Audit Report

Aetna Better Health of Texas, Inc.
Special Investigative Unit

A Texas Medicaid Managed Care Organization

August 18, 2021
OIG Report No. AUD-21-023

Inspector General

Texas Health and Human Services

HHS OIG
TEXAS HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

WHY THE OIG CONDUCTED THIS AUDIT

The HHS OIG Audit and Inspections Division conducted an audit of SIU activities at Aetna, a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

HHS agencies administer public health and social service programs for Texas. Within HHSC, Medicaid and CHIP Services is responsible for overall management and monitoring of the contract with Aetna. The OIG Investigations and Reviews Division receives Aetna's annual fraud, waste, and abuse plan, as well as evaluates any fraud referrals it receives from Aetna. Aetna received $297 million in 2019 and $313 million in 2020 to administer Texas managed care programs for an average of 86,888 and 87,797 members per month, respectively.

The audit objective was to determine if, for the period from September 1, 2018, through August 31, 2020, Aetna's SIU was in compliance with 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 HHSC.

WHAT THE OIG RECOMMENDS

Aetna should implement processes to ensure all required elements of preliminary and extensive investigations are completed timely and are sufficiently documented.

MANAGEMENT RESPONSE

OIG Audit presented audit results and recommendations to Aetna in a draft report dated July 29, 2021. Aetna indicated it had put a remediation plan in place in July 2021. Aetna's responses are included in the report.

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AETNA BETTER HEALTH OF TEXAS, INC. SPECIAL INVESTIGATIVE UNIT

A Texas Medicaid Managed Care Organization

WHAT THE OIG FOUND

Aetna Better Health of Texas, Inc. (Aetna)'s special investigative unit (SIU) complied with most state and contractual requirements related to preventing, detecting, and investigating fraud, waste, and abuse; and reporting reliable information on SIU activities, results, and recoveries to the Texas Health and Human Services Commission (HHSC). During the audit period, Aetna's SIU had required staff, conducted required training, and monitored provider and member service patterns. Furthermore, it ensured all required elements of a preliminary investigation and extensive investigation were completed, maintained a log of incidences of suspected fraud, waste, and abuse, and submitted required reports and referrals to The Texas Health and Human Services (HHS) Office of Inspector General (OIG) within required deadlines.

However, Aetna's SIU did not comply with timeframes for completing required preliminary and extensive investigation activities listed in Texas Administrative Code, including those for:

- Completing preliminary investigations and timelines for selecting a sample of provider claims.
- Making requests for medical records and encounter data.
- Completing the review of requested records and data for extensive investigations.

Not performing required investigations tasks timely can limit Aetna's ability to (a) mitigate fraud, waste, and abuse, (b) quickly identify overpayments, (c) recover Medicaid funds, or (d) adequately address fraud, waste, and abuse allegations. Specifically, in the 30 investigations reviewed, Aetna did not:

- Maintain sufficient documentation to support when the required elements for a preliminary investigation were completed in 4 investigations reviewed.
- Complete the required elements of the preliminary investigation within 15 working days, as required, in 4 investigations reviewed. On average, the 4 preliminary investigations were completed within 27 working days.
- Select a sample of provider's claims for review within 15 working days of completing a preliminary investigation in 4 of the applicable 7 extensive investigations reviewed.
- Request records from the provider within 15 working days of sample selection in 4 of the 7 applicable investigations reviewed.
- Review requested records within 45 working days of receipt in 2 of the 8 applicable investigations reviewed.

BACKGROUND

HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, and abuse by members and health care service providers. While an MCO may contract with an outside organization to perform all or part of the activities associated with the SIU, Aetna maintains an internal SIU department. Suspected fraud, waste, or abuse is investigated and reported to the OIG.

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INTRODUCTION

The Texas Health and Human Services (HHS) Office of Inspector General (OIG) Audit and Inspections Division (OIG Audit) conducted an audit of special investigative unit (SIU) activities at Aetna Better Health of Texas, Inc. (Aetna), a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

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 2019, the period is September 1, 2018, through August 31, 2019.

Objective and Scope

The audit objective was to determine if Aetna's SIU was in compliance with 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 Commission (HHSC).

The audit scope covered SIU activities in 2019 and 2020. The scope also included a review of significant controls and control components including the prevention, detection, investigation, recovery (as applicable), and reporting of fraud, waste, and abuse allegations through the end of fieldwork in July 2021.

OIG Audit presented audit results, issues, and recommendations to Aetna in a draft report dated July 29, 2021. Aetna provided management responses to the recommendations, indicating it agreed with the recommendations and had put a remediation plan in place in July 2021. Aetna's management responses are included in the report following each recommendation.

Background

HHSC contracts with Aetna to coordinate health services in Texas for members enrolled in the Medicaid State of Texas Access Reform (STAR) program, the STAR Kids program, and CHIP.[1] Aetna is a licensed MCO that provides Medicaid and CHIP services through its network of providers.

[1] The managed care contracts relevant to this audit include the Uniform Managed Care Contract and the STAR Kids Contract. The Uniform Managed Care Contract is used for referencing contract requirements for this report.

Aetna's 2019 total enrolled member months was 917,261 for Medicaid and 125,399 for CHIP. In 2020, Aetna's total enrolled member months was 937,457 for Medicaid and 116,109 for CHIP.[2] Table 1 shows Aetna's capitation payments by program.

Table 1: Aetna's Capitation Payments by Program[3]

Program	2019	2020	Total
Medicaid	$ 279,299,284	$ 296,646,361	$ 575,945,645
CHIP	17,261,575	16,267,338	33,528,913
Total	$ 296,560,859	$ 312,913,699	$ 609,474,558

Source: HHSC 2019 334-day and 2020 90-day Financial Statistical Reports[4]

Aetna is one of 18 contracted MCOs responsible for administering, on behalf of the state of Texas, $22.7 billion of Medicaid and CHIP health care services in 2019 through its health plans. In 2020, the contracted MCOs provided $23.0 billion in Medicaid and CHIP health care services.[5]

HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, and abuse by members and health care service providers.[6] While an MCO may contract with an outside organization to perform all or part of the activities associated with the SIU, Aetna maintains an internal SIU department. Suspected fraud, waste, or abuse is investigated and reported to the OIG.

This audit evaluated Aetna's SIU efforts related to:

- Prevention processes, such as 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 and extensive investigations and the SIU's adherence to investigation time frames required by the Texas Administrative Code (TAC).
- Disposition of fraud, waste, and abuse investigations, including referrals to the OIG, corrective action plans, and monetary recovery.

[2] HHSC 2019 334-day Financial Statistical Report, data through Aug. 31, 2019; and 2020 90-day Financial Statistical Report, data through Sept. 30, 2020.

[3] Amounts reflect only medical and pharmacy capitation payments.

[4] According to HHSC, the state fiscal year 2019 334-day and 2020 90-day FSRs were not final at the time of this audit. Draft reports were used for the purposes of this audit.

[5] HHSC Financial Statistical Reports; 2019 data through Aug. 31, 2019; 2020 data through Sept. 30, 2020.

[6] Uniform Managed Care Contract, Attachment B-1 § 8.1.19.1, v. 2.26 (Sept. 1, 2018) through v. 2.30 (Mar. 1, 2020).

HHS agencies administer public health and social service programs for Texas. Within HHSC, Medicaid and CHIP Services is responsible for overall management and monitoring of the contract with Aetna. The OIG Investigations and Reviews Division receives Aetna's annual fraud, waste, and abuse plan, as well as evaluates any fraud referrals it receives from Aetna. The plan submitted by Aetna must describe the procedures for referring suspected fraud, waste, and abuse to the OIG.[7]

Methodology

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

- A description of the SIU function and organizational structure.
- A list of individuals in the SIU function, including their names, titles, and a description of their qualifications.
- Policies and practices 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 2019 and 2020.
- Significant SIU internal controls, including components of internal control,[8] and processes in place to prevent, detect, investigate, and recover (as applicable) fraud, waste, and abuse, and to report reliable information to HHSC.
- Relevant information systems that support the SIU activities.

OIG Audit interviewed responsible SIU personnel regarding their roles in SIU activities, evaluated policies and practices relevant to the SIU function, and reviewed relevant SIU activities related to investigations, including those related to prevention, detection, investigation, disposition, and reporting. OIG Audit determined that the data used in this audit was sufficiently reliable for the purposes of the audit.

OIG Audit selected a sample of 30 investigations from a population of the 116 referrals Aetna's SIU received in 2019 and 2020. The 30 investigations included preliminary and extensive investigations, as detailed in Appendix A.

[7] 1 Tex. Admin. Code §§ 353.502(c)(5) (Mar. 1, 2012, and July 18, 2019) and 370.502(c)(5) (Mar. 1, 2012).

[8] 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 Apr. 16, 2021).

Criteria

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

- 1 Tex. Admin. Code §§ 353.501 through 505 (2012 and 2019)
- 1 Tex. Admin. Code §§ 370.501 through 505 (2004 and 2012)
- Uniform Managed Care Contract, v. 2.26 (2018) to v. 2.30 (2020)
- Aetna Fraud, Waste, and Abuse Compliance Plan (2019 and 2020)

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.

AUDIT RESULTS

Aetna's SIU complied with most 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 OIG. During the audit period, Aetna's SIU:

- Had a full-time SIU manager and one full-time investigator dedicated solely to the Texas Medicaid and CHIP programs.
- Ensured staff fraud, waste, and abuse training included (a) required topics, and (b) was completed within the required timeframes. Completed training was documented in a training log or equivalent that included all required elements.
- Monitored provider and member service patterns via trend analysis, data matching, and random payment reviews of claims to identify potential fraud waste, and abuse.
- Ensured (a) all required elements of a preliminary investigation and extensive investigation were completed; (b) samples of provider's claims included the required number of recipients or claims related to the suspected fraud, waste, and abuse; and (c) medical records, dental records, and encounter data received from the providers were reviewed.
- Maintained a log of incidences of suspected fraud, waste, and abuse containing required elements.
- Submitted required reports to HHS OIG within required deadlines.
- Referred possible acts of fraud, waste, or abuse to HHS OIG within required deadlines.
- Established corrective action plans to improve providers' performance.
- Began payment recovery efforts when necessary, remitted half of recovered amounts to HHS OIG, and submitted reports detailing the amounts recovered to HHS OIG.

However, Aetna's SIU did not comply with timeframes for completing required preliminary and extensive investigation activities listed in TAC, including the timelines for (a) completing preliminary investigations and timelines for selecting a sample of provider claims, (b) making requests for medical records and encounter data, and (c) completing the review of requested records and data for extensive investigations. Details of those issues follow. OIG Audit communicated less significant non-reportable issues to Aetna SIU in writing.

PRELIMINARY INVESTIGATIONS

TAC requires Aetna's SIU to complete a preliminary investigation within 15 working days of the identification or reporting of suspected or potential fraud, waste, or abuse.[9] Preliminary investigations must include five specific elements for a provider investigation[10] and three specific elements for a member investigation.[11]

Issue 1: Preliminary Investigation Timeline Requirements Were Not Always Met or Sufficiently Documented

Aetna's SIU performed all the required elements of a preliminary investigation. However, 8 of 30 (26.7 percent) preliminary investigations tested were not in compliance with the 15-working-day requirement. Specifically,

- In four preliminary investigations, Aetna's SIU did not maintain sufficient documentation to support when the required elements for a preliminary investigation were completed.

- In four preliminary investigations, Aetna's SIU did not complete the required elements of the preliminary investigation within 15 working days. On average, the four preliminary investigations were completed within 27 working days.

Aetna's SIU asserted that when it closes a preliminary investigation and determines a more extensive investigation is warranted, it sends an email to Aetna's compliance manager to indicate a more extensive investigation has been opened. While evidence of those emails was provided and those emails were sent within 15 days of the start of the preliminary investigation, OIG Audit could not validate that the required elements for a preliminary investigation had occurred prior to that email and within 15 days of the identification or reporting of suspected or potential fraud, waste, and abuse. Not performing timely preliminary investigations can limit Aetna's ability to quickly identify overpayments, recover Medicaid funds, or address fraud, waste, or abuse allegations.

Testing of controls during fieldwork indicated that Aetna's SIU management performs a supervisory review of activities to ensure all required elements of a preliminary investigation are completed during the investigation. However, Aetna's

[9] 1 Tex. Admin. Code §§ 353.502 (c)(2)(A) (Mar. 1, 2012, and July 18, 2019) and 370.502 (c)(2)(A) (Mar. 1, 2012).

[10] 1 Tex. Admin. Code §§ 353.502 (c)(2)(B) (Mar. 1, 2012, and July 18, 2019) and 370.502 (c)(2)(B) (Mar. 1, 2012).

[11] 1 Tex. Admin. Code §§ 353.502 (c)(4)(B) (Mar. 1, 2012, and July 18, 2019) and 370.502 (c)(4)(B) (Mar. 1, 2012).

SIU did not have a process to consistently ensure (a) all required elements of a preliminary investigation were completed within the 15 working days or (b) sufficient documentation was maintained to support when required elements were completed.

Recommendation 1

Aetna's 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 workdays of the identification or reporting of suspected or potential fraud, waste or abuse.

Management Response

Action Plan

A remediation plan was put in place and completed in July 2021. The remediation plan included:

- *Staff was trained/retrained on all required elements of a preliminary investigation including the completion of the preliminary investigation within 15 working days of identification or reporting of suspected or potential fraud, waste or abuse.*
- *Templates were created to assist the investigators with ensuring proper documentation of each of the required elements of a preliminary investigation for both member and provider investigations.*
- *Bi-weekly reports (Monday & Thursday) have been created and are distributed to both supervisory and investigative staff to assist with timely completion of the preliminary investigation. The monitoring reports highlight actions needed to ensure completion of required steps.*
- *A procedure for Case Tracker workflow Audits has been created that includes an overview of the roles and responsibilities as it relates to the development, implementation, monitoring and escalation of Workflow Audit reports.*
- *A TX specific desktop procedure has been created.*

Results of the monitoring report will be shared with Sr. Leadership during the Monthly FWA meetings beginning in August 2021.

Responsible Managers

- *Sr. Director, Special Investigations Unit*
- *Director, Special Investigations Unit*
- *Supervisor, Special Investigations Unit*

Target Implementation Date

August 31, 2021

EXTENSIVE INVESTIGATIONS

Aetna's SIU is required to perform an extensive investigation if it determines suspicious indicators of possible fraud, waste, or abuse exist during the preliminary investigation of a provider. An extensive investigation involves more extensive tasks, such as selecting a sample of claims for review, requesting the records, and reviewing the records.

TAC currently requires Aetna's SIU to select a minimum of 30 members or 15 percent of a provider's claims related to the suspected fraud, waste, or abuse to review within 15 working days of completing a preliminary investigation that determined suspicious indicators of fraud, waste, or abuse exist within Medicaid.[12] Prior to the current requirements and from March 2012 to July 2019, TAC required Aetna to select a minimum of 50 members or 15 percent of a provider's claims to be reviewed within 15 working days for Medicaid. Aetna remains required to select that higher sample number for CHIP.[13]

After selecting claims for review, the MCO has 15 working days to request medical or dental records and encounter data. The requested records must be reviewed within 45 working days of receipt of those records to:

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

Issue 2: Extensive Investigations Were Not Completed Within Required Timelines

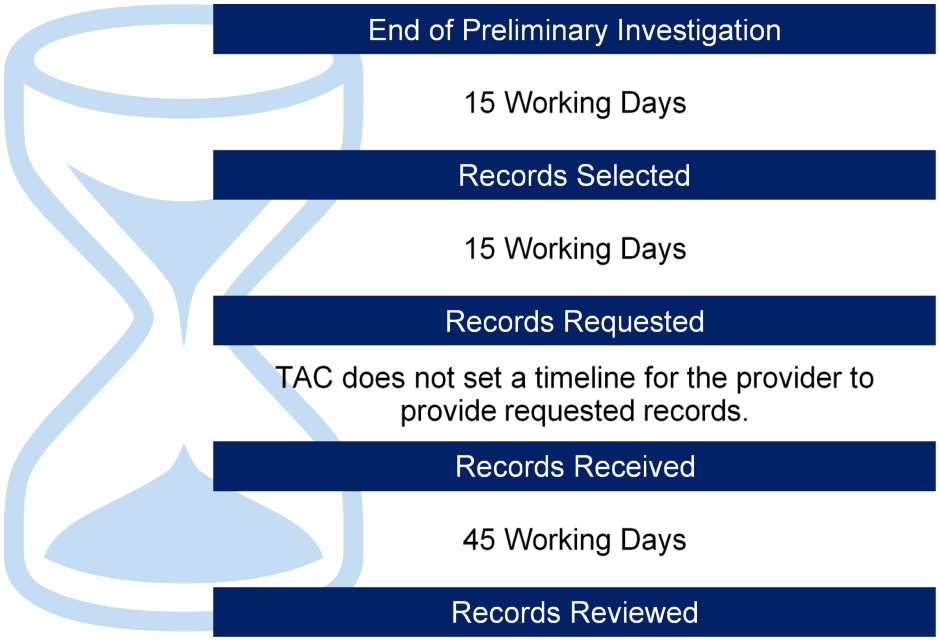
Of the 30 preliminary investigations tested, 8 found suspicious indicators of fraud, waste, and abuse, which resulted in additional extensive tasks being performed to determine if fraud, waste, or abuse had occurred. Each required element for an extensive investigation was completed; however, some elements were not always

[12] 1 Tex. Admin. Code § 353.502 (c)(2)(C) (July 18, 2019), states, "The MCO must select a minimum of 30 recipients or 15% of a provider's claims related to the suspected waste, abuse, and fraud; provided, however, that if the MCO selects 15% of the claims, the MCO must include claims relating to at least 30 recipients."

[13] 1 Tex. Admin. Code §§ 353.502 (c)(2)(C) (Mar. 1, 2012) and 370.502 (c)(2)(C) (Mar. 1, 2012), state: "The sample must 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."

completed within the required timelines. Specifically, Aetna did not always (a) select claims for review, (b) request records of the selected claims, or (c) complete its review of the requested records within required timelines. Figure 1 details the timelines for each task in an extensive investigation.

Figure 1: Timeline of Tasks in an Extensive Investigation



Source: 1 Tex. Admin. Code §353.502(c)(2) (2012 and 2019) and 1 Tex. Admin. Code § 370.502 (c)(2) (2012)

Table 2 shows the number of errors by extensive investigation task and the average number of days to complete the selection of claims or recipients for review, to request records of the selected claims, and to complete the review of requested records.

Table 2: Extensive Review Elements and Timelines

	TAC Timeline	# in Sample[14]	# Not Performed Timely	% Not Performed Timely	Average Time to Complete
Records Selected	15 days	7	4	57.1%	30 days
Records Requested	15 days	7	4	57.1%	44 days
Records Reviewed	45 days	8	2	25.0%	132 days

Source: OIG Audit

[14] One extensive investigation tested did not require a sample of claims for review so the timeline requirements for selecting claims and requesting associated records was not applicable. However, medical records were requested and reviewed by Aetna's SIU.

When fraud, waste, or abuse is suspected, delays in selecting a sample of claims, requesting the related records, or reviewing those records can impair Aetna's ability to mitigate fraud, waste, and abuse within the Medicaid and CHIP programs and effectively (a) investigate potential fraud, waste, and abuse, (b) timely identify overpayments and recover Medicaid funds, and (c) appropriately report SIU activities and results to OIG.

Testing of controls during fieldwork indicated that Aetna's SIU management performs a supervisory review to ensure all required activities of extensive investigations are completed during the investigation. However, Aetna's SIU did not ensure the elements were completed timely, specifically:

- Samples of claims were selected within 15 working days of completing a preliminary investigation that concluded suspicious indicators of fraud, waste, or abuse exist.

- Records related to suspected fraud, waste, or abuse were requested within 15 working days of samples being selected.

- Requested records were reviewed within 45 working days of receiving the requested records.

Recommendation 2

Aetna's 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.

Management Response

Action Plan

A remediation plan was put in place and completed in July 2021. The remediation plan included:

- *Staff was trained/retrained to ensure the following timelines are met during an extensive investigation:*
  - *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.*

- *Bi-weekly reports (Monday & Thursday) have been created and are distributed to both supervisory and investigative staff to assist with timely completion of the extensive investigation. The monitoring reports highlight actions needed to ensure completion of required steps and assist with the prioritization of record reviews by the SIU/plan clinical resources.*

- *A procedure for Case Tracker workflow Audits has been created that includes an overview of the roles and responsibilities as it relates to the development, implementation, monitoring and escalation of Workflow Audit reports.*

- *A TX specific desktop procedure has been created and includes the specifics timelines related to extensive investigations.*

Results of the monitoring report will be shared with Sr. Leadership during the Monthly FWA meetings beginning in August 2021.

Responsible Managers

- *Sr. Director, Special Investigations Unit*
- *Director, Special Investigations Unit*
- *Supervisor, Special Investigations Unit*

Target Implementation Date

August 31, 2021

CONCLUSION

Aetna's SIU generally complied with 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 HHSC. During the audit period, Aetna's SIU:

- Had a full-time SIU manager and one full-time investigator dedicated solely to the Texas Medicaid and CHIP programs.
- Ensured staff fraud, waste, and abuse training included required topics and was completed within the required timeframes, and completed training was documented in a training log or equivalent that included all required elements.
- Monitored provider and member service patterns via trend analysis, data matching, and random payment reviews of claims to identify potential fraud waste, and abuse.
- Ensured all required elements of a preliminary investigation and extensive investigation were completed; samples of provider's claims included the required number of recipients or claims related to the suspected fraud, waste, and abuse; and medical records, dental records, and encounter data received from the providers were reviewed.
- Maintained a log of incidences of suspected fraud, waste, and abuse containing required elements, submitted required reports to HHS OIG within required deadlines, referred all possible acts of fraud, waste, or abuse to HHS OIG within required deadlines, and established corrective action plans to improve providers' performance.
- Began payment recovery efforts when necessary, remitted half of recovered amounts to HHS OIG, and submitted reports detailing the amounts recovered to HHS OIG.

However, Aetna has opportunities to improve the timing and documentation of some of its SIU efforts in both preliminary and extensive investigations. Specifically, in those areas, Aetna should ensure:

Preliminary Investigations

- All required elements of a preliminary investigation are completed timely and are sufficiently documented to demonstrate all required elements of a preliminary investigation are completed within 15 working days of the identification or reporting of suspected or potential fraud, waste or abuse.

Extensive Investigations

- A sample of provider's claims are selected for review within 15 working days of completing a preliminary investigation.

- Medical records, dental records, and encounter data are requested from the provider within 15 working days of sample selection of provider claims.

- Medical records, dental records, and data requested from providers are reviewed within 45 working days of receipt.

OIG Audit offered recommendations to Aetna, which, if implemented, will support Aetna SIU's ability to effectively investigate potential fraud, waste, and abuse, and timely identify overpayments and recover Medicaid funds.

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

Appendix A: Sampling Methodology

OIG Audit performed audit testing on samples selected based on the following approaches.

Elements of Investigations

OIG Audit examined Aetna's SIU investigations for the period from September 1, 2018, through August 31, 2020. Aetna's SIU had a total of 116 total cases open during that timeframe. After an initial assessment of risks and associated controls, OIG Audit selected a risked-based sample of 30 cases, 17 from 2019 and 13 from 2020, stratified to include:

- Open cases
- Closed cases
- Cases that were referred to Aetna SIU from various sources
- Preliminary investigations that were completed
- Extensive investigations that were completed
- Cases that resulted in various corrective actions
- Cases involving recoupment of funds
- Cases with outcomes that are required to be referred to the HHS OIG

The samples selected from the strata were not always proportionate to the total number of cases within the strata population and the total population of 116 cases and therefore it would not be appropriate to project the findings to the population.

Training

OIG Audit examined Aetna's fraud, waste, and abuse training for the period September 1, 2018, to August 31, 2020. After an initial assessment of risks and associated controls, OIG Audit selected a risked-based sample of 30 employees, 9 from Aetna's SIU and 21 from Aetna's Texas Medicaid department. Twenty-four of the employees sampled were new hires during the audit period. OIG Audit tested the timing of new hire training for this group.

Appendix B: Report Team and Distribution

Report Team

OIG staff members who contributed to this audit report include:

- Audrey O'Neill, CIA, CFE, CGAP, Chief of Audit and Inspections
- Kacy J. VerColen, CPA, Deputy Inspector General of Audit and Inspections
- Anton Dutchover, CPA, Audit Director
- Jeffrey Jones, CPA, CIGA, Audit Project Manager
- Marcos Castro, CIGA, Staff Auditor
- Errol Baugh, Staff Auditor
- Toni Gamble, Quality Assurance Reviewer
- Kanette Blomberg, Quality Assurance Reviewer
- Mo Brantley, Senior Audit Operations Analyst

Report Distribution

Health and Human Services

- Cecile Erwin Young, Executive Commissioner
- Kate Hendrix, Chief of Staff
- Maurice McCreary, Jr., Chief Operating Officer
- Victoria Ford, Chief Policy and Regulatory Officer
- Karen Ray, Chief Counsel
- Michelle Alletto, Chief Program and Services Officer
- Nicole Guerrero, Director of Internal Audit
- Stephanie Stephens, State Medicaid Director, Medicaid and CHIP Services
- Shannon Kelley, Associate Commissioner for Managed Care, Medicaid and CHIP Services
- Camisha Banks, Director, Medicaid and CHIP Services
- Latoya King-Escalante, Manager, Special Projects Team, Medicaid and CHIP Services

- Aminat Dennis, Special Projects Team Coordinator, Medicaid and CHIP Services
- Adriana Ramirez-Byrnes, Project Manager, Medicaid and CHIP Services

Aetna

- Stephanie Rogers, Chief Executive Officer
- David Hall, Compliance Manager
- Rick Stratchen, Senior Director, Special Investigative Unit
- Tabitha Kielb, Director, Medicaid Special Investigative Unit
- Angela Williams, Supervisor, Special Investigative Unit Manager, Texas

Appendix C: 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
- Susan Biles, Chief of Staff
- Dirk Johnson, Chief Counsel
- Christine Maldonado, Chief of Operations and Workforce Leadership
- Juliet Charron, Chief of Strategy
- Steve Johnson, Chief of Investigations and Reviews

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- Phone: 1-800-436-6184

To Contact OIG

- Email: OIGCommunications@hhs.texas.gov
- Mail: Texas Health and Human Services
  Office of Inspector General
  P.O. Box 85200
  Austin, Texas 78708-5200
- Phone: 512-491-2000