Audit Report

Wellpoint Texas
Special Investigative Unit

A Texas Medicaid Managed Care Organization

February 28, 2025
OIG Report No. AUD-25-009

Inspector General

Texas Health and Human Services

Wellpoint Texas Special Investigative Unit

A Texas Medicaid Managed Care Organization

Results in Brief

Why OIG Conducted This Audit

The Texas Medicaid and CHIP programs cost approximately $33.6 billion per year. Estimates of healthcare fraud range from 3 to 10 percent of all healthcare expenditures. Texas MCOs reported total recoveries of $6.7 million and $4.2 million in 2022 and 2023, respectively.

Across 2022 and 2023, HHSC paid Wellpoint Texas (Wellpoint) $14.9 billion in capitation payments to provide Medicaid- and CHIP-covered services to an average of 1,029,971 Texas members per month for all programs and service areas.

Summary of Review

The audit objective was to evaluate the effectiveness of Wellpoint's special investigative unit (SIU) performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services (HHS) Office of Inspector General (OIG). The audit scope covered SIU activities in state fiscal years 2022 and 2023.

Conclusion

The Wellpoint Texas (Wellpoint) Special Investigative Unit (SIU) did not consistently comply with certain state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services (HHS) Office of Inspector General (OIG).

While Wellpoint did commit 10 full-time staff and one full-time manager to its SIU for Texas Medicaid and had processes in place to complete fraud, waste, and abuse investigations, these resources and processes were not effective and resulted in reported recoveries of $426,467. Wellpoint paid medical claims of $12.8 billion for the audit period.

Key Results

The HHS OIG Audit and Inspections Division (OIG Audit) conducted an audit of SIU activities at Wellpoint, a Medicaid and CHIP managed care organization (MCO). While Wellpoint proactively mined data for indicators of Medicaid fraud, waste, and abuse and performed investigations, it did not:

- Conduct CHIP-specific data mining or investigations.
- Complete investigations, maintain supporting documents, or meet timeliness requirements.
  - For 39 of 50 (78 percent) sampled preliminary investigations, Wellpoint did not have support to show that it completed all required elements of a preliminary investigation.
  - Of the 11 preliminary investigations that included all required preliminary investigation elements, Wellpoint completed 3 (27 percent) beyond the required timeline.
  - Wellpoint either did not document the dates it completed elements of its extensive investigations or it did not complete the elements within the required timeframes for 17 of the 23 (74 percent) extensive investigations tested.
  - For one of the 23 investigations, Wellpoint did not maintain supporting documentation to show the sample it chose to test in the investigation met minimum sample size requirements.

Recommendations

- Wellpoint must perform required SIU activities for CHIP including data mining, data analysis and fraud, waste, and abuse investigations.
- For preliminary investigations, Wellpoint should improve processes and controls to (a) perform and document all required elements, and (b) complete investigations within required timeframes.
- Wellpoint should strengthen processes to meet and document the timelines to complete all extensive investigation elements.
- Wellpoint should improve processes and controls to (a) capture all required data accurately in its case management system, (b) report complete and accurate information on the MCO Open Case List Report, and (c) provide feedback and request technical assistance from OIG as soon as a problem arises.
- For personnel who are involved in data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, quality assurance, and marketing for Medicaid or CHIP, Wellpoint must provide to employees and ensure subcontractors receive training that is specific to their areas of responsibility.

For more information, contact:
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- Accurately document or report its fraud, waste, and abuse investigations. Wellpoint's SIU documented a total of 418 investigations with $16.6 million of identified overpayments in its case management system in 2022 and 2023. However, Wellpoint reported to the OIG 413 investigations with a total identified overpayments of $11.6 million in the same period.

  Table 1 shows the variances between Wellpoint's internal data and what was reported to the OIG for number of investigations, identified overpayments, and recoveries.

Table 1: Wellpoint's SIU Investigations Opened and Reported in 2022 and 2023

Reported Item	Maintained in Wellpoint's Case Management System	Reported to OIG
Number of Investigations	418	413
Identified Overpayments	$16,697,931	$11,649,802
Total Recovered	$ 428,069	$ 426,467

- Ensure the required fraud, waste, and abuse training was tailored to individuals based on their specific job functions.

Management Response

OIG Audit presented preliminary audit results, issues, and recommendations to Wellpoint in a draft report dated February 6, 2025. Wellpoint indicated it had already implemented some corrective actions and it would implement others by the end of March 2025. Wellpoint's management responses are included in the report following the recommendations.

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Audit Overview

Overall Conclusion

The Wellpoint[1] Special Investigative Unit (SIU) did not consistently comply with certain state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services (HHS) Office of Inspector General (OIG).

Objective

The audit objective was to evaluate the effectiveness of Wellpoint'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 the OIG.

Scope

The audit scope covered SIU activities for Texas Medicaid and CHIP for the period September 1, 2021, through August 31, 2023.

While Wellpoint did commit 10 full-time staff and one full-time manager to its SIU for Texas Medicaid and had processes in place to complete fraud, waste, and abuse investigations, these resources and processes were not effective and resulted in reported recoveries of $426,467. Wellpoint paid medical claims of $12.8 billion for the audit period.

Key Audit Results

The HHS OIG Audit and Inspections Division (OIG Audit) conducted an audit of SIU activities at Wellpoint, a Medicaid and CHIP managed care organization (MCO).

[1] During the scope of the audit, Wellpoint Texas, Inc., and Wellpoint Insurance Company were known as Amerigroup Texas, Inc., and Amerigroup Insurance Company, respectively. The entities changed their legal names in January 2024 and are collectively referred to as Wellpoint in this report.

While Wellpoint proactively mined data for indicators of Medicaid fraud, waste, and abuse and performed investigations, it did not:

- Conduct CHIP-specific data mining or investigations.
- Always document that it performed all required elements of investigations or conduct investigations within required timeframes.
- Always maintain supporting documents or report information about its SIU investigations.
- Tailor fraud, waste, and abuse training for employees' and subcontractors' specific jobs.

The "Detailed Audit Results" section of this report presents additional information about the audit results and is considered written education in accordance with Texas Administrative Code.[2] In addition, audit issues identified in this report may be subject to liquidated damages or OIG administrative enforcement measures,[3] including administrative penalties.[4] This report does not address compliance beyond the scope and objective of this audit.

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

OIG Audit presented preliminary audit results, issues, and recommendations to Wellpoint in a draft report dated February 6, 2025. Wellpoint indicated it had already implemented some corrective actions and it would implement others by the end of March 2025. Wellpoint's management responses are included in the report following the recommendations. OIG Audit communicated other, less significant issues to Wellpoint in a separate written communication.

OIG Audit thanks management and staff at Wellpoint for their cooperation and assistance during this audit.

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[2] 1 Tex. Admin. Code § 371.1701 (May 1, 2016).

[3] 1 Tex. Admin. Code § 371.1603 (May 20, 2020).

[4] Tex. Hum. Res. Code § 32.039 (Apr. 2, 2015).

Key Wellpoint Program Data

The Texas Health and Human Services Commission (HHSC) contracts with Wellpoint to coordinate health services in Texas for members enrolled in the Medicaid and CHIP programs.[5] Under the managed care model, MCOs receive a capitation payment for each member enrolled, based on historical expenses of the populations served. Capitation payments are monthly, prospective payments HHSC makes to MCOs for the provision of covered services.

What Prompted This Audit

The Texas Medicaid and CHIP programs cost approximately $33.6 billion per year. Estimates of healthcare fraud range from 3 to 10 percent of all healthcare expenditures. Texas MCOs reported total recoveries of $6.7 million and $4.2 million in 2022 and 2023, respectively.

Across 2022 and 2023, HHSC paid Wellpoint $14.9 billion in capitation payments to provide Medicaid- and CHIP-covered services to an average of 1,029,971 Texas members per month for all programs and service areas. Table 1 shows Wellpoint's capitation payments by program.

Table 1: Wellpoint's Capitation Payments by Program[6]

Program	2022	2023	Total
Medicaid	$7,298,611,128	$7,551,318,849	$14,849,929,977
CHIP	54,626,740	39,693,773	94,320,513
Total	**$7,353,237,868**	**$7,591,012,622**	**$14,944,250,490**

Source: HHSC 2022 and 2023 90-day-working Financial Statistical Reports

[5] The managed care contracts relevant to this audit include the Uniform Managed Care Contract, the STAR Kids Contract, STAR+PLUS Expansion, and STAR+PLUS MRSA. The Uniform Managed Care Contract is used for referencing contract requirements for this report.

[6] Amounts reflect medical and pharmacy capitation payments.

Wellpoint's Special Investigation Unit

HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, or abuse by members and health care service providers.[7] Wellpoint indicated it has 11 employees dedicated to Texas Medicaid investigations. In 2022 and 2023, Wellpoint reported to the OIG it opened 413 investigations, made 56 referrals, and recovered $426,467. Table 2 shows Wellpoint's reported SIU activities and total claims dollars for 2022 and 2023.

Table 2: Wellpoint's Reported SIU Activities in 2022 and 2023[8]

Year	Medical and Pharmacy Claims Paid	Investigations	Referrals To OIG	Recoveries By Wellpoint
2022	$ 6.4 billion	206	23	$ 196,178
2023	6.4 billion	207	33	230,289
Total	**$12.8 billion**	**413**	**56**	**$426,467**

Source: HHSC 2022 and 2023 90-day-working Financial Statistical Reports
Wellpoint's Monthly MCO Open Case List Reports for investigations started between September 2021 through August 2023

Auditing Standards

Generally Accepted Government Auditing Standards

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[7] Uniform Managed Care Contract, Attachments B-1 § 8.1.19.1 and B-3, Item IG-1, v. 2.34 (Sept. 1, 2021, as amended).

[8] The SIU activities included in this table are based on information Wellpoint reported to the OIG in its Monthly MCO Open Case List Reports. Wellpoint's actual annual SIU activities may vary from this self-reported data. Chapter 3 includes additional information about Wellpoint's reporting of SIU activities.

Detailed Audit Results

Wellpoint complied with certain state and contractual requirements related to (a) detecting and investigating fraud, waste, and abuse and (b) reporting information on SIU activities, results, and recoveries to the OIG. Specifically, Wellpoint:

- Performed proactive data mining and data analysis to identify fraud, waste, and abuse.
- Offered general fraud, waste, and abuse training to its employees.
- Dedicated 10 full-time staff and one full-time manager to Texas Medicaid.
- Generally remitted half of recoveries tested to the OIG. Wellpoint remitted $42,229.87 of $43,007.01 due to the OIG.

The following sections of this report provide details about the findings of noncompliance identified by OIG Audit.

Chapter 1: Wellpoint Did Not Conduct CHIP Investigations

Wellpoint did not conduct CHIP-specific fraud, waste, and abuse activities in 2022 or 2023. Wellpoint conducted data mining and analysis to identify possible instances of Medicaid fraud, waste, and abuse and accepted referrals from internal and external sources. However, these activities were not specific to CHIP and Wellpoint was unable to demonstrate which, if any, investigations involved CHIP services.

Wellpoint is responsible for investigating possible acts of fraud, waste, or abuse for both Medicaid and CHIP services, including those that the MCO subcontracts to outside entities.[9] Rules governing MCOs' SIU responsibilities to CHIP have equal weight to Medicaid in their own subchapter in Texas Administrative Code.[10]

Wellpoint is required to make use of audits to monitor compliance and assist in detecting and identifying CHIP program violations and possible fraud waste, and abuse overpayments through data matching, analysis, trending, and statistical activities.[11]

Wellpoint did not have procedures in place to perform data mining or data analysis specifically for CHIP. By not performing data mining or analysis specifically for CHIP, Wellpoint did not identify indicators of fraud, waste, and abuse in CHIP, which could lead to the misuse of program funds.

Recommendation 1

Wellpoint must perform required SIU activities for CHIP including data mining, data analysis and fraud, waste, and abuse investigations.

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[9] 1 Tex. Admin. Code §§ 353.502 (b) (July 18, 2019) and 370.502 (b) (Mar. 1, 2012).

[10] 1 Tex. Admin. Code, Chapter 353, Subchapter F concerns Medicaid SIUs, while Chapter 370, Subchapter F governs CHIP SIUs.

[11] 1 Tex. Admin. Code §§ 353.502 (c)(1)(A) (July 18, 2019) and 370.502 (c)(1)(A) (Mar. 1, 2012).

Management Response

Action Plan

Wellpoint reviewed the data analysis and research conducted during the audit period and confirmed that CHIP claims are included when exposure data is requested and assessed. However, it was observed that the review of CHIP claims is not specifically highlighted in case notes. A review of sampling methodology did show that CHIP claims were included in both the Universe and Sample if the services being reviewed included CHIP members, however none of the cases were focused directly on CHIP claims during post payment medical review.

On January 31, 2025, the Texas Medicaid SIU Team received additional training on the requirement to open CHIP specific cases and to ensure that we comply with the specific rules outlined in Texas Administrative Code 370.502. This training reinforces our commitment to thoroughly addressing all necessary CHIP activities, including data mining, data analysis, and investigations into fraud, waste, and abuse.

Responsible Managers

- Director, Special Investigations Unit
- SIU Manager, Special Investigations Unit
- Payment Integrity Manager, Special Investigations Unit

Implementation Date

January 31, 2025

Chapter 2: Wellpoint Investigations Did Not Always Meet Minimum Requirements

Wellpoint did not always complete investigations, maintain supporting documents, or meet timeliness requirements. MCOs are responsible for investigating possible acts of fraud, waste, and abuse for all services, starting with a preliminary investigation. Wellpoint must perform an extensive investigation if it determines during the preliminary provider investigation that 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, and (c) reviewing the records.

Preliminary Investigations

Wellpoint did not always (a) document the steps it took to complete preliminary investigations or (b) conduct those preliminary investigations within required timelines. For 39 of 50 (78 percent) sampled investigations, Wellpoint did not have support to show that it completed all required elements of a preliminary investigation. Of the 11 preliminary investigations that included all required preliminary investigation elements, Wellpoint completed 3 (27 percent) investigations beyond the required timeline.[12]

Wellpoint must complete a preliminary investigation within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse by providers. Preliminary provider investigations must include the following elements:[13]

- Determining if the MCO has received any previous reports of suspected fraud, waste, or abuse or conducted any previous investigations of the provider in question.
- Determining if the provider has received educational training from the MCO regarding the allegation.

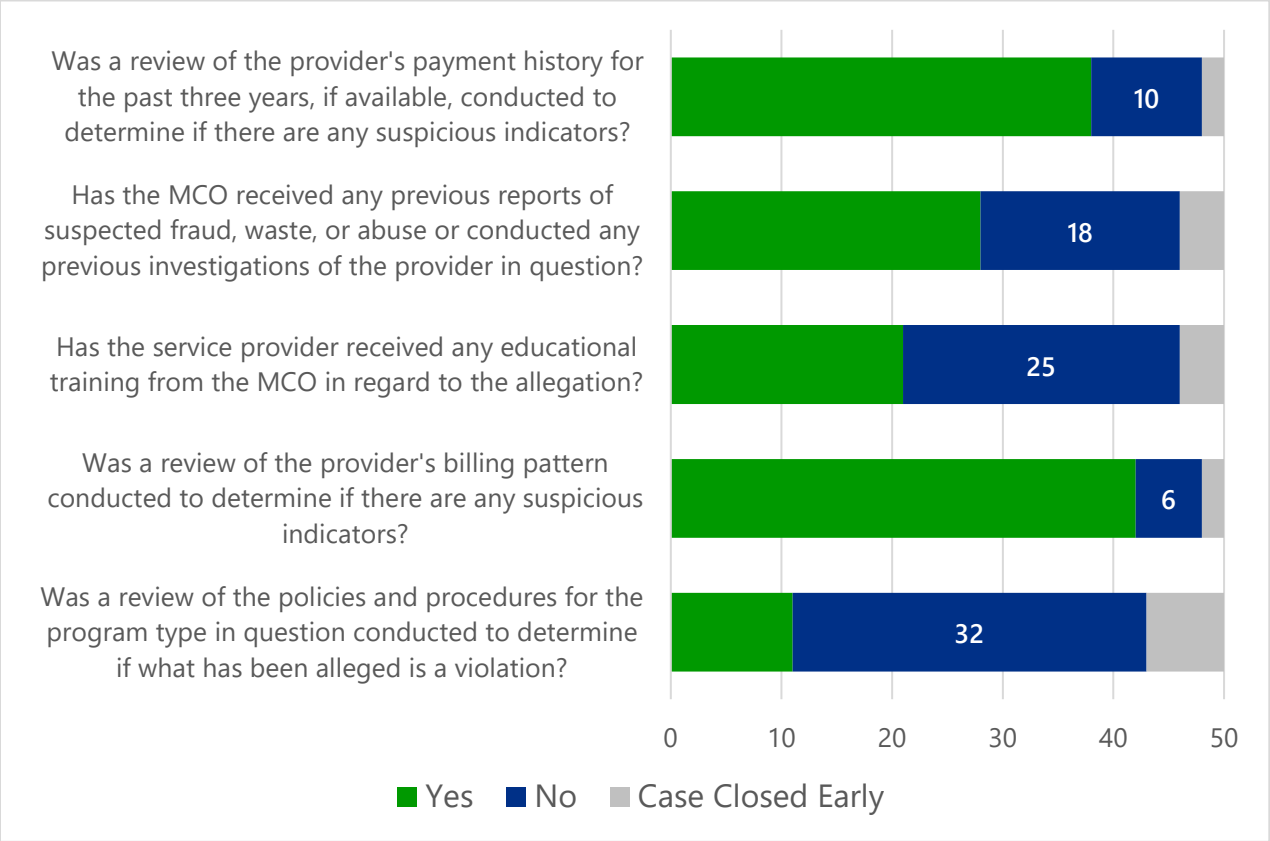
[12] For these three cases, Wellpoint completed the preliminary investigations in an average of 52 days.

[13] 1 Tex. Admin. Code §§ 353.502 (c)(2) (July 18, 2019) and 370.502 (c)(2) (Mar. 1, 2012); Uniform Managed Care Contract, Attachments B-1 § 8.1.19.1 and B-3, Item IG-1, v. 2.34 (Sept. 1, 2021, as amended).

- Reviewing the provider's billing patterns for any suspicious indicators.
- Reviewing the provider's payment history for the past three years, if available, to identify any suspicious indicators.
- Determining whether the investigated allegation is a violation of program policy or procedure.

Figure 1 shows the results of testing for the five required elements.

Figure 1: Preliminary Investigation Testing Results[14]



Source: OIG Audit

[14] The investigations with the "Case Closed Early" designation are those for which all preliminary elements were not completed due to (a) a case already being open for the provider, (b) a review of billing patterns or payment history indicating the allegations could not have occurred, or (c) the OIG opening an investigation.

Wellpoint did not have an effective process in place to consistently perform or document it completed all required preliminary investigation elements within 15 working days of suspected fraud, waste, or abuse being identified or reported. Wellpoint asserted that the preliminary investigation elements were completed but not documented.

By not conducting timely preliminary investigations or documenting all required elements, Wellpoint may hinder its ability to (a) effectively investigate potential fraud, waste, and abuse, (b) timely identify overpayments and recover Medicaid and CHIP funds, and (c) accurately report SIU activities and results to the OIG.

Extensive Investigations

Wellpoint either did not document the dates it completed elements of its extensive investigations or it did not complete the elements within the required timeframes for 17 of the 23 (74 percent) extensive investigations tested. Additionally, for one of the 23 investigations, Wellpoint did not maintain supporting documentation to show the sample it chose to test in the investigation met minimum sample size requirements.

Wellpoint must perform an extensive investigation if it determines during the preliminary provider investigation that 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, and (c) reviewing the records.[15]

Wellpoint has 15 working days after completing a preliminary investigation to select a sample of claims for review.

[15] 1 Tex. Admin. Code § 353.502 (c)(2)(C) (July 18, 2019) and 370.502 (c)(2)(C) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1 and B-3, Item IG-1, v. 2.34 (Sept. 1, 2021, as amended).

Wellpoint must select a minimum sample of claims related to the suspected fraud, waste, or abuse to review based on either a percentage or a minimum number of members. It may select either:

- A minimum of 30 Medicaid or 50 CHIP members.
- 15 percent of claims, as long as it represents at least 30 Medicaid or 50 CHIP members.

After selecting the sample, Wellpoint has an additional 15 working days to request medical or dental records and encounter data from the provider.[16]

Wellpoint must review the requested records and encounter data within 45 working days of receipt of those records to:[17]

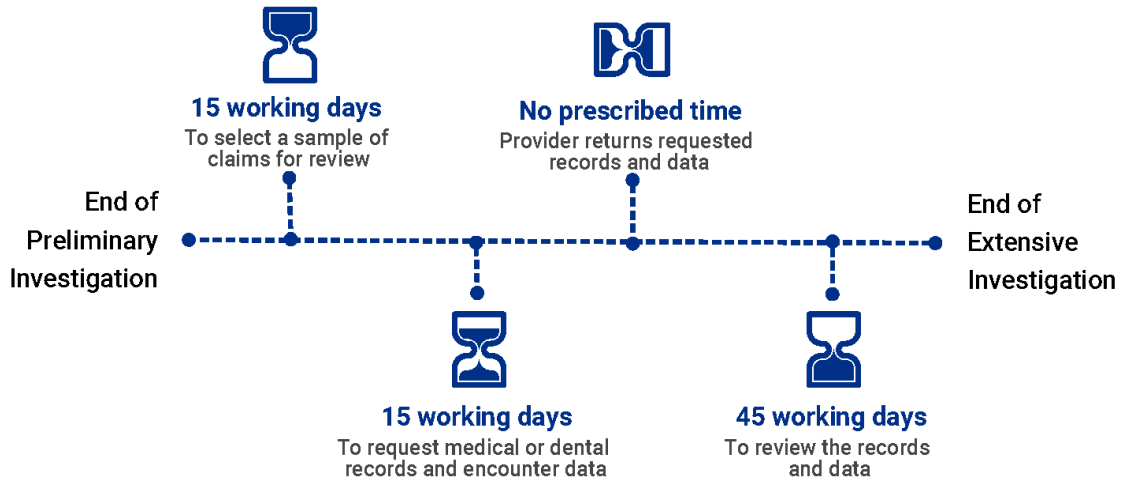
- Validate the sufficiency of service delivery data and to assess utilization and quality of care.
- Ensure encounter data submitted by the provider are accurate.
- Evaluate whether review of other pertinent records is necessary to determine whether fraud, waste, or abuse has occurred. If review of additional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

[16] 1 Tex. Admin. Code § 353.502 (c)(2)(C)(i) (July 18, 2019) and 370.502 (c)(2)(C)(i) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1 and B-3, Item IG-1, v. 2.34 (Sept. 1, 2021, as amended).

[17] 1 Tex. Admin. Code § 353.502 (c)(2)(C)(ii) (July 18, 2019) and 370.502 (c)(2)(C)(ii) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1 and B-3, Item IG-1, v. 2.34 (Sept. 1, 2021, as amended).

Figure 2 details the required timelines for each task in an extensive investigation.

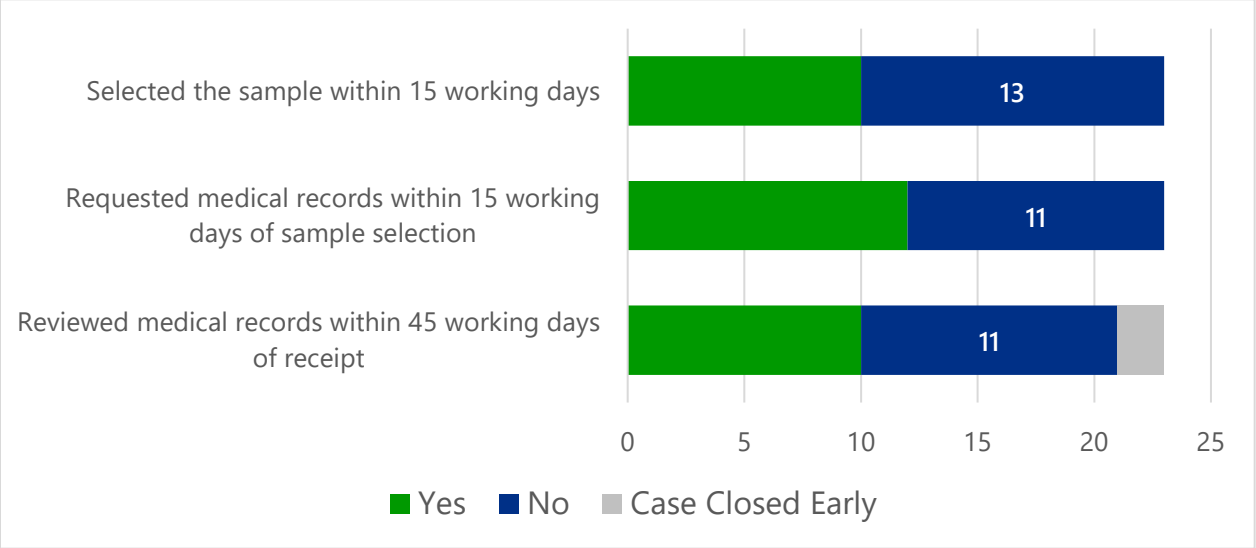
Figure 2: Timeline of Tasks in an Extensive Investigation



Source: OIG Audit

Figure 3 summarizes the results from the 23 extensive investigations tested.

Figure 3: Extensive Investigation Testing Results[18]



Source: OIG Audit

[18] The designation "No" in the table includes investigations that were not completed within required timeframes and investigations for which it could not be determined whether the element was completed within the required timeframe. The "Case Closed Early" designation indicates cases for which Wellpoint did not receive medical records from the providers and took other action.

Wellpoint had a review process; however, it was not always effective in all elements of investigations being performed timely or completion dates documented.

Delays in investigations can impair Wellpoint's ability to mitigate fraud, waste, and abuse in Medicaid or CHIP. Delays are also obstacles to (a) effectively investigating potential fraud, waste, and abuse, (b) timely identifying overpayments and recovering Medicaid and CHIP funds, and (c) accurately and timely reporting SIU activities and results to the OIG.

In addition, if Wellpoint does not select appropriate sample sizes, it can prevent Wellpoint from identifying patterns and may impede detection of potential fraud, waste, and abuse.

Recommendation 2a

For preliminary investigations, Wellpoint should improve processes and controls to:

- Perform and document all required elements.
- Complete investigations within required timeframes.

Management Response

Action Plan

Wellpoint reviewed the recommendation regarding preliminary investigations, and we are confident that preliminary actions were appropriately conducted prior to the formal opening of cases in the case documentation system. However, it was noted that these actions were not consistently documented in detail within the case documentation system. To enhance clarity and ensure comprehensive documentation, the Payment Integrity Manager has instructed the Texas Medicaid SIU Team to clearly and unambiguously list each factor and step within the case documentation system.

Additionally, the Payment Integrity Manager has developed a comprehensive tracking spreadsheet detailing both preliminary and extensive steps required for each case. Investigators are responsible for completing this spreadsheet, which is then saved in the case file for ongoing reference. The Payment Integrity Manager further ensures adherence to this process by meeting with

the Investigators bi-weekly to review the completion and accuracy of the tracking spreadsheet. This approach supports our commitment to meeting all required elements and completing investigations within the mandated timeframes.

Responsible Managers

- Director, Special Investigations Unit
- SIU Manager, Special Investigations Unit
- Payment Integrity Manager, Special Investigations Unit

Implementation Date

September 24, 2024

Recommendation 2b

Wellpoint should strengthen processes to meet and document the following timelines:

- Selection of providers' claims samples related to suspected fraud, waste, or abuse within 15 working days of completing a preliminary investigation that had suspicious indicators of fraud, waste, or abuse.
- Request for medical records and encounter data related to claims selected for review within 15 working days of choosing the sample.
- Review of requested medical records, dental records, and encounter data within 45 working days of receipt.

Additionally, Wellpoint should implement processes to select and document that sample size requirements were met.

Management Response

Action Plan

Wellpoint has thoroughly reviewed the recommendation and respectfully disagrees with the overall findings. We maintain that our processes effectively meet established standards, evidenced by our compliance with the sampling requirements of Texas Administrative Code 353.502, aside from a singular

exception. We are confident in our ability to execute necessary preliminary investigations and extensive elements within the specified timeframes.

However, we recognize the opportunity to enhance our documentation practices to address and alleviate the concerns identified. To this end, we acknowledge the need to further refine our process for documenting the selection of provider claims samples associated with suspected fraud, waste, or abuse, ensuring these are conducted within 15 working days of completing preliminary investigations. Likewise, we are committed to promptly requesting medical records and encounter data within 15 working days of selecting samples and completing the review of these records within 45 working days of receipt.

To support these timelines, we have enhanced our procedures for documenting that sample size requirements are met consistently. The Payment Integrity Manager has reinforced the documentation of these processes, ensuring that every sample is thoroughly cataloged in the case documentation system, and aligned with applicable Texas Administrative Codes.

We have implemented a tracking spreadsheet that details the necessary steps for each case, to be completed by Investigators and stored in the case file. The Payment Integrity Manager conducts bi-weekly meetings with Investigators to verify the completion and accuracy of these tracking documents, ensuring transparency and regulatory adherence. Through these improvements, we aim to bolster our documentation and further substantiate our commitment to compliance and process integrity.

Responsible Managers

- Director, Special Investigations Unit
- SIU Manager, Special Investigations Unit
- Payment Integrity Manager, Special Investigations Unit

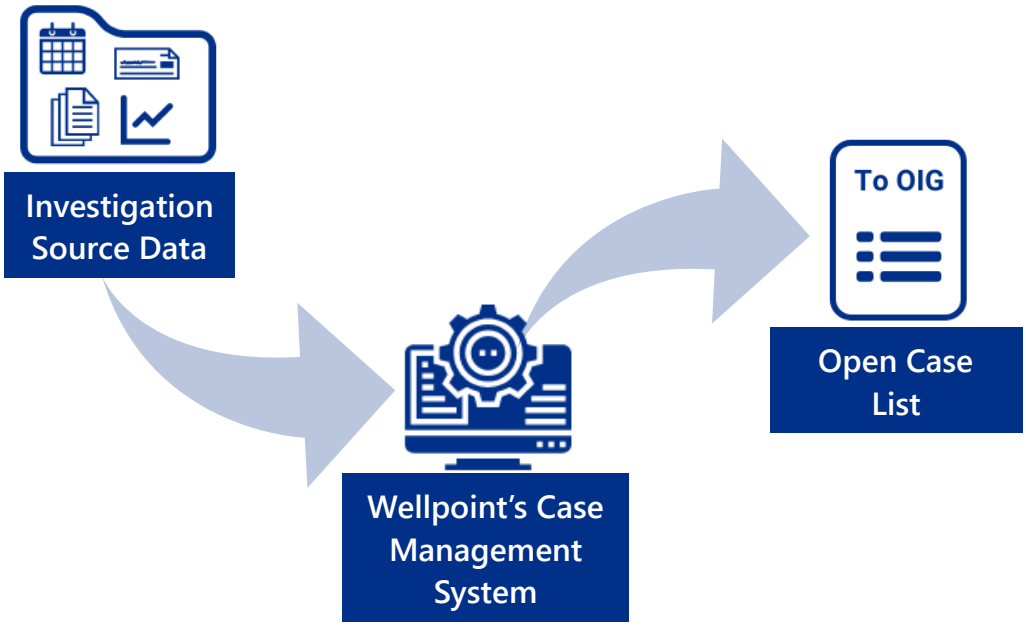
Implementation Date

September 24, 2024

Chapter 3: Wellpoint's Investigations Were Inaccurately Documented and Reported

Wellpoint did not accurately document or report its fraud, waste, and abuse investigations. Wellpoint uses a case management system to document its SIU investigations and exports investigation information from this system to meet reporting requirements. Wellpoint is required to submit a monthly report of all Medicaid and CHIP fraud, waste, and abuse investigations opened by its SIU and the status of each investigation to the OIG on the MCO Open Case List Report. Figure 4 depicts the relationships among Wellpoint's SIU information elements.

Figure 4: Flow of Information About SIU Investigations



Source: OIG Audit

Wellpoint's SIU documented a total of 418 investigations with $16.6 million of identified overpayments in its case management system in 2022 and 2023. However, Wellpoint reported to OIG 413 investigations with a total identified overpayments of $11.6 million in the same period.

Table 3 shows the variances between Wellpoint's internal data and what was reported to the OIG for number of investigations, identified overpayments, and recoveries.

Table 3: Wellpoint's SIU Investigations Opened and Reported in 2022 and 2023

Reported Item	Maintained in Wellpoint's Case Management System	Reported to OIG
Number of Investigations	418	413
Identified Overpayments	$16,697,931	$11,649,802
Total Recovered	$ 428,069	$ 426,467

Source: Wellpoint's Monthly MCO Case List Reports to the OIG for investigations started between September 2021 through August 2023 and Wellpoint's case management system

Wellpoint's SIU documented an additional 189 leads not reported to the OIG. Wellpoint asserts that leads are not SIU preliminary investigations and therefore reporting is not required. However, the SIU provided documentation for 14 of 20 leads tested where preliminary investigation activities were performed.

Further, Wellpoint asserted that specific fields included in its case management system, such as the source of fraud allegations, the results of an investigation, and the amount of overpayment identified by the investigation, should not be relied on because investigators may make errors when entering information. Investigators may document the result of the investigation and the identified overpayment before an investigation is complete, leading to frequent discrepancies between what is recorded in the case management system and the actual SIU activity.

Additionally, Wellpoint stated that for years it had experienced difficulties with OIG's reporting system, compounding the discrepancies between its case management system and what was reported to the OIG. A review of Wellpoint's process and reporting indicates the technical issue was not a specific system limitation and Wellpoint did not request assistance from the OIG until this audit started.

Wellpoint did not have a review process in place to verify its case management system accurately reflected source documents or the status of an investigation. Documenting

inaccurate or unsupported information limits Wellpoint's and OIG's effectiveness in identifying and addressing fraud, waste, and abuse in Medicaid and CHIP.

Recommendation 3

Wellpoint should improve processes and controls to:

- Capture all required data accurately in its case management system, including the investigation results and overpayments.
- Report complete and accurate information to OIG on the MCO Open Case List Report.
- Provide feedback and request technical assistance from OIG as soon as a potential problem arises.

Management Response

Action Plan

Upon reviewing the recommendation, Wellpoint respectfully disagrees with the findings. We have previously engaged in discussions with [staff from the Medicaid Program Integrity team] of Health and Human Services Commission Office of Inspector General (HHSC-OIG) on November 19, 2024, to address the challenges related to the current reporting schema. As it stands, the Managed Care Organization (MCO) is limited to submitting only three statuses for overpayment: (1) Not referred, (2) Not accepted, and (3) Closed completed SIU. Within this framework, updating overpayment amounts post-reduction, settlement, or when identified as non-recoverable, is not a mandated requirement. HHSC-OIG has confirmed that our submissions align with current expectations. However, we acknowledge that this report is anticipated to undergo changes in 2025, requiring reporting of adjusted overpayment amounts. In light of this forthcoming change, we recognize an opportunity to improve our documentation processes further to ensure seamless compliance. We will enhance our internal procedures to capture all required data more accurately within our case management system, particularly regarding investigation results and overpayments. Additionally, we commit to ensuring the completeness and accuracy of information reported to OIG on the MCO Open Case List Report.

We are also committed to fostering proactive communication with OIG by providing feedback and seeking technical assistance promptly whenever potential issues are identified. These improvements aim to bolster the robustness of our reporting processes and support our dedication to transparency and compliance.

Responsible Managers

- Director, Special Investigations Unit
- SIU Manager, Special Investigations Unit
- Payment Integrity Manager, Special Investigations Unit

Target Implementation Date

To be determined – during the meeting on November 19, 2024, HHSC-OIG stated that there will be changes to the report in 2025 to accommodate the monthly reporting requirement to CMS. Once this report is updated then overpayment amounts will be updated accordingly.

Auditor Comment

The Uniform Managed Care Manual § 5.5.2, "MCO Open Case List Report," requires MCOs to submit information about the status of all investigations opened by their Special Investigative Units.

MCOs are not limited to reporting identified overpayments as Wellpoint describes. As discussed during the audit, the MCO Open Case List report includes a field for MCOs to report the sum of dollars paid in error for any provider investigation. OIG's expectation is that all fields in a required report are completed. In the monthly submissions from September 2021 through February 2025, Wellpoint did not use this field.

Chapter 4: Wellpoint's Fraud, Waste and Abuse Training Was Not Specific to Job Functions

Wellpoint must train each employee and ensure each subcontractor who is directly involved in any aspect of Medicaid or CHIP receives fraud, waste, and abuse training annually.

The MCO must:[19]

- Provide general training to all employees and ensure subcontractors receive training that includes the definition of fraud, waste, and abuse, and how and where to report it.
- Tailor training provided to individuals responsible for certain job functions. Annual training for employees and subcontractors directly involved in any aspect of Medicaid or CHIP—at a minimum, those in data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance, and marketing—must be specific to the area of responsibility for the MCO and subcontractor staff receiving the training and contain examples of fraud, waste, or abuse in their particular area of interest.

While Wellpoint employees and subcontractor staff received fraud, waste, and abuse training, Wellpoint did not tailor required fraud, waste, and abuse training to individuals based on their specific job functions. The likelihood of detecting potential fraud, waste, and abuse may be decreased when training specific to job duties is not provided.

[19] 1 Tex. Admin. Code § 353.502 (c)(6)(A-C) (July 18, 2019) and 370.502 (c)(6)(A-C) (Mar. 1, 2012); Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1 and B-3, Item IG-1, v. 2.34 (Sept. 1, 2021, as amended).

Recommendation 4

For personnel who are involved in data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, quality assurance, and marketing for Medicaid or CHIP, Wellpoint must provide to employees and ensure subcontractors receive training that is specific to their areas of responsibility.

Management Response

Action Plan

While Wellpoint agrees with the recommendation, we want to emphasize that we are fully compliant in our current practices. We proudly confirm that 100% of our associates have completed the mandatory general fraud, waste, and abuse (FWA) training with the same requirement extended to subcontractors. Recognizing the added value of targeted training tailored to specific functions, such as data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, quality assurance, and marketing for Medicaid or CHIP. We are actively developing tailored training material to address its distinct operational needs. We are dedicated to having these tailored trainings available by the end of the first quarter of 2025, ensuring that our teams are thoroughly equipped with the knowledge pertinent to their roles.

Responsible Managers

- Director, Network Management
- Director, Process Improvement
- Director, Utilization Management
- Director, Quality
- Director, Marketing
- Encounters Operations Consultant

Target Implementation Date

March 31, 2025

Auditor Comment

Title 1 of Texas Administrative Code §§ 353.502 (c)(6)(B) and 370.502 (c)(6)(B) requires fraud, waste, and abuse training for some staff to be specific to the area of responsibility.

Wellpoint did not provide this tailored training and is not in compliance with Texas Administrative Code requirements.

Appendix A: Objective, Scope, and Criteria

Objective and Scope

The audit objective was to evaluate the effectiveness of Wellpoint'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 the OIG.

The audit scope covered SIU activities for Texas Medicaid and CHIP for the period September 1, 2021, through August 31, 2023.

Criteria

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

- Texas Government Code §531.1131 (2019)
- 1 Tex. Admin. Code §§ 353.502 and 505 (2019, as amended)
- 1 Tex. Admin. Code §§ 370.502 and 505 (2012, as amended)
- Uniform Managed Care Manual, Chapter 5.5.1, Version 2.1 (2019, as amended) and Chapter 5.5.2, Version 2.5 (2019, as amended)
- Uniform Managed Care Contract, v. 2.34 (2021, as amended)

Appendix B: Detailed Methodology

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

- A description of the SIU function and organizational structure.
- Policies and processes associated with prevention, detection, investigation, disposition, and reporting of fraud, waste, and abuse.
- Data and other supporting evidence related to SIU performance, including investigations, recoveries, and referrals in 2022 and 2023.
- Significant internal controls, including components of internal control, within context of the audit objectives.[20]

Specifically, OIG Audit tested samples of investigations to determine whether:

- The case management system included complete and accurate data.
- Wellpoint's SIU performed preliminary and extensive investigative activities, as applicable, within required timelines and included required elements.
- The MCO Open Case List Report included complete and accurate data.
- Wellpoint remitted half of all recoveries related to the identification of fraud or abuse to the OIG.

[20] For more information on the components of internal control, see the United States Government Accountability Office's "Standards for Internal Control in the Federal Government" (Sept. 2014), https://www.gao.gov/assets/gao-14-704g.pdf (accessed Nov. 15, 2024).

OIG Audit also tested the following:

- Training materials to determine whether employees and subcontractors received tailored training.
- Whether the case management system user access was appropriately limited.

Data Reliability

To assess the reliability of data, auditors (a) traced and reconciled selected records to source documents to assess completeness and accuracy, (b) observed the process of producing the datasets, and (c) interviewed relevant Wellpoint staff knowledgeable about the data. Large portions of data elements maintained in the case management system and reported to OIG that were key to our review of investigations were missing or incorrect (see chapter 3 for details). Therefore, we determined that the data was not sufficiently reliable for the purposes of this report; however, this was the only source of data available.

Sampling Methodology

OIG auditors selected two risk-based, nonstatistical samples of investigations for testing to address specific risk factors, such as investigation start date, outcome, identified overpayments, and applicable recoveries identified in the population. The sample items were not necessarily representative of the population; therefore, it would not be appropriate to project the test results to the population.

Appendix C: Summary of Recommendations

Table C: Summary of Recommendations to Wellpoint Texas

No.	Recommendation
1	Wellpoint must perform required SIU activities for CHIP including data mining, data analysis and fraud, waste, and abuse investigations.
2a	For preliminary investigations, Wellpoint should improve processes and controls to: • Perform and document all required elements. • Complete investigations within required timeframes.
2b	Wellpoint should strengthen processes to meet and document the following timelines: • Selection of providers' claims samples related to suspected fraud, waste, or abuse within 15 working days of completing a preliminary investigation that had suspicious indicators of fraud, waste, or abuse. • Request for medical records and encounter data related to claims selected for review within 15 working days of choosing the sample. • Review of requested medical records, dental records, and encounter data within 45 working days of receipt. Additionally, Wellpoint should implement processes to select and document that sample size requirements were met.
3	Wellpoint should improve processes and controls to: • Capture all required data accurately in its case management system, including the investigation results and overpayments. • Report complete and accurate information on the MCO Open Case List Report. • Provide feedback and request technical assistance from OIG as soon as a potential problem arises.
4	For personnel who are involved in data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, quality assurance, and marketing for Medicaid or CHIP, Wellpoint must provide to employees and ensure subcontractors receive training that is specific to their areas of responsibility.

Source: OIG Audit

Appendix D: Related Reports

- Driscoll Children's Health Plan Special Investigative Unit, AUD-23-032, August 23, 2023
- Parkland Community Health Plan: Special Investigative Unit, AUD-23-023, August 10, 2023
- Summary of Results: Audits of Medicaid and CHIP MCO Special Investigative Units, AUD-23-003, November 28, 2022
- 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
- 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

Appendix E: Resources for Additional Information

The following resources provide additional information about the topics covered in this report.

For more information on Texas Health and Human Services Medicaid and CHIP Programs and Services:

Medicaid and CHIP Homepage, Texas Health and Human Services, https://www.hhs.texas.gov/services/health/medicaid-chip (accessed September 24, 2024)

For more information on Wellpoint Texas:

Homepage, Wellpoint Texas, https://www.wellpoint.com/tx/medicaid (accessed February 27, 2025)

Appendix F: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Anton Dutchover, CPA, Deputy Inspector General of Audit and Inspections
- Sarah Corinne Warfel, CPA, Audit Director
- Nakeesa Shahparasti, CPA, CISA, CFE, Audit Project Manager
- Abelardo Lopez Jr., Staff Auditor
- Christopher Alexander, Staff Auditor
- Shaun Craig, Staff Auditor
- Christine Alexander, Quality Assurance Reviewer
- James Hicks, CISA, Quality Assurance Reviewer
- Karen Mullen, CGAP, CIGA, Quality Assurance Reviewer
- Leia Villaret, CGAP, Quality Assurance Reviewer
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Texas Health and Human Services Commission

- Cecile Erwin Young, Executive Commissioner
- Kate Hendrix, Chief of Staff
- Maurice McCreary, Jr., Chief Operating Officer
- Jordan Dixon, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Michelle Alletto, Chief Program and Services Officer
- Sylvia Hernandez Kauffman, Chief Information Officer

- Nicole Guerrero, Chief Audit Executive
- Emily Zalkovsky, Chief Medicaid and CHIP Services Officer, Medicaid and CHIP Services
- Camisha D. Banks, Deputy Executive Commissioner for Managed Care
- Michael Lopez, Deputy Executive Commissioner for Operations, Medicaid and CHIP Services

Wellpoint Texas

- Gregory Thompson, Chief Executive Officer
- Jessica McFarlin, Director of Medicaid Operations
- Francisco Hardy, Director of Compliance
- Kathryn Duarte, Director of Compliance (MMP)
- Katherine Stevenson, Director of Compliance (Texas)
- Chris Utley, Director, Special Investigations Unit
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- Bill Miller, Payment Integrity Manager, Special Investigations Unit
- Marcella Webb, Director, Network Management
- Menchie Hall, Director, Process Improvement
- Jennifer Cox, Director, Utilization Management
- Dana Muncy, Director, Quality
- Tara Kimbell, Director, Marketing
- Rohit Bataju, Encounters Operations Consultant

Appendix G: 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:

- Raymond Charles Winter, Inspector General
- Susan Biles, Principal Deputy Inspector General
- Kacy J. VerColen, Chief of Audit and Inspections
- Diane Salisbury, Chief of Data Reviews
- Eugenia Krieg, Chief of Staff, Chief of Policy and Performance
- Erik Cary, Chief Counsel
- Matt Chaplin, Chief of Operations
- Steve Johnson, Chief of Investigations and Utilization Reviews

To Obtain Copies of OIG Reports

- OIG website: ReportTexasFraud.com

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

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

To Contact OIG

- Email: oig.generalinquiries@hhs.texas.gov
- Mail: Texas Health and Human Services
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
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