Summary Report

Summary of Results: Audits of Medicaid and CHIP MCO Special Investigative Units

Selected Texas Managed Care Organizations

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Inspector General

Texas Health and Human Services

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Results in Brief

Audits Summarized in this Report

Between 2018 and 2022, the Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted five audits of special investigative unit (SIU) activities at five managed care organizations (MCOs):

- Aetna Better Health of Texas, Inc.
- Blue Cross and Blue Shield of Texas
- Community First Health Plans, Inc.
- Driscoll Health Plan
- Molina Healthcare of Texas, Inc.

In 2021, 17 MCOs administered, on behalf of the state of Texas, nearly $32 billion in Medicaid and Children's Health Insurance Program (CHIP) services. The five audited MCOs served 16 percent of all Texas Medicaid and CHIP members in 2021.

Summary of Review

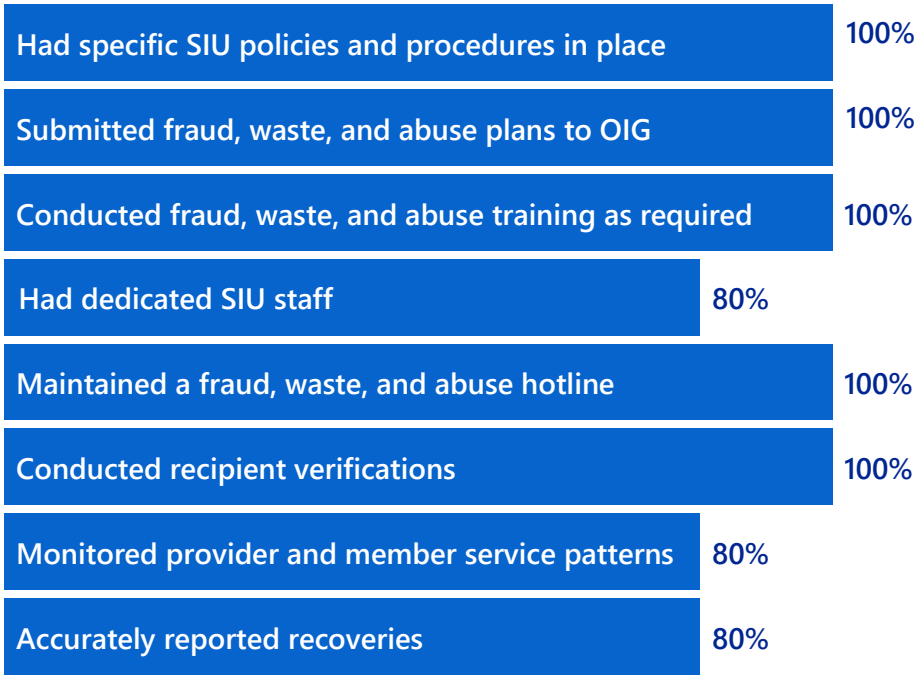
The audits evaluated each MCO's compliance with requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse in Texas Medicaid and CHIP and (b) reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services Commission. The audit scopes included some or all of the two state fiscal years prior to each report's publication and spanned the period from September 2015 through August 2020.

Conclusion

The five audited managed care organizations (MCOs) met requirements for (a) conducting recipient verifications and monitoring provider and member service patterns; (b) having specific special investigative unit (SIU) policies and procedures in place; (c) submitting fraud, waste, and abuse plans to the Texas Health and Human Services (HHS) Office of Inspector General (OIG); (d) conducting fraud, waste, and abuse training; and (e) maintaining a fraud, waste, and abuse hotline.

Four of the five MCOs had dedicated SIU staff to handle Texas volume. Four of the five MCOs also accurately reported recoveries, although some MCOs did not always complete investigative activities in an appropriate time frame. Figure 1 reflects the positive results across the five audits.

Figure 1: SIU Areas of Compliance



Source: OIG Audit

Background

HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, or abuse by Texas Medicaid and CHIP members and health care service providers. Fraud, waste, and abuse monitoring and prevention activities MCOs must conduct include (a) maintaining an SIU, (b) claims analysis, (c) hotlines, and (d) training.

As defined in Texas Administrative Code, requirements of the SIU function are prevention, detection, investigation, and reporting.

Prevention requirements include assigning responsibility for the fraud, waste, and abuse plan to someone at an appropriately high level in the MCO and providing training to prevent, detect, and report fraud, waste, and abuse.

Detection includes monitoring service patterns, conducting random payment reviews, and implementing procedures to receive and work on referrals by hotline.

Investigations must meet required timelines for completing preliminary and extensive investigations, include required elements for each type of investigation, and meet minimum sample sizes.

Reporting requirements include monthly and quarterly submissions to OIG detailing investigations conducted and monies recovered.

Corrective Actions

OIG Audit made recommendations to the MCOs to address the audit findings. All implemented corrective action plans timely.

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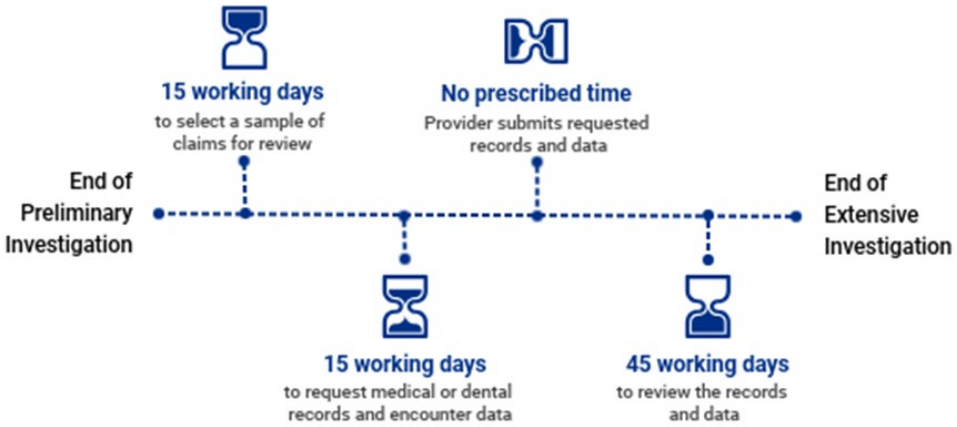
Four of the five audited MCOs had findings for not reporting all open investigations to OIG, which indicates that OIG is not consistently receiving reports of potential fraud, waste, and abuse as required. The Texas Health and Human Services Commission (HHSC) Uniform Managed Care Manual requires each MCO to submit a monthly report to OIG outlining all Medicaid fraud, waste, and abuse investigations opened by its SIU and the status of each investigation. OIG relies on MCOs to perform required reporting on their SIU activities and refer possible instances of fraud, waste, and abuse. Inconsistent reporting by MCOs impairs OIG's ability to effectively analyze, detect, and pursue fraud, waste, and abuse statewide.

Two of the five audited MCOs did not consistently comply with preliminary investigation timelines. MCOs are responsible for investigating possible acts of fraud, waste, and abuse for all Medicaid and CHIP services, starting with a preliminary investigation. SIUs must complete each preliminary investigation within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse.

Two of the five audited MCOs did not consistently comply with extensive investigation timelines. An extensive investigation involves additional required elements, including (a) selecting a sample of claims for review, (b) requesting the records, and (c) reviewing the records. Figure 2 details the timeline for each task in an extensive investigation.

Figure 2: Timeline of Tasks in an Extensive Investigation



Source: OIG Audit

Three of the five audited MCOs had findings about preliminary investigation elements, including not identifying previous allegations or provider education, not reviewing the provider's billing pattern, or not reviewing the past three years of payment history. Not reviewing all the required elements during a preliminary investigation limits the effectiveness of the preliminary investigation and may impede detection of potential fraud, waste, and abuse committed by the provider.

Two of the five audited MCOs had findings about insufficient sample sizes for extensive investigations. Limiting sample sizes can prevent SIUs from identifying claim patterns and may impede detection of potential fraud, waste, and abuse committed by the provider.

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Audit Summary Overview

This report summarizes the results and conclusions of five audits conducted by the Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) performed in accordance with generally accepted government auditing standards. While this report is not an audit report, it does provide current information about the numbers of members served, capitation payments, and special investigative unit (SIU) reporting to OIG.

The audits were of SIU activities at five Texas Medicaid and Children's Health Insurance Program (CHIP) managed care organizations (MCOs):

- Driscoll Health Plan (Driscoll), report issued April 3, 2018
- Blue Cross and Blue Shield of Texas (BCBS), report issued September 28, 2018
- Molina Healthcare of Texas, Inc. (Molina), report issued May 22, 2020
- Aetna Better Health of Texas, Inc. (Aetna), report issued August 18, 2021
- Community First Health Plans, Inc. (Community First), report issued April 28, 2022

Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31. For state fiscal year 2021, the period is September 1, 2020, through August 21, 2021.

Objective

For Driscoll, BCBS, and Molina:

- 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 the Texas Health and Human Services Commission (HHSC).

For Aetna and Community First:

- To determine if each MCO's SIU was in compliance with state and contractual requirements related to (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.

Scope

The audit scopes included some or all of the two state fiscal years prior to each report's publication and spanned the period from September 2015 through August 2020.

Key Program Data

HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, or abuse by Texas Medicaid and CHIP members and health care service providers.[1] Fraud, waste, and abuse monitoring and prevention activities MCOs must conduct include:

- Maintaining an SIU
- Analyzing claims
- Hotlines
- Training

What Prompted These Audits

OIG Audit's annual risk assessment has included risks associated with SIU activities for many years, and OIG Audit plans to conduct more audits of MCO SIUs in the coming years. See Appendix C for a complete list of past reports.

In 2021, there were 17 contracted MCOs[2] responsible for administering, on behalf of the state of Texas, nearly $32 billion in Medicaid and CHIP health care services.[3] Table 1 shows the total capitation amounts for the five audited MCOs along with the remaining MCOs as a group.

Table 1: MCO Capitation 2017 through 2021 (millions of dollars)

	2017	2018	2019	2020	2021
Aetna	$ 280.2	$ 292.8	$ 296.6	$ 313.0	$ 686.5
BCBS	205.7	234.3	263.9	306.9	359.5
Community First	450.7	487.6	526.3	571.0	682.8
Driscoll	624.8	620.9	671.2	737.2	970.3
Molina	1,753.7	1,911.8	2,007.4	2,087.4	2,260.9
Remaining MCOs	18,363.0	19,837.3	20,694.6	22,334.3	26,700.6
Total Capitation	$21,678.1	$23,384.7	$24,460.0	$26,349.8	$31,660.6

Source: HHSC MCO Financial Summaries 2017, 2018, 2019, and 2020 – 334-Day and HHSC MCO Financial Summary SFY 2021 – 90-Day Based on MCO Financial Statistical Reports

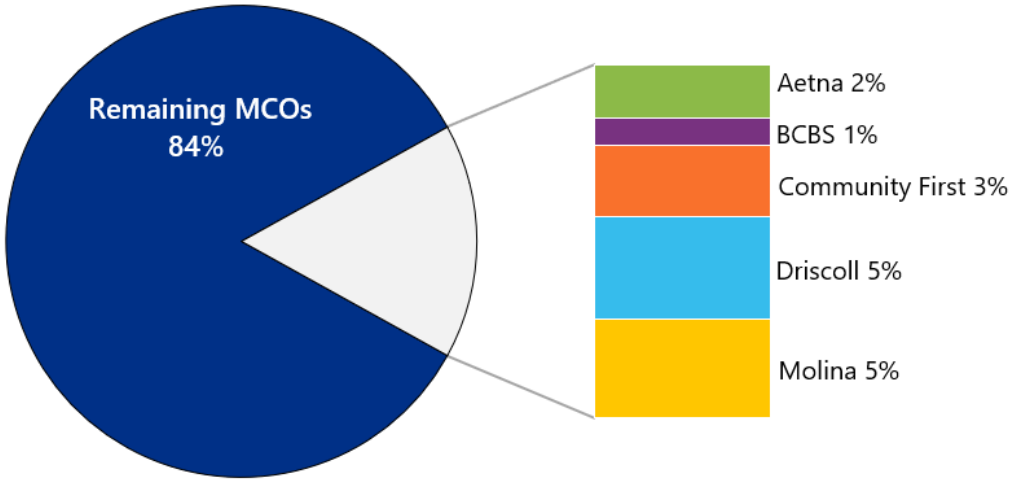
[1] Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, v. 2.16 (Sept. 1, 2015) through v. 2.30 (Mar. 1, 2020).

[2] In 2017 and 2018, there were 20 contracted MCOs; in 2019 and 2020, there were 18 contracted MCOs.

[3] HHSC, "MCO Financial Summary SFY 2021 – 90-Day: Based on MCO Financial Statistical Reports" (Sept. 2020 through Aug. 2021).

The five audited MCOs served 16 percent of all Texas Medicaid and CHIP members in 2021, as shown in Figure 1.

Figure 1: Percentage of Texas Medicaid and CHIP Members Served in 2021



Source: HHSC MCO Financial Summary SFY 2021 – 90-Day Based on MCO Financial Statistical Reports

Summary of Audit Results

As defined in Texas Administrative Code,[4] requirements of the SIU function are prevention, detection, investigation, and reporting. All the audit programs were tested in all the functional areas of an SIU, including many of the elements shown in Figure 2.

Figure 2: Audit Tests of SIU Function Areas

PREVENTION	• Whether the MCO assigned responsibility for the fraud, waste, and abuse plan to someone at an appropriately high level in the MCO. • Whether the MCO implemented procedures for educating recipients and providers and training personnel to prevent, detect, and report fraud, waste, and abuse. • Whether the MCO maintained a training log, with all required elements, for all training pertaining to fraud, waste, and abuse in Medicaid. • Whether the MCO SIU verified that providers are not on the OIG's Texas providers exclusions list.
DETECTION	• Whether the MCO monitored the service patterns for providers, subcontractors, and recipients. • Whether the MCO used random payment reviews of claims submitted by providers for reimbursement. • Whether the MCO verified and documented MCO members actually received services billed. • Whether the MCO implemented procedures to receive and work on referrals by hotline or another mechanism. • Whether the MCO performed audits to monitor compliance or detect fraud, waste, and abuse through data matching and analysis.
INVESTIGATION	• Whether preliminary investigations were conducted within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse. • Whether preliminary investigations included the required elements. • Whether extensive investigation sample sizes met minimum requirements. • Whether the MCO selected and requested records from providers within 30 days. • Whether the MCO reviewed requested records and data within 45 working days of receipt. • Whether the SIU had adequate staff and resources to conduct Texas Medicaid cases sufficiently and effectively.
REPORTING	• Whether the fraud, waste, and abuse plan submitted by the MCO met compliance and regulatory requirements in Texas Administrative Code, contracts, and other applicable regulations. • Whether the MCO submitted a report to OIG monthly, listing all investigations conducted • Whether the MCO began recovery efforts. • Whether the MCO submitted a quarterly report to OIG detailing the amount of money recovered.

Source: OIG Audit

[4] 1 Tex. Admin. Code § 353.502 (Mar. 1, 2012, and July 18, 2019).

Chapter 1: MCOs Generally Performed Most Required SIU Functions

The five audited MCOs met requirements for (a) conducting recipient verifications and monitoring provider and member service patterns; (b) having specific SIU policies and procedures in place; (c) submitting fraud, waste, and abuse plans to OIG; (d) conducting fraud, waste, and abuse training; and (e) maintaining a fraud, waste, and abuse hotline.

Four of the five MCOs had dedicated SIU staff to handle Texas volume.[5] Four of the five MCOs also accurately reported recoveries, although some MCOs did not always complete investigative activities in an appropriate time frame. Figure 3 reflects the positive results across the five audits.

Figure 3: SIU Areas of Compliance

Source: OIG Audit

[5] Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, rev. 2.16 (Sept. 1, 2015) through rev. 2.31 (Sept. 1, 2020).

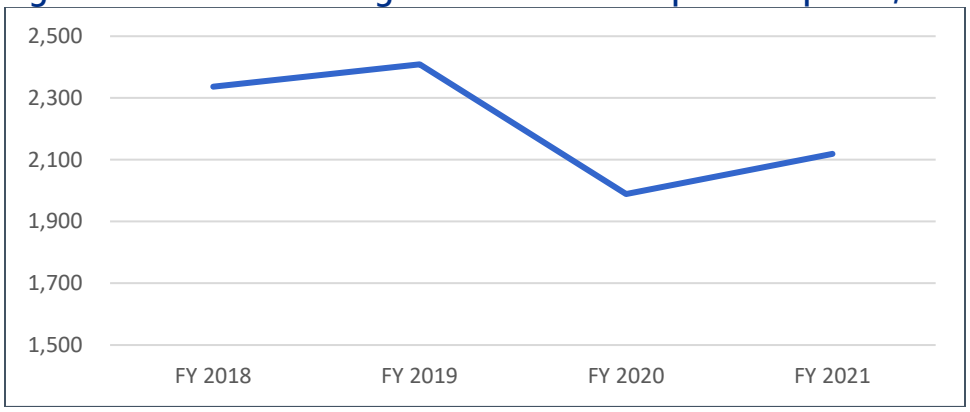
Chapter 2: Most MCOs Had Findings Related to Reporting SIU Activities to OIG or Referrals to OIG

OIG relies on MCOs to report on their SIU activities and refer possible instances of fraud, waste, and abuse. Inconsistent reporting by MCOs weakens OIG's ability to effectively analyze, detect, and pursue fraud, waste, and abuse statewide. Not reporting investigations to OIG within the required time frames may limit OIG's ability to effectively analyze encounter data, evaluate evidence, and make determinations to pursue fraud, waste, and abuse recoveries. Not reporting referrals timely limits OIG's ability to coordinate and oversee efforts to prevent fraud, waste, and abuse throughout Texas HHS programs.

Reporting Open Investigations

The HHSC Uniform Managed Care Manual requires each MCO to submit a monthly report to OIG outlining all Medicaid fraud, waste, and abuse investigations opened by its SIU and the status of each investigation.[6] This report is called the Monthly Open Case List Report. OIG Program Integrity tracks the SIU investigations MCOs report having opened every month. Based on information from OIG Program Integrity, all MCO SIUs opened fewer investigations during the beginning of the COVID-19 public health emergency, but SIUs collectively opened between 2,000 and 2,400 preliminary investigations from 2018 through 2021, as shown in Figure 4.

Figure 4: Total SIU Investigations All MCOs Reported Opened, 2018 Through 2021



Source: MCO Provider Investigations Opened: MCO Open Case List Reports

[6] Uniform Managed Care Manual, Chapter 5.5.1, v. 2.1, (Sept. 6, 2012) through v. 2.4 (Apr. 26, 2019).

These reports can only track information reported and do not capture investigations not reported, as this series of audits did. Four of the five audited MCOs had findings for not reporting all open investigations to OIG, which indicates that OIG is not consistently receiving reports of potential fraud, waste, and abuse as required. OIG uses information provided by MCOs to analyze potential fraud, waste, and abuse trends. Reporting all investigations through the Monthly Open Case List Report creates a central repository of potential and actual fraud, waste, and abuse.

Referring Possible Acts of Fraud, Waste, or Abuse

In addition to reporting opened cases monthly,[7] SIUs are required to assign an officer to report all investigations resulting in a finding of possible acts of fraud, waste, or abuse to OIG. The assigned officer must notify and refer these acts to OIG within 30 working days of receiving reports of possible acts of fraud, waste, or abuse identified in an SIU extensive investigation.[8] The referral must contain certain information, such as the investigative report identifying the allegation, statutes or regulations violated or considered, and the results of the investigation.[9,10] OIG Program Integrity tracks the referrals for potential fraud SIUs refer to the OIG every month.

[7] Uniform Managed Care Manual, Chapter 5.5.1, v. 2.1, (Sept. 6, 2012) through v. 2.4 (Apr. 26, 2019).

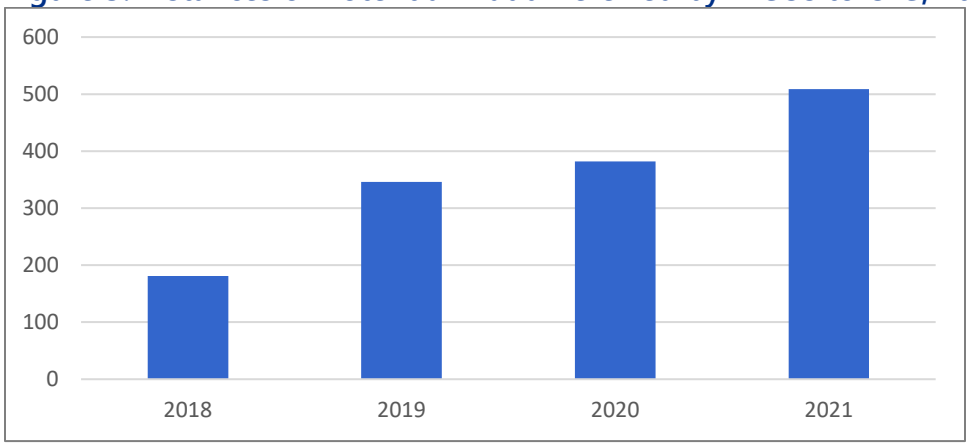
[8] 1 Tex. Admin. Code § 353.502 (c)(5)(D) (Mar. 1, 2012, and July 18, 2019); 1 Tex. Admin. Code § 370.502 (c)(5)(D) (Mar. 1, 2012); and Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, rev. 2.16 (Sept. 1, 2015) through rev. 2.3 (Mar. 1, 2020).

[9] 1 Tex. Admin. Code § 353.502 (c)(5)(D)(i) – (x) (Mar. 1, 2012, and July 18, 2019); 1 Tex. Admin. Code § 370.502 (c)(5)(D) (Mar. 1, 2012); and Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, rev. 2.16 (Sept. 1, 2015) through rev. 2.3 (Mar. 1, 2020).

[10] This requirement applies to all reports of possible acts of fraud, waste, or abuse except an expedited referral.

Based on information from OIG Program Integrity, the MCO SIU referrals to OIG for potential fraud have consistently increased since 2018, as shown in Figure 5.

Figure 5: Instances of Potential Fraud Referred by MCOs to OIG, 2018 Through 2021



Source: Fraud Referrals to IG: Case Tracker

These reports can only track information MCOs reported. This series of audits reviewed all SIU investigations at the audited MCOs and was able to identify potential fraud they had not reported. Two of the five MCOs audited had findings for not referring potential fraud, waste, and abuse to OIG.

Not consistently referring all possible fraud, waste, or abuse also limits OIG's ability to effectively investigate potential fraud, waste, and abuse across the state's Medicaid and CHIP programs.

Chapter 3: Most MCOs Did Not Consistently Comply with Some Aspect of Investigation Timelines

Texas Administrative Code (a) outlines the instances when SIUs must conduct preliminary and extensive investigations and (b) mandates time frames for each investigation type.[11]

Preliminary Investigations

MCOs are responsible for investigating possible acts of fraud, waste, and abuse for all Texas Medicaid and CHIP services, starting with a preliminary investigation. SIUs must complete each preliminary investigation within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse.

Two of the five audited MCOs did not consistently comply with preliminary investigation timelines. Conducting timely preliminary investigations and performing all required elements helps ensure SIUs (a) effectively investigate potential fraud, waste, and abuse, (b) timely identify overpayments and recover Medicaid funds, and (c) appropriately report SIU activities and results to OIG.

Extensive Investigations

SIUs are required to perform an extensive investigation if, during the preliminary investigation, they determine suspicious indicators of possible fraud, waste, or abuse exist.

An extensive investigation involves additional required elements, including (a) selecting a sample of claims for review, (b) requesting the records of those claims, and (c) reviewing the records. SIUs have 15 working days after the completion of a preliminary investigation to select a sample of claims for review. After selecting claims for review, the MCO has 15 working days to request medical or dental records and encounter data.

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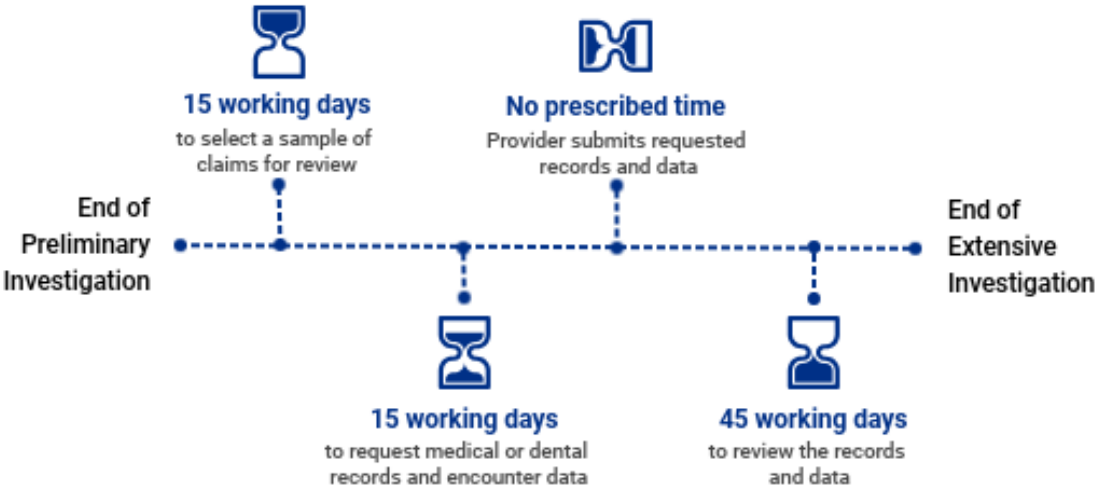
[11] 1 Tex. Admin. Code §§ 353.502 (c)(2)(A), (c)(2)(C), and (c)(4)(A) (Mar. 1, 2012, and July 18, 2019); 1 Tex. Admin. Code § 370.502 (c)(2)(A), (c)(2)(C), and (c)(4)(A) (Mar. 1, 2012); and Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, rev. 2.16 (Sept. 1, 2015) through rev. 2.3 (Mar. 1, 2020).

SIUs must review the requested records and encounter data within 45 working days of receipt of those records to:

- Validate the sufficiency of service delivery data and assess utilization and quality of care.
- Ensure that the encounter data submitted by the provider under investigation is accurate.
- Evaluate whether the review of other pertinent records is necessary to determine if fraud, waste, or abuse occurred. If review of additional records is necessary, then the SIU must conduct such a review.

Figure 6 details the timeline for each task in an extensive investigation.

Figure 6: Timeline of Tasks in an Extensive Investigation



Source: OIG Audit

Two of the five audited MCOs did not consistently comply with extensive investigation timelines, as shown in Table 2.

Table 2: Extensive Review Elements and Timelines for Two MCOs with Issues

Investigation Task	Required Timeline	# in Sample[12]	# Not Performed Timely	% Not Performed Timely	Average Time to Complete[13]
MCO A Records Selected	15 days	7	4	57.10%	30 days
MCO B Records Selected	15 days	16	3	18.75%	39 days
MCO A Records Requested	15 days	7	4	57.10%	44 days
MCO B Records Requested	15 days	16	3	18.75%	39 days
MCO A Records Reviewed	45 days	8	2	25.00%	132 days
MCO B Records Reviewed	45 days	13	5	38.46%	77 days

Source: OIG Audit

When fraud, waste, or abuse is suspected, delays can impair each MCO's ability to mitigate fraud, waste, and abuse within the Medicaid and CHIP programs and (a) effectively investigate potential fraud, waste, and abuse, (b) timely identify overpayments and recover Medicaid funds, and (c) appropriately report SIU activities and results to OIG.

[12] Auditors tested 16 extensive investigations; however, MCO B received records for only 13 of the 16 investigations.

[13] For records selected and records requested, the average time to complete is based on the number of days between when fraud, waste, or abuse was suspected and when the MCOs requested medical records. This occurred because the MCOs did not document either the date the preliminary investigation was closed or the date the sample was selected.

Chapter 4: Some MCOs Did Not Adequately Perform All Required Investigation Elements

An SIU opens a preliminary investigation based on suspicion of fraud, waste, or abuse. The preliminary investigation may lead to an extensive investigation, which may lead to (a) a referral to OIG and (b) recoupments or other consequences if the SIU determines there was fraud, waste, or abuse. To ensure investigations are robust, Texas Administrative Code and the Uniform Managed Care Contract define the elements required in preliminary investigations and the sample size minimums for extensive investigations.

Not reviewing all the required elements during a preliminary investigation limits the effectiveness of the preliminary investigation and may impede detection of potential fraud, waste, and abuse committed by the provider. Performing the required elements may help determine whether there is a pattern of inappropriate behavior.

Limiting sample sizes can prevent SIUs from identifying claim patterns and may impede detection of potential fraud, waste, and abuse committed by the provider. Additionally, limited sample sizes may result in incomplete recoveries of Medicaid and CHIP overpayments and could result in MCOs not referring possible fraud, waste, or abuse to OIG.

Elements of Preliminary Investigations

Preliminary investigations must include specific elements, which differ for provider[14] and member[15] investigations.

[14] 1 Tex. Admin. Code § 353.502 (c)(2)(B) (Mar. 1, 2012, and July 18, 2019); 1 Tex. Admin. Code § 370.502 (c)(2)(B) (Mar. 1, 2012); and Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, rev. 2.16 (Sept. 1, 2015) through rev. 2.3 (Mar. 1, 2020).

[15] 1 Tex. Admin. Code § 353.502 (c)(4)(B) (Mar. 1, 2012, and July 18, 2019); 1 Tex. Admin, Code § 370.502 (c)(4)(B) (Mar. 1, 2012); and Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, rev. 2.16 (Sept. 1, 2015) through rev. 2.3 (Mar. 1, 2020).

Preliminary Provider Investigations

Preliminary provider investigations have these specific required elements:

- Determining whether the MCO has received any previous reports of fraud, waste, or abuse or if it has conducted any previous investigations of the provider in question.
- Determining whether the provider has received educational training from the MCO regarding the allegation.
- Reviewing the provider's billing patterns.
- Reviewing the provider's payment history for the past three years, if available.
- Determining whether the new allegation is a violation of program policy or procedure.

Three of the five audited MCOs had findings about preliminary investigation elements.

Preliminary Member Investigations

The required elements for preliminary member investigations are:

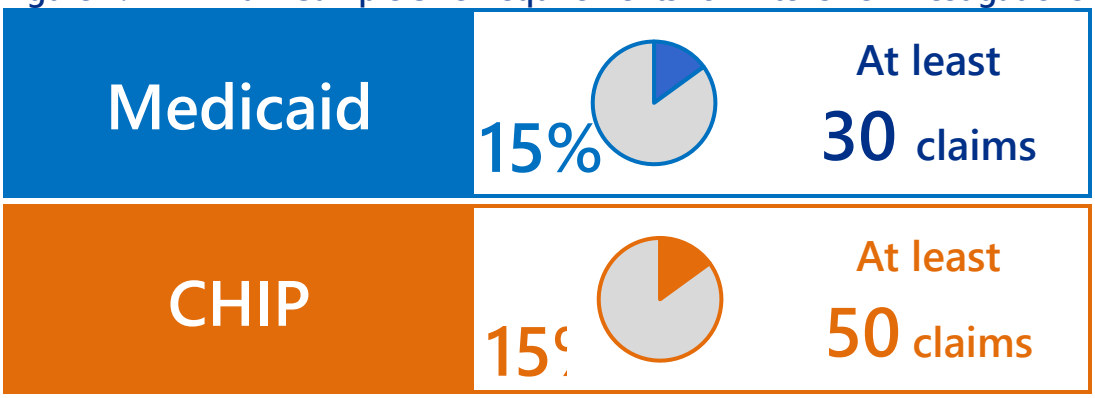
- Reviewing acute care and emergency room claims submitted for the recipient suspected of fraud, waste, or abuse.
- Analyzing pharmacy claim data submitted for the recipient suspected of fraud, waste, or abuse to determine possible abuse of controlled or non-controlled medications.
- Analyzing claims submitted by providers to determine if the diagnosis was appropriate for the medications prescribed.

OIG Audit did not identify any issues with elements of preliminary member investigations with any of the SIUs tested.

Sample Sizes for Extensive Investigations

When a preliminary investigation of a provider indicates possible fraud, waste, or abuse, SIUs must review a sample of the provider's claims in an extensive investigation. The minimum required sample sizes vary depending on whether the claims in question were for Medicaid[16] or CHIP[17] services, as shown in Figure 7.

Figure 7: Minimum Sample Size Requirements for Extensive Investigations



Source: 1 Tex. Admin. Code § 353.502 (c)(2)(C) and 1 Tex. Admin. Code § 370.502 (c)(2)(C); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8

Two of the five audited MCOs had findings about insufficient sample sizes for extensive investigations. Limiting sample sizes can prevent SIUs from identifying claim patterns and may impede detection of potential fraud, waste, and abuse committed by the provider. Reviewing claims for at least 30 Medicaid members or 50 CHIP members may help determine if there is a pattern of inappropriate behavior. Additionally, limited sample sizes may result in incomplete recoveries of Medicaid and CHIP overpayments and could result in SIUs not referring possible fraud, waste, or abuse to OIG.

[16] 1 Tex. Admin. Code § 353.502 (c)(2)(C) (Mar. 1, 2012, and July 18, 2019); and Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, Attachment B-3, Item 8, rev. 2.16 (Sept. 1, 2015) through rev. 2.3 (Mar. 1, 2020).

[17] 1 Tex. Admin. Code § 370.502 (c)(2)(C) (Mar. 1, 2012); and Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, rev. 2.16 (Sept. 1, 2015) through rev. 2.3 (Mar. 1, 2020).

Appendix A: Audit Methodology and Criteria

Methodology

To accomplish its objectives, OIG Audit collected information for the five audits through discussions and interviews with responsible staff at the five audited MCOs and through request and review of the following information:

- A description of the SIU function and organizational structure.
- Lists of SIU employees, including names, titles, and qualifications.
- Policies and practices for prevention and detection of fraud, waste, and abuse.
- Data related to SIU performance, including investigations, recoveries, and referrals.
- A description of the SIU investigation process.
- Data and information systems that support the SIU activities and data processing necessary to produce reports for submission to OIG.
- A list and description of each automated process or control in place to detect fraud, waste, and abuse.

This report summarizes the information from the five audits.

Criteria

OIG Audit used the following criteria that were in effect during each audit scope to evaluate the information provided:

- Tex. Gov. Code § 531.113
- 1 Tex. Admin. Code § 353
- 1 Tex. Admin. Code § 370
- Uniform Managed Care Contract
- Uniform Managed Care Manual
- MCO Fraud, Waste, and Abuse Compliance Plans
- MCO SIU Policies and Procedures

Appendix B: Summary of Recommendations

OIG Audit made the following recommendations to the MCOs to address the audit findings. All implemented corrective action plans timely.

Table B.1: Summary of Recommendations

MCO	No.	Recommendation
Driscoll	1	HHS Medicaid and CHIP Services (MCS), through its contract oversight responsibility, should require the MCO 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
Driscoll	2.1	MCS, through its contract oversight responsibility, should require the MCO to continuously initiate and conduct investigations of potential fraud, waste, and abuse. MCS should consider utilizing available tailored contractual remedies to compel the MCO to initiate and investigate all potential fraud, waste, and abuse on an ongoing basis.
Driscoll	2.2	MCS, through its contract oversight responsibility, should require the MCO to initiate and conduct preliminary and full-scale investigations of suspected fraud, waste, and abuse in accordance with Texas Administrative Code timeliness requirements.
Driscoll	2.3	MCS, through its contract oversight responsibility, should require the MCO to strengthen its SIU function by expanding the number of recipients reviewed in SIU investigations in compliance with Texas Administrative Code.
Driscoll	2.4	MCS, through its contract oversight responsibility, should require the MCO to recover identified overpayments as required by Texas Administrative Code.
Driscoll	3.1	MCS, through its contract oversight responsibility, should require the MCO to report complete and accurate information to OIG regarding the MCO's annual recoveries of identified overpayments.
Driscoll	3.2	MCS, through its contract oversight responsibility, should require the MCO to submit accurate information to the OIG on the monthly Open Case List Report.
Driscoll	3.3	MCS, through its contract oversight responsibility, should require the MCO to refer all possible acts of fraud, waste, or abuse to the OIG.
Driscoll	4	MCS, through its contract oversight responsibility, should require the MCO to enhance post-payment data analytic techniques to identify unusual trends and anomalies in provider claims to effectively detect fraud, waste, and abuse.
BCBS	1	MCS, through its contract oversight responsibility, should ensure that the MCO reports all preliminary investigations to OIG monthly as required by Texas Administrative Code and the Uniform Managed Care Manual.
Molina	1	The MCO should ensure its fraud, waste, and abuse plan includes waste as an educational topic for members and that topics required by the plan are included in its online member content.

MCO	No.	Recommendation
Molina	2	The MCO should (a) develop controls to ensure that, when determined necessary, research is performed on all parties involved in a potential fraud, waste, and abuse case and (b) when additional research is determined to be unnecessary, document the justification for not conducting the additional research.
Molina	3	The MCO should develop controls to ensure that all preliminary investigations are conducted within 15 working days of identification or reporting of potential fraud, waste, or abuse as required by Texas Administrative Code and the MCO's fraud, waste, and abuse plan.
Molina	4	The MCO should develop controls to ensure that all cases of potential fraud, waste, or abuse are reported to OIG within 30 working days as required by Texas Administrative Code and the MCO's fraud, waste, and abuse plan.
Aetna	1	The SIU should implement processes to ensure all required elements of preliminary investigations are completed timely and are sufficiently documented to demonstrate all required elements were completed within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse.
Aetna	2	The SIU should implement processes to ensure, during extensive investigations, the following timelines are met: • Samples of providers' claims related to suspected fraud, waste, or abuse are selected within 15 working days of completing a preliminary investigation that had suspicious indicators of fraud, waste, or abuse. • Medical records, dental records, and encounter data related to claims selected for review are requested within 15 working days of choosing the sample. • The review of requested medical records, dental records, and data is completed within 45 working days of receipt.
Community First	1	The MCO should implement processes to ensure it completes all required elements of preliminary investigations timely and sufficiently documents to demonstrate all required elements were completed within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse.
Community First	2	The MCO should implement processes to ensure it records the date the allegation of fraud, waste, or abuse is received on its log.
Community First	3	The MCO should ensure it selects at least the minimum sample sizes of members or claims.

MCO	No.	Recommendation
Community First	4	The MCO should implement processes to ensure it meets and adequately documents the following timelines: • Samples of providers' claims related to suspected fraud, waste, or abuse are selected within 15 working days of completing a preliminary investigation that had suspicious indicators of fraud, waste, or abuse. • Medical records, dental records, and encounter data related to claims selected for review are requested within 15 working days of choosing the sample. • The review of requested medical records, dental records, and encounter data is completed within 45 working days of receipt.
Community First	5	The MCO should implement processes to consistently log cases and ensure all opened investigations are reported on the Monthly Open Case List Report.
Community First	6	The MCO should: • Ensure all possible fraud, waste, and abuse findings are referred to OIG as required and remit half of the money collected from such referrals. • Document its rationale when it determines that the results of an investigation do not constitute possible fraud, waste, and abuse. • Develop a documented process to ensure it conducts a follow-up audit of providers who have received education as the result of an extensive investigation. • Implement processes to ensure the assigned officer submits referrals within 30 working days of receiving the report of possible fraud, waste, or abuse.
Community First	7	The MCO should ensure employees and subcontractors directly involved with any aspect of Medicaid or CHIP receive fraud, waste, and abuse training within 90 days of employment and annually.

Source: OIG Audit

Appendix C: Related Reports

- Community First Health Plans, Inc.: Special Investigative Unit, AUD-22-008, April 28, 2022
- Aetna Better Health of Texas: Special Investigative Unit, AUD-21-023, August 18, 2021
- Audit of Medicaid and CHIP MCO Special Investigative Units: Molina Healthcare of Texas, AUD-20-011, May 22, 2020
- Audit of Medicaid and CHIP MCO SIUs: Blue Cross and Blue Shield of Texas, AUD-19-001, September 28, 2018
- Audit of Medicaid and CHIP MCO SIUs: Driscoll Health Plan, AUD-18-012, April 3, 2018
- Medicaid and CHIP MCO Special Investigative Units: Initiatives Underway to Improve Collaboration and Performance, IG-16-018, February 28, 2017
- Audit of Medicaid and CHIP MCO Special Investigative Units: Christus Health Plan SIU, IG-16-017, November 22, 2016
- Audit of Medicaid and CHIP MCO SIUs: Health Management Systems, Inc.: Third Party SIU, IG-16-15, August 29, 2016
- Audit of Medicaid and CHIP MCO SIUs: Superior HealthPlan, Inc. SIU, IG-16-014, August 26, 2016
- Audit of Medicaid and CHIP MCO SIUs: DentaQuest SIU, IG-16-013, August 24, 2016
- Audit of Medicaid and CHIP MCO SIUs: Texas Children's Health Plan SIU, IG-16-016, August 24, 2016
- Audit of Medicaid and CHIP MCO SIUs: Cigna Health-Spring SIU, IG-16-012, August 24, 2016
- Audit of Medicaid and CHIP MCO Special Investigative Units: Seton Health Plan, IG-16-011, June 9, 2016
- Audit of Medicaid and CHIP MCO Special Investigative Units: Informational Report, IG-16-010, February 5, 2016

Appendix D: Report Team and Distribution

Report Team

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- Sarah Corinne Warfel, CPA, CISA, Audit Director
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Driscoll Health Plan

- Jennifer Henderson, Vice President of General Counsel, Chief Ethics and Compliance Officer

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- Paul Sturm, Vice President, Compliance

Appendix E: OIG Mission, Leadership, and Contact Information

The mission of 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
- Audrey O'Neill, Principal Deputy Inspector General, Chief of Audit and Inspections
- Susan Biles, Chief of Staff, Chief of Policy and Performance
- Erik Cary, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Steve Johnson, Chief of Investigations and Reviews

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- Online: https://oig.hhs.texas.gov/report-fraud-waste-or-abuse
- Phone: 1-800-436-6184

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- Email: OIGCommunications@hhs.texas.gov
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