample must include claims relating to at least 50 recipients.”²⁷

Driscoll management indicated that sample size requirements were not met due to limited staffing resources.

Because it limited its sample sizes, Driscoll’s reviews were too narrowly focused to find claims patterns and effectively capture potential cases of fraud, waste, and abuse. Limited sample sizes may result in smaller recoveries and fewer referrals to the OIG.

Recommendation 2.3

MCS, through its contract oversight responsibility, should require Driscoll to strengthen its SIU function by expanding the number of recipients reviewed in SIU investigations in compliance with TAC.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to meet sample size requirements for SIU investigations.

²⁶ A “recipient” is an MCO member that has received Medicaid or CHIP services.

²⁷ 1 Tex. Admin. Code § 353.502(c)(2)(C) (Mar. 1, 2012).

Management Response

Action Plan

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that identifies the specific steps that Driscoll will take to ensure that Driscoll expands the number of recipients reviewed in SIU investigations to provide a greater opportunity to successfully detect, investigate, refer, and recover dollars lost to fraud, waste, and abuse.

MCS expects Driscoll to take immediate corrective action under the CAP and will allow 90 calendar days to implement all actions within the CAP. MCS will require Driscoll to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, MCS will request the OIG Medicaid Program Integrity Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

Issue 2.4: Driscoll Did Not Fully Recover Overpayments

Driscoll recovered \$32,674 of the \$90,256 identified by Driscoll as potential recoveries through SIU investigations initiated between September 2015 and February 2017. Driscoll recovered an additional \$136,111 of the \$141,092 identified from SIU investigations initiated in prior years.²⁸ Table 3 shows the number of SIU cases with their respective overpayment amounts, totals recovered, and outstanding balances as of July 2017.

²⁸ Recovery efforts took place during the scope of the audit.

Table 3: Driscoll’s Overpayment Recovery Efforts

SIU Case Initiation	Number of Cases with Identified Overpayments	Identified Overpayments	Total Recovered	Outstanding Balance
September 2015 - February 2017	5	\$ 90,256	\$ 32,674	\$ 57,582
Prior to September 2015	19	141,092	136,111	4,981
Total	24	\$ 231,348	\$ 168,785	\$ 62,563

Source: *Driscoll Investigation and Recoupment Logs*

Upon completion of an investigation, Driscoll is required to pursue recoupment of suspected fraud or abuse, unless the recoupment effort was referred to and accepted by the OIG.²⁹ Recoupment of overpayments is necessary to deter fraud, waste, and abuse, and to ensure medical expenses reported to HHSC are accurate when used by HHSC to develop future capitation rates.

Recommendation 2.4

MCS, through its contract oversight responsibility, should require Driscoll to recover identified overpayments as required by TAC.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to pursue recovery of all identified overpayments.

Management Response

Action Plan

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that identifies the specific steps that Driscoll will take to ensure that Driscoll recovers identified overpayments as required by TAC.

MCS expects Driscoll to take immediate corrective action under the CAP and will allow 90 calendar days to implement all actions within the CAP. MCS will require Driscoll to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, MCS will request the OIG Medicaid Program Integrity Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

²⁹ 1 Tex. Admin. Code § 353.505 (Mar. 1, 2012).

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

DRISCOLL PERFORMED LIMITED REPORTING AND REFERRAL ACTIVITIES

The OIG Audit Division evaluated Driscoll’s reporting and referral processes and identified issues in which Driscoll:

- Overstated annual recoveries
- Reported inaccurate information on the Monthly Open Case List Report
- Did not refer all possible acts of fraud, waste, and abuse to the OIG

Issue 3.1: Driscoll Overstated Annual Recoveries

Driscoll overstated the amounts recovered as a result of SIU investigations by \$81,949. Driscoll reported recoveries of \$249,734 to the OIG in 2016 but, as of the end of audit fieldwork in October 2017, only provided evidence to support \$167,785 in recoveries. Table 4 shows reported recoveries, actual recoveries, and overstated recoveries for 2016.

Table 4: Driscoll SIU Reported and Actual Recoveries

Year	Reported Recoveries	Actual Recoveries	Overstated Recoveries
2016	\$ 249,734	\$ 167,785 ³⁰	\$ 81,949

Source: HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - 2016; Driscoll Recoupment Logs

OIG Investigations requests MCOs submit SIU recoveries annually by fiscal year. This annual request for SIU recoveries is not a part of the monthly MCO Open Case List Report described in Issue 3.2. The annual recovery figures are compiled and submitted to the legislature in the HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries.

Inaccurate or imprecise reporting by Driscoll hinders OIG efforts to fairly and consistently measure SIU performance and fight fraud, waste, and abuse.

³⁰ State fiscal year 2016 recoveries vary from the total recoveries, 2016 and the first half of 2017, discussed in Issue 2.4. Table 2 provides a breakdown of recoveries per year and reflects this variance.

Recommendation 3.1

MCS, through its contract oversight responsibility, should require Driscoll to report complete and accurate information to OIG regarding Driscoll's annual recoveries of identified overpayments.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to accurately report annual recoveries.

Management Response

Action Plan

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a CAP that identifies the specific steps that Driscoll will take to ensure that Driscoll submits complete and accurate information to OIG regarding annual recoveries of identified overpayments.

MCS expects Driscoll to take immediate corrective action under the CAP and will allow 90 calendar days to implement all actions within the CAP. MCS will require Driscoll to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, MCS will request the OIG Medicaid Program Integrity Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

Issue 3.2: Driscoll Reported Incomplete Information in its Monthly Report to the OIG

Driscoll did not report to the OIG all required case information of suspected fraud, waste, and abuse on the monthly MCO Open Case List Report. The OIG Audit Division compared documentation provided by Driscoll to the audit team with information contained in the monthly reports submitted to the OIG. Driscoll did not report 8 of its 35 SIU investigations to the OIG. Additional discrepancies in the monthly MCO Open Case List Report included understating identified overpayments by \$34,602 and understating recoveries by \$167,234.

The HHSC Uniform Managed Care Manual, which is incorporated into the HHSC Uniform Managed Care Contract by reference, requires MCOs to “submit, using the prescribed OIG template, a monthly open case list report electronically to OIG-Medicaid Provider Integrity...”³¹ The Uniform Managed Care Manual requires that the report include all open and recently completed cases and “a report of all overpayment and other recoupments by the MCO.”³² Inaccurate or imprecise reporting by Driscoll hinders OIG efforts to monitor and measure SIU performance and to fight fraud, waste, and abuse.

Recommendation 3.2

MCS, through its contract oversight responsibility, should require Driscoll to submit accurate information to the OIG on the monthly Open Case List Report.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to submit complete and accurate information in its monthly Open Case List Report.

Management Response

Action Plan

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a CAP that identifies the specific steps that Driscoll will take to ensure that Driscoll submits accurate information to the OIG on the monthly Open Case List Report.

MCS expects Driscoll to take immediate corrective action under the CAP and will allow 90 calendar days to implement all actions within the CAP. MCS will require Driscoll to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, MCS will request the OIG Medicaid Program Integrity Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

³¹ HHSC Uniform Managed Care Manual, Chapter 5, Consolidated Deliverables Matrix, Deliverable 51 MCO Open Case List Report, v. 2.3 (Jan. 5, 2015) through v.2.4 (Sept. 1, 2016).

³² HHSC Uniform Managed Care Manual, Chapter 5, Consolidated Deliverables Matrix, Deliverable 51 MCO Open Case List Report, v. 2.3 (Jan. 5, 2015) through v. 2.4 (Sept. 1, 2016).

Issue 3.3: Driscoll Did Not Refer all Possible Acts of Fraud, Waste, and Abuse to the OIG

Driscoll referred one case to the OIG during the audit period. During 2016, Driscoll initiated 35 investigations in which at least 21 cases involved full-scale investigation record review, and at least 3 cases resulted in recoupment due to possible acts of fraud, waste, or abuse. However, Driscoll only referred a single case to the OIG in 2016.

TAC requires MCOs to “refer all possible acts of waste, abuse or fraud to the HHSC-OIG within 30 working days of receiving the reports of possible acts of waste, abuse or fraud from the SIU.”³³

By not referring all possible acts of waste, abuse, or fraud to the OIG, Driscoll limits the OIG’s ability to coordinate and oversee fraud, waste, and abuse efforts throughout Texas.

Recommendation 3.3

MCS, through its contract oversight responsibility, should require Driscoll to refer all possible acts of waste, abuse, or fraud to the OIG.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to refer all possible acts of waste, abuse, or fraud to the OIG.

Management Response

Action Plan

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a CAP that identifies the specific steps that Driscoll will take to ensure that Driscoll refers all possible acts of waste, abuse, or fraud to the OIG.

MCS expects Driscoll to take immediate corrective action under the CAP and will allow 90 calendar days to implement all actions within the CAP. MCS will require Driscoll to submit monthly updates detailing the status of each milestone.

Prior to approving actions within the CAP, MCS will request the OIG Medicaid Program Integrity Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

³³ 1 Tex. Admin. Code § 353.502(c)(5)(D) (Mar. 1, 2012).

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

DRISCOLL PERFORMED LIMITED DETECTION ACTIVITIES

The OIG Audit Division evaluated Driscoll's SIU detection processes and found Driscoll did not effectively perform SIU activities that could have resulted in the detection of fraud, waste, and abuse. The OIG Audit Division identified one issue related to SIU performance, in which Driscoll did not adequately employ data analytics.

Issue 4: Driscoll Did Not Consistently Utilize Data Analytic Techniques to Detect Fraud, Waste, and Abuse

Driscoll did not adequately utilize automated standardized queries that are effective for detecting potential fraud, waste, and abuse for post-payment data analytics. Additionally, Driscoll did not implement automatic triggers or establish application parameters that would identify and report suspected fraud and other abnormal claims to the SIU for further research.

According to Driscoll, the SIU's knowledge of the provider base allows for targeted analysis of predefined providers and billing codes. Consequently, Driscoll predominantly performed manual reviews of post-payment claims data to detect potential fraud, waste, and abuse.

TAC requires SIUs to have "procedures for detecting possible acts of waste, abuse, and fraud by providers"³⁴ that addresses requirements for:

- Identifying Medicaid program violations and possible waste, abuse, and fraud overpayments through data matching, analysis, trending, and statistical activities.
- Monitoring of service patterns for providers, subcontractors, and recipients.
- Using edits or other evaluation techniques.

By not supplementing the manual review efforts of its SIU investigators with automated post-payment data analytics, Driscoll is less likely to detect potential fraud, waste, and abuse committed by providers warranting further investigation and identification of recoveries.

³⁴ 1 Tex. Admin. Code § 353.502(c)(1) (Mar. 1, 2012).

Recommendation 4

MCS, through its contract oversight responsibility, should require Driscoll to enhance post-payment data analytic techniques to identify unusual trends and anomalies in provider claims to effectively detect fraud, waste, and abuse.

MCS should consider utilizing available tailored contractual remedies to compel Driscoll to strengthen its use of data analytics in the detection of fraud, waste, and abuse.

Management Response**Action Plan**

MCS agrees with the recommendation. MCS will allow Driscoll ten (10) business days from receipt of the final audit report to submit a CAP that identifies the specific steps that Driscoll will take to ensure that Driscoll enhances post-payment data analytic techniques to identify unusual trends and anomalies in provider claims to effectively detect fraud, waste, and abuse.

Responsible Manager

Director, Managed Care Compliance & Operations

Target Implementation Date

July 2018

CONCLUSION

The OIG Audit Division completed an audit of Driscoll's SIU performance. The audit included an evaluation of policies and practices associated with preventing, detecting, investigating, and reporting fraud, waste, and abuse.

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

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

Based on the results of its audit of Driscoll's SIU, the OIG Audit Division concluded that Driscoll:

- Had an approved fraud, waste, and abuse plan in place that served as its SIU policies and procedures.
- Conducted recipient verifications.
- Maintained a fraud, waste, and abuse hotline.
- Did not commit adequate personnel resources to the SIU.
- Recovered 0.02 percent of total medical claim dollars.
- Did not consistently detect and investigate new cases of potential fraud, waste, and abuse throughout the scope of the audit.
- Did not conduct investigations within required timeframes.
- Utilized limited sample sizes to conduct investigations.
- Did not pursue recovery of all identified overpayments.

- Overstated its annual recoveries to the OIG.
- Did not submit complete and accurate information about all cases in its monthly Open Case List Reports to the OIG.
- Did not refer all possible acts of fraud, waste, and abuse to the OIG.
- Did not adequately analyze post-payment data analytics.

The OIG Audit Division offered recommendation to MCS which, if implemented, will:

- Increase the time and personnel allocated to SIU activities, providing greater opportunity to successfully prevent, detect, and investigate fraud, waste, and abuse.
- Increase the scope of SIU investigation and recovery efforts, providing greater opportunity to investigate, refer, and recover fraud, waste, and abuse.
- Strengthen SIU reporting and referral activities to accurately reflect SIU fraud, waste, and abuse efforts and to allow the OIG to coordinate and oversee fraud, waste, and abuse efforts throughout Texas.
- Improve detection capabilities, increase identification of potential fraud, waste, and abuse, and increase recoveries.

The OIG Audit Division appreciates management and staff at MCS and at Driscoll for their cooperation and assistance during this audit.

Appendix A: Objective, Scope, and Methodology

Objective

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

Scope

The scope of the audit included the period of September 2015 through February 2017, as well as a review of relevant SIU activities through the end of fieldwork in October 2017. The OIG Audit Division focused on:

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

Methodology

To accomplish its objectives, the OIG Audit Division collected information for this audit through discussions and interviews with responsible staff at Driscoll, and through request and review of the following information:

- A description of the SIU function and organizational structure.
- A list of SIU employees, including their names, titles, and a description of their qualifications.
- Policies and practices associated with prevention and detection of fraud, waste, and abuse.
- Data related to SIU performance, including investigations, recoveries, and referrals in 2016 and 2017.
- A description and flowchart of the SIU investigation process.

- Data and information systems that support the SIU activities and data processing necessary to produce reports for submission to HHSC.
- A list and a description of each automated process or control in place to detect fraud, waste, and abuse.

The OIG Audit Division issued an engagement letter on July 6, 2017, to Driscoll providing information about the upcoming audit, and conducted fieldwork at Driscoll's facility in Corpus Christi, Texas, from July 17, 2017, through July 20, 2017. While on site, the OIG Audit Division interviewed responsible SIU personnel, evaluated policies and practices relevant to the SIU function, and reviewed relevant SIU activities, including those related to prevention, detection, investigation, disposition, and reporting.

Criteria

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

- Tex. Gov. Code § 531.113 (Sept. 1, 2003) through (Sept. 1, 2015)
- 1 Tex. Admin. Code § 353 (Mar. 1, 2012)
- 1 Tex. Admin. Code § 370 (Mar. 1, 2012)
- Uniform Managed Care Contract, Attachment B-1, v. 2.16 (Sept. 1, 2015) through v. 2.21 (Feb. 1, 2017)
- Uniform Managed Care Manual, Chapter 5.0, v. 2.3 (Jan. 5, 2015) through v. 2.4 (Sept. 1, 2016)
- Driscoll Fraud, Waste, and Abuse Compliance Plan
- Driscoll SIU Policies and Procedures

Auditing Standards

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

Appendix B: Testing Methodology

The OIG Audit Division examined SIU activities for the period from September 2015 through February 2017. After an initial assessment of risk across SIU activities and performance outcomes, the OIG Audit Division performed testing from the population of Driscoll SIU employees and SIU investigations.

Driscoll SIU Employee Training

The OIG Audit Division conducted testing to assess whether Driscoll SIU employees had attended annual ethics and fraud, waste, and abuse trainings required by TAC. The OIG Audit Division tested the SIU staff who were employed during the 18-month audit period.

Driscoll SIU Investigations

The OIG Audit Division identified a total of 35 investigations during the 18-month audit period. A random number generator was used to select a judgmental sample of 15 cases from the population of 35 investigations. The OIG Audit Division assessed whether investigations were conducted on a timely basis by determining whether Driscoll met the timeframes required by TAC for the 15 cases sampled.

The OIG Audit Division also assessed recovery efforts and whether all 35 investigations during the audit review period were reported to the OIG, including all overpayments that were recovered resulting from the investigations.

Appendix C: Driscoll Health Plan Management Response



March 1, 2018

Steve Sizemore, CIA, CISA, CGAP
Performance Audit Director
Inspector General - Texas Health and Human Services Commission
11501 Burnet Road, Building 902
Austin, Texas 78758

Dear Mr. Sizemore,

Driscoll Health Plan (DHP) appreciates the opportunity to provide comments on the draft report from the Inspector General's audit of DHP's Special Investigation Unit (SIU) activities. DHP is proud to serve the children of South Texas, and is committed to preventing fraud, waste and abuse in the Medicaid program.

DHP transitioned from using HMS as an external SIU contractor to implementing an internal SIU function in 2015 and 2016. The scope of the IG audit includes 2016 and the first half of 2017. During 2015 and 2016 period DHP was winding down HMS SIU services, implementing the use of Lexis Nexis Analytics, and creating internal SIU processes and procedures. DHP SIU was also carrying out other proactive fraud, waste and abuse prevention activities such as enhanced credentialing, coordinating DRG audits, creating and implementing EVV processes and procedures and managing the Lock-in program. All of these activities prevent potential fraud, waste and abuse and are considered Medicaid program integrity functions as noted in the audit findings.

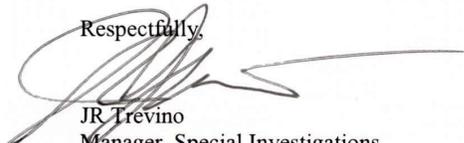
During the transition period, DHP's SIU identified over \$200K in potential overpayments and as validated by this audit, recovered in excess of \$165K. Recoveries on the overpayments identified during the transition period have continued in the post audit period, many resulting from administrative, technical or clerical errors but identified through the DHP SIU's investigative efforts.

Since transitioning to an internal SIU process, DHP has always used data analytics to detect fraud, waste and abuse. DHP believes that the SIU carried out the functions noted in the IG approved Fraud, Waste and Abuse plan. All of the requirements contained were met through a collaborative effort between the SIU and other DHP departments. DHP respectfully disagrees with any contradictory finding.

DHP asserts that the current SIU process complies fully with all statutory requirements. We are using the IG audit review findings in a constructive and positive way to strengthen and enhance our fraud, waste and abuse identification and prevention activities. DHP remains committed to serving the most vulnerable population in South Texas and preventing any fraud, waste and abuse threatening it.

Thank you very much for your consideration of the facts outlined above.

Respectfully,



JR Trevino
Manager, Special Investigations
Driscoll Health Plan

cc: Dr. Mary Dale Peterson, CEO, Stephen Collins, COO, Lauren Parsons, ED Compliance

Appendix D: Report Team and Distribution

Report Team

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

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Joel Brophy, CIA, CFE, CRMA, CICA, Audit Director
- Edward Maldonado, CGAP, Audit Project Manager
- Sarah Warfel, CISA, IT Staff Auditor
- Scott Miller, Senior Audit Operations Analyst

Report Distribution

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- Charles Smith, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
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- Karin Hill, Director of Internal Audit
- Enrique Marquez, Deputy Executive Commissioner of Medical and Social Services
- Stephanie Muth, State Medicaid Director, Medicaid and CHIP Services
- Tony Owens, Deputy Associate Commissioner, Health Plan Monitoring and Contract Services
- Grace Windbigler, Director, Managed Care Compliance and Operations

Driscoll Health Plan

- Dr. Mary Dale Peterson, Chief Executive Officer
- Lauren Parsons, Executive Director, Compliance and Privacy Officer
- JR Trevino, Manager, Special Investigations/Regulatory Reporting

Appendix E: OIG Mission and Contact Information

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

- Sylvia Hernandez Kauffman, Inspector General
- Anita D'Souza, Chief of Staff and Chief Counsel
- Olga Rodriguez, Chief Strategy Officer
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Roland Luna, Deputy IG for Investigations
- Brian Klozik, Deputy IG for Medicaid Program Integrity
- David Griffith, Deputy IG for Audit
- Quinton Arnold, Deputy IG for Inspections
- Alan Scantlen, Deputy IG for Data and Technology
- Judy Hoffman-Knobloch, Interim Deputy IG for Medical Services

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- OIG website: <https://oig.hhsc.texas.gov>

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: <https://oig.hhsc.texas.gov/report-fraud>
- Phone: 1-800-436-6184

To Contact the OIG

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