OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

Christus Health Plan SIU

November 22, 2016
IG Report No. IG-16-017

HHSC IG
TEXAS HEALTH AND HUMAN SERVICES COMMISSION
INSPECTOR GENERAL

AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

Christus Health Plan SIU

WHY THE IG CONDUCTED THIS AUDIT

Christus is one of 22 managed care organizations (MCOs) contracted to provide Medicaid and CHIP health care services in Texas. Approximately 84 percent of Medicaid and CHIP enrollees are members of an MCO. At nearly $27 billion a year, the Medicaid and CHIP programs constitute over 27 percent of the total Texas budget.

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

The Texas Health and Human Services Commission is responsible for oversight of MCO contracts. The IG is responsible for approving SIU annual plans, and evaluating and sometimes investigating SIU referrals.

This is one of a series of performance audits to determine how effective selected MCO SIUs are at (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries.

WHAT THE IG RECOMMENDS

HHSC should require Christus to implement corrective actions to achieve full compliance and strengthen Christus' SIU fraud, waste, and abuse detection, investigation, and training activities.

View **IG-16-017**
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WHAT THE IG FOUND

Christus Health Plan (Christus) maintains a contractually required annual SIU fraud, waste, and abuse plan, but needs to improve its SIU function in order to comply with the plan and effectively detect and investigate fraud, waste, and abuse.

Christus received approximately $23.7 million in Medicaid and CHIP capitation and delivery supplemental payments in 2014, and $20.9 million in 2015, and paid approximately $37.8 million in medical claims dollars over those two years. During the three year period that includes 2016, for which medical claims dollar amounts are not yet available, Christus and its SIU contractor opened three SIU cases, identified and recovered $499.82 in overpayments, and did not refer any fraud, waste, and abuse cases to the IG.

Year	Medical Claims $	# of Possible SIU Cases	SIU Recoveries	# of Referrals to IG
2014	$ 18,274,429	0	$ 0	0
2015	$ 19,534,814	1	$ 499.82	0
2016	Not Available	2	$ 0	0
Total	$ 37,809,243	3	$ 499.82	0

Although Christus' annual fraud, waste, and abuse plan outlined the essential activities needed for an effective SIU, some SIU activities necessary to detect fraud, waste, and abuse were not performed, and Christus' SIU investigation activities were limited in scope. From March 2015 through July 2016, Christus did not have an active SIU function. Christus did not initiate or conduct investigations of referrals of suspected fraud, waste, or abuse in accordance with regulations. Christus did not maintain a required log of the fraud referrals it received and could not demonstrate that its subcontractors received required annual fraud, waste, and abuse training.

Christus' SIU investigation activities were also limited. It did not conduct recipient verifications to confirm that services billed by providers were delivered to the recipient, and it did not perform post-payment data analytics to identify unusual trends and anomalies in provider claims.

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

The HHSC Medicaid and CHIP Services Department concurred with the IG Audit Division recommendation outlined in this report, and will facilitate Christus' development of a corrective action plan designed to improve Christus' SIU function.

The IG Audit Division will continue to publish reports of Medicaid and CHIP SIU performance audits as it completes testing and validation for selected MCOs.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Inspector General (IG) Audit Division is conducting an audit of Medicaid and Children's Health Insurance Program (CHIP) special investigative units (SIU). The objective of the audit is to evaluate the effectiveness of managed care organization (MCO) SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC. The audit includes state fiscal years 2014, 2015, and 2016 which covers the period from September 2013 through August 2016, and includes a review of relevant SIU activities through the end of fieldwork in October 2016.

This audit report is one of a series of reports on MCO SIUs. The first report was an informational report that provided background, context, and a compilation of information provided by the 22 Texas Medicaid and CHIP MCOs.[1] This audit report is focused on SIU activities at Christus Health Plan (Christus).

Background

Christus is a licensed Texas MCO contracted to provide Medicaid services through its network of providers. Christus coordinates health services for STAR and CHIP members[2] in Nueces County.

Christus is one of 22 contracted MCOs responsible for administering, on behalf of the State of Texas, billions of dollars of Medicaid and CHIP health care services each year through its health plans. By contract, HHSC requires MCOs to establish and maintain an SIU to investigate potential fraud, waste, and abuse by members and health care service providers.[3] An MCO may contract with an outside organization to perform all or part of the activities associated with the SIU. Christus contracted with Aetna Better Health of Texas, Inc. (Aetna) from September 2013 through February 2015 to perform its SIU function. During the contract period, Aetna performed all SIU activities on behalf of Christus. In March 2015,

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

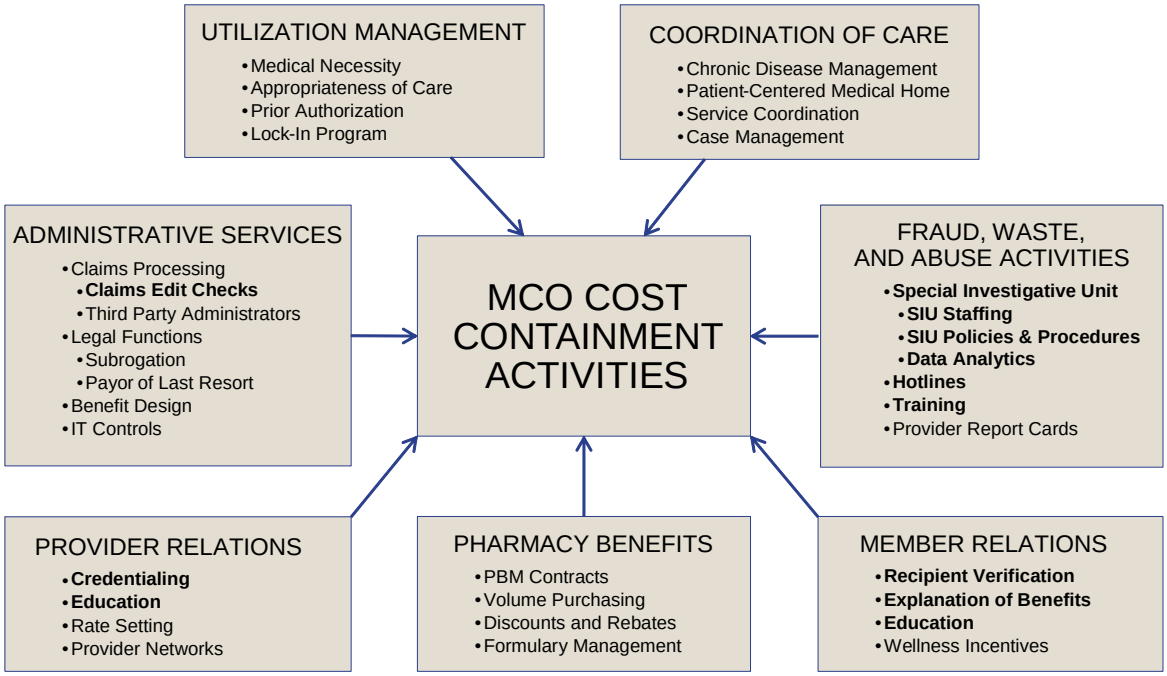
[2] MCOs refer to enrollees as "members." An "enrollee" is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

[3] Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015); Texas Government Code, Title 4, Subtitle 1, § 531.113 (September 1, 2003). See also Texas Administrative Code Title 1, Part 15, § 353.502 and § 370.502 (March 1, 2012).

Christus signed a contract under which Health Management Systems (HMS) would provide SIU services, but the contract was never implemented and was cancelled in April 2016.

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

Figure 1: MCO Functions and Activities Related to Cost Containment



Source: IG Audit Division

The activities bolded in Figure 1 designate some of the areas of focus of this audit. This performance audit evaluated Christus' SIU efforts related to:

- Prevention processes, such as the organizational code of ethics, credentialing and re-credentialing, exclusion verification, and fraud, waste, and abuse training.
- Detection activities, such as complex data analysis, periodic provider audits, intake of fraud referrals, and verification that recipients received billed services.
- Investigation efforts, such as conducting preliminary investigations and SIU case management.

- Disposition of fraud, waste, and abuse investigations, including referrals to the IG, corrective action plans, and monetary recovery.
- Reporting of SIU activities to the IG, including a monthly report of ongoing investigations and annual reporting of SIU recoveries.

Texas Health and Human Services (HHS) agencies administer public health programs for the State of Texas. Within HHS, the HHSC Medicaid and CHIP Services Department oversees Medicaid and CHIP, which are jointly funded state-federal programs that provide medical coverage to eligible individuals. In 2013, there were approximately 4.3 million individuals enrolled in Medicaid or CHIP.

The HHSC Medicaid and CHIP Services Department is responsible for overall management and monitoring of the contract with Christus. The IG is responsible for approving Christus' annual fraud, waste, and abuse plan, and evaluating and sometimes investigating any fraud referrals it receives from Christus. Christus is required by its contract to refer suspected fraud, waste, and abuse to the IG. When the IG determines it will not pursue an SIU referral, Christus is responsible for recovery of any Medicaid and CHIP overpayments associated with the referral.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. Through the STAR + PLUS program, Medicaid provides health services for individuals age 65 and older, or with a disability requiring long-term health care services. CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid. In federal fiscal year 2013, Texas spent $26.8 billion on Medicaid and CHIP. This represented 27 percent of the entire 2013 Texas state budget.

Medicaid and CHIP programs deliver health care services (including medical, dental, prescription drug, disability, behavioral health, and long-term support services) to eligible individuals. CHIP provides services to individuals in Texas through a managed care model. Texas Medicaid provides services to some individuals through a traditional fee-for-service model, but most are enrolled through a managed care model. For providing these services, MCOs receive capitation payments, which are monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to MCOs at fixed, per member, per month, rates based on members' associated risk groups. These payments include federal and state funds.

In 2013, 100 percent of CHIP enrollees were in managed care. Collectively, approximately 84 percent of the combined Medicaid and CHIP populations (3.6 million individuals) were enrolled in managed care.

The IG Audit Division conducted this audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Unless otherwise described, any year that is referenced is the state fiscal year, which covers the period from September 1 through August 31.

The IG Audit Division presented audit results, issues, and recommendations to the HHSC Medicaid and CHIP Services Department and to Christus in a draft report dated November 9, 2016. Each was provided with the opportunity to study and comment on the report. HHSC Medicaid and CHIP Services Department management responses to the recommendations contained in the report are included in the report following each recommendation. Christus' comments are included in Appendix C. HHSC Medicaid and CHIP Services Department concurred with the IG Audit Division recommendations, and will facilitate Christus' development of a corrective action plan designed to improve Christus' SIU function.

RESULTS, ISSUES, AND RECOMMENDATIONS

Christus maintains a fraud, waste, and abuse plan; the fundamental contractual and regulatory SIU requirement for MCOs. The plan describes ways Christus can strengthen program integrity by monitoring service providers, auditing claims, identifying overpayments, and educating members and providers. Though the fraud, waste, and abuse plan is in place, Christus has not effectively implemented the plan. As a result, weaknesses exist in the structure and function of Christus' SIU. During this audit, the IG Audit Division evaluated Christus' SIU and identified issues related to the:

- Number of fraud, waste, and abuse investigations and referrals; and the amount of recoveries.
- Tracking of fraud referrals submitted through a fraud hotline or other source.
- Verification of member services.
- Utilization of data analytics to detect potential fraud, waste, or abuse.

Christus received approximately $23.7 million in Medicaid and CHIP capitation and delivery supplemental payments in 2014, and $20.9 million in 2015. Christus maintained an average monthly membership of 7,385 Medicaid members and 787 CHIP members during 2014; and 7,057 Medicaid members and 545 CHIP members during 2015. Table 1 shows capitation and delivery supplemental payments by program and year. Capitation payments include both medical and pharmacy payments. Data for 2016 was not yet available at the time of this report.

Table 1: Christus Capitation and Delivery Supplemental Payments by Program

Program	2014	2015	Total
Medicaid	$ 22,410,330	$ 19,939,060	$ 42,349,390
CHIP	$ 1,252,888	$ 953,122	$ 2,206,010
Total	$ 23,663,218	$ 20,892,182	$ 44,555,400

Source: HHSC 2014 Year-End 334 Day FRS and HHSC 2015 Year-End FSR

Issue 1: THE SCOPE OF SIU INVESTIGATION ACTIVITIES WAS LIMITED

As specified by contract and regulations, SIU fraud, waste, and abuse plans define the essential activities of the SIU. Performance of these activities is critical for successful prevention, detection, investigation, and reporting of fraud, waste, and abuse. Christus maintains an approved SIU fraud, waste, and abuse plan, but the scope of activities it outsourced or performed to implement the plan was limited.

Christus Did Not Have a Fully Functional SIU From March 2015 to July 2016

In March 2015, after its contract for SIU services with Aetna ended, Christus signed an SIU contract with Health Management Systems (HMS) for the provision and performance of some of its SIU functions. However, Christus did not meet the contract provision that required a minimum of 20,000 members prior to implementation of SIU services. As a result, claims data was never sent to HMS to be analyzed for potential fraud, waste, and abuse. Consequently, between March 2015 and September 2015, Christus did not have a functional SIU to prevent, detect, and investigate potential fraud, waste, and abuse. During this period, Christus could have utilized HMS services on a project basis but did not request services. By contract and state law, MCOs are required to establish and maintain SIUs to investigate potential fraud, waste, and abuse by members and health care service providers.[4]

In October 2015, the Christus Compliance Department incorporated some fraud, waste, and abuse oversight activities in its claims processing system. At that time, there was no assigned officer responsible for leading, coordinating, and overseeing operation of the SIU. The Director of Implementation was assigned to oversee and coordinate the activities of the SIU in April 2016, and in July 2016 Christus began implementing SIU activities.

At the time of the IG Audit Division site visit in October 2016, Christus had not yet implemented all activities necessary to detect fraud, waste, and abuse in accordance with contract and regulatory requirements.

From 2014 through 2016, Christus Conducted Few Fraud, Waste, and Abuse Investigations

Prior to March 2015, while Christus' SIU functions were being performed by Aetna, there was a single recovery of $499.82. No documentation exists to indicate whether or not this was the result of a fraud, waste, or abuse investigation. Between March 2015 and August 2016,

[4] Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015); Texas Government Code, Title 4, Subtitle 1, § 531.113 (September 1, 2003). See also Texas Administrative Code Title 1, Part 15, § 353.502 and § 370.502 (March 1, 2012).

Christus opened two fraud, waste, and abuse cases, but did not identify or record any recoveries associated with fraud, waste, and abuse investigations.

From 2014 through 2016, Christus' health care providers submitted 249,163 Medicaid and CHIP medical claims, and were paid approximately $37.8 million in medical claims dollars in 2014 and 2015.[5] During this three year period, Christus opened three SIU cases, identified and collected $499.82 in SIU recoveries, and did not refer any cases to the IG or to the Office of Attorney General Medicaid Fraud Control Unit. Table 2 shows the number and amount of medical claims by year along with the number of SIU cases, amounts of SIU recoveries, and number of referrals to the IG.

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

Year	Medical Claims	Medical Claims $	# of Possible SIU Cases[6]	SIU Recoveries[7]	Referrals to IG
2014	90,331	$ 18,274,429	0	$ 0	0
2015	82,725	$ 19,534,814	1	$ 499.82	0
2016	76,107	Not Available	2	$ 0	0
Total	249,163	$ 37,809,243	3	$ 499.82	0

Sources: Christus Correspondence; HHSC 2014 Year-End 334-Day FSR and HHSC 2015 Year-End 334-Day FSR; Information about 2016 medical claims dollars will not be available until February 2017

Preliminary Investigations Were Not Conducted in Accordance With Regulatory Requirements

Christus did not perform preliminary investigations for the two cases referred to its SIU during 2016 according to regulatory requirements. The first of these cases was referred to the Christus SIU by the IG on April 22, 2016. The case was closed by the SIU on April 29, 2016, prior to receipt of an internal peer review report on the complaint dated May 2, 2016. The report recommended Christus, at the very least, conduct a site visit of the provider's facility in order to determine the validity of the allegations.[8] On October 7, 2016, Christus opened a new investigation on the case.

[5] "Medical claims dollars" are the total amounts submitted to MCOs by health care providers as payment requests for medical services performed. MCOs pay these medical claims as expenses for delivering covered health care services to members. Medical claims dollars include claims with a date of service that falls within the referenced year, and may or may not have been paid during the referenced year. Medical claims dollars for 2014 and 2015 include both medical and pharmacy amounts, but do not include MCO administrative costs. The informational report previously published for this audit did not include pharmacy amounts in medical claims dollars.

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

[7] This includes the amounts recovered during the referenced year. Investigations may have been opened during the current or prior years.

[8] Christus Quality Management Case Review for Potential Quality Issue (April 28, 2016)

Additionally, Christus did not provide any evidence that a case it reported in January 2014 involving the same provider was also reviewed as required by regulation. Texas Administrative Code requires that preliminary investigations include "any previous reports of incidences of suspected waste, abuse, or fraud or conducted any previous investigations of the provider in question. If so, the investigation should include a review of all materials related to the previous investigations, the outcome of the previous investigations, and a determination of whether the new allegations are the same or relate to the previous investigation."[9]

A second case was referred to the Christus SIU by its claims processing department on June 24, 2016. Investigative activities were initiated by the newly constituted SIU on July 27, 2016. This case was not initiated within 15 days as required. Texas Administrative Code states, "…the MCO must conduct a preliminary investigation within 15 working days of the identification or reporting of suspected or potential waste, abuse, or fraud."[10]

A potential third case, which may have been associated with the collection of a $499.82 overpayment in 2015 that was reported to HHSC, was not reported as an active SIU case during 2014 or 2015, and Christus had no documentation to indicate whether or not this was the result of a fraud, waste, or abuse investigation, or whether a preliminary investigation, if conducted, was initiated within 15 days as required.

A Log of Fraud Referrals Was Not Maintained

Christus did not maintain a log of suspected fraud, waste, and abuse referrals received by the SIU. The Christus SIU may receive potential fraud, waste, and abuse referrals from several sources, including Christus' provider services, member services hotline, the fraud, waste, and abuse hotline, and the IG.

Texas Administrative Code requires each MCO to keep a "log of all incidences of suspected waste, abuse and fraud received by the MCO regardless of the source. The log must contain the subject of the complaint, the source, the allegation, the date the allegation was received, the recipient's or provider's Medicaid number, and the status of the investigation."[11]

Responsible management at Christus indicated that in the three-year period under review, no referrals were received from either members or providers, and that one referral was received from IG and another was generated from Christus' claims processing activities. Without a referral log, Christus may not have readily available information it needs to ensure that referrals are monitored, appropriately investigated, and addressed in a timely manner.

[9] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c)(2)(B) (March 1, 2012)

[10] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c)(2)(A) (March 1, 2012)

[11] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(d)(2) (March 1, 2012).

Recommendations 1.1-1.3

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require Christus to put corrective actions in place to strengthen its fraud, waste, and abuse activities, including:

1.1 Fully implementing and maintaining an SIU function that meets contractual and regulatory requirements.

1.2 Initiating and conducting investigations of referrals of suspected fraud, waste, or abuse in accordance with regulatory requirements.

1.3 Maintaining referral logs to record and track referrals of suspected fraud, waste, and abuse received from the IG, providers, and Christus fraud hotlines.

The HHSC Medicaid and CHIP Services Department should consider tailored contractual remedies to compel Christus to perform SIU activities effectively.

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department is in agreement with the recommendation and will allow Christus ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of:

- An SIU function that meets contractual and regulatory requirements.
- Preliminary investigations initiated within 15 working days of the identification or reporting of suspected or potential waste, abuse, or fraud.
- Referral logs maintained to record and track referrals of suspected fraud, waste, and abuse received from the IG, providers, and Christus fraud hotlines.

The Medicaid and CHIP Services Department expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Christus. Additionally, Medicaid and CHIP Services Department leadership will consider tailored contractual remedies to compel Christus to effectively perform SIU activities.

Prior to approving actions within the CAP, the Medicaid and CHIP Services Department will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Individual
Director, Health Plan Management

Target Implementation Date
March 2017

Issue 2: SIU ACTIVITIES NECESSARY TO DETECT FRAUD, WASTE, AND ABUSE WERE NOT PERFORMED

SIU fraud, waste, and abuse plans define the activities of the SIU that are critical for the successful prevention, detection, investigation, and reporting of fraud, waste, and abuse.

The IG Audit Division evaluated Christus' prevention processes and found no issues with provider credentialing, re-credentialing, or trainings related to ethics and fraud, waste, and abuse. In the samples tested, Christus completed the credentialing process prior to the addition of each provider to the Christus network, and completed the re-credentialing process every three years. The IG Audit Division found no exceptions in the samples tested regarding the provision of fraud, waste, and abuse training to employees and subcontractors, and found no issues with the training materials and support that Christus delivers to the 75 providers in its network. Other activities that the IG Audit Division tested with no exceptions included the performance of (a) the exclusion verification process and (b) periodic provider audits.

Christus did not, however, effectively perform SIU activities that could have resulted in the detection of fraud, waste, and abuse. Christus detected no fraud, waste, or abuse cases through SIU efforts such as verification of services or data analytics.

Verification of Services Was Not Performed

Christus' SIU did not conduct recipient verifications to confirm that services billed by providers were delivered to the recipient. Christus' approved fraud, waste, and abuse plan states that the SIU will verify that recipients received billed services by regularly conducting activities including member interviews and member surveys. As indicated in its fraud, waste, and abuse plan, "CHRISTUS Health Plan will conduct random telephonic surveys to verify with members that services billed by providers were received."[12]

By not performing verification procedures, Christus was less likely to detect potential fraud, waste, and abuse committed by providers that would indicate the need for further investigation and possible recovery.

Data Analytic Techniques Were Not Adequately Utilized to Detect Fraud, Waste, or Abuse

Christus did not, during the period under review (a) open or conduct limited fraud, waste, or abuse investigations using data analytics, (b) refer any cases to the IG or to the Office of

[12] Christus Health Plan Fraud, Waste, and Abuse Compliance Plan, CHIP and STAR Programs (2014, 2015, and 2016).

Attorney General Medicaid Fraud Control Unit using data analytics, and (c) recover substantial Medicaid or CHIP dollars lost to fraud using data analytics.

Christus used the Meditrac claims application to process all claims and to conduct prepayment review of claims for reasonableness, completeness, and accuracy. Christus management indicated that, beginning in October 2015, prepayment fraud, waste, and abuse detection activities were implemented using Meditrac. However, Christus did not provide evidence of any prepayment review activities performed during the audit period.

In addition, Christus did not utilize post-payment data analytic techniques to detect abnormal claims patterns or suspicious indicators of fraud, waste, and abuse.

Texas Administrative Code requires SIUs to detect and identify "Medicaid program violations and possible waste, abuse, and fraud overpayments through data matching, analysis, trending, and statistical activities…monitoring of service patterns for providers, subcontractors, and recipients…[and] use of edits or other evaluation techniques."[13] Post-payment claims analysis enables more complex data analysis over larger periods of time than is available at a prepayment level. Both post-payment claims analysis and prepayment analysis are critical components of an effective SIU function.

Recommendations 2.1-2.2

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require Christus to put corrective actions in place to strengthen its fraud, waste, and abuse activities, including:

2.1 Conducting recipient verifications to confirm that services billed by providers were delivered to the recipient.

2.2 Developing post-payment data analytic techniques to identify unusual trends and anomalies in provider claims to effectively detect fraud, waste, and abuse.

The HHSC Medicaid and CHIP Services Department should consider tailored contractual remedies to compel Christus to perform SIU activities effectively.

[13] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c) (March 1, 2012).

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department is in agreement with the recommendations and will allow Christus ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of:

- Recipient verifications to confirm that services billed by providers were delivered to the recipient.
- Data analytic techniques to identify unusual trends and anomalies in provider claims, and applying data analytics to effectively detect fraud, waste, and abuse.

The Medicaid and CHIP Services Department expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Christus. Additionally, Medicaid and CHIP Services Department leadership will consider tailored contractual remedies to compel Christus to effectively perform SIU activities.

Prior to approving actions within the CAP, the Medicaid and CHIP Services Department will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Individual
Director, Health Plan Management

Target Implementation Date
March 2017

Issue 3: TRAINING WAS NOT PROVIDED IN ACCORDANCE WITH REGULATIONS AND THE FRAUD, WASTE, AND ABUSE PLAN

The IG Audit Division reviewed fraud, waste, and abuse training attestations submitted by Christus for its three subcontractors. Christus subcontractors are required to annually attest to the completion of mandatory compliance training, one element of which is fraud, waste, and abuse training. Christus did not provide signed attestations that its subcontractors had completed annual fraud, waste, and abuse training.

Texas Administrative Code requires MCOs to maintain a fraud waste, and abuse plan that includes employee training. Specifically, Texas Administrative Code states, "On an annual basis, the MCO must ensure that waste, abuse, and fraud training is provided to each employee and subcontractor who is directly involved in any aspect of Medicaid."[14]

All 50 Christus employees selected for review received fraud, waste, and abuse training, as required by Texas regulation and Christus' fraud, waste, and abuse plan.[15] The IG Audit Division selected a sample of employees and subcontractors to determine whether each had received required training. Christus provided evidence that all 50 employees tested received fraud, waste, and abuse training within 90 days of hire.

Without training, Christus subcontractors may lack the knowledge and awareness needed to prevent, detect, and report suspected fraud, waste, and abuse to the SIU.

Recommendation 3

The HHSC Medicaid and CHIP Services Department, through its contract oversight responsibility, should require Christus to strengthen its SIU infrastructure by ensuring that subcontractors receive fraud, waste, and abuse training in accordance with its fraud, waste, and abuse plan, and obtain and maintain attestations from its subcontractors to document that training was completed.

The HHSC Medicaid and CHIP Services Department should consider tailored contractual remedies to compel Christus to effectively perform SIU activities.

[14] Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c)(6) (March 1, 2012).

[15] Christus Health Plan Fraud, Waste, and Abuse Plan (2016).

HHSC Medicaid and CHIP Services Department Management Response

The Medicaid and CHIP Services Department is in agreement with the recommendations and will allow Christus ten (10) business days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of:

- Ensuring subcontractors receive fraud, waste, and abuse training in accordance with its fraud, waste, and abuse plan.
- Obtain and maintain attestations from subcontractors to document that training was completed.

The Medicaid and CHIP Services Department expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Christus. Additionally, Medicaid and CHIP Services Department leadership will consider tailored contractual remedies to compel Christus to effectively perform SIU activities.

Prior to approving actions within the CAP, the Medicaid and CHIP Services Department will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Individual
Director, Health Plan Management

Target Implementation Date
March 2017

CONCLUSION

The IG Audit Division completed an audit of Christus Health Plan's SIU performance. The audit included an evaluation of policies and practices associated with preventing, detecting, investigating, and reporting fraud, waste, and abuse. The IG Audit Division conducted a site visit from October 3, 2016 through October 6, 2016 at Christus' facility in Irving, Texas.

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

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

Based on the results of its audit of Christus SIU, the IG Audit Division concludes that:

- Christus' SIU was not effective during the audit period.
- Christus did not initiate and conduct investigations of referrals it received in accordance with regulations.
- Christus did not maintain a fraud referral log.
- Christus did not conduct recipient verifications to confirm that services billed by providers were delivered to the recipient.
- Christus' SIU did not perform post-payment data analytics designed to detect fraud, waste, and abuse.
- Christus subcontractors did not submit attestations indicating compliance with training requirements.

The IG Audit Division offered recommendations to the HHSC Medicaid and CHIP Services Department which, if implemented, will:

- Increase the scope of Christus SIU investigations, providing greater opportunity to investigate, refer, and recover fraud, waste, and abuse.
- Improve detection capabilities, increase identification of potential fraud, waste, and abuse, and increase recoveries.

The IG Audit Division thanks management and staff at the HHSC Medicaid and CHIP Services Department and at Christus for their cooperation and assistance during this audit.

Appendix A: OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

The scope of the performance audit of the Christus SIU included the period of September 2013 through August 2016. The scope of this audit included review of:

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

Methodology

To accomplish its objective, the IG Audit Division collected information for this audit through discussions and interviews with responsible management at Christus, and through request and review of the following information from Christus:

- A description of the SIU function and organizational structure.
- A list of SIU employees, including their names, titles, and a description of their qualifications.
- Policies and practices associated with prevention and detection of fraud, waste, and abuse.
- Data related to SIU performance, including investigations, recoveries, and referrals in 2014, 2015, and 2016.
- A description and flowchart of the SIU investigation process.
- Data and information systems that support the SIU activities and data processing necessary to produce reports for submission to HHSC.
- A list and a description of each automated process or control in place to detect fraud, waste, and abuse.

The IG Audit Division issued an engagement letter to Christus providing information about the upcoming SIU audit, and conducted fieldwork at Christus' facility in Irving, Texas from October 3, 2016 through October 6, 2016. While on-site, the IG Audit Division interviewed

responsible SIU personnel, evaluated policies and practices relevant to the SIU function, and reviewed relevant SIU activities, including those related to prevention, detection, investigation, disposition, and reporting.

While at Christus' facility, the IG Audit Division reviewed and copied documentation and records related to the SIU function. No original records were removed from Christus' premises. Upon request, Christus sent additional documents that were requested during the audit, but were not available during the on-site review, to the IG Audit Division offices for review.

Professional judgment was exercised in planning, executing, and reporting the results of this audit. The IG Audit Division used the following criteria to evaluate the information provided:

- Christus Fraud, Waste, and Abuse Compliance Plan
- Christus SIU Policies and Procedures
- Uniform Managed Care Manual
- Uniform Managed Care Contract Terms and Conditions
- Texas Administrative Code
- Texas Government Code
- Code of Federal Regulations

The IG Audit Division reviewed the SIU data and reports produced by the claims management system at Christus. The IG Audit Division determined the data was not sufficiently reliable for the purposes of the audit. Therefore, the completeness and accuracy of data processed by Christus was not assessed or relied upon for the purposes of this audit. In order to make this determination, the IG Audit Division:

- Interviewed MCO officials knowledgeable about the data.
- Validated that the queries and parameters used to produce SIU reports were appropriately modified.
- Reviewed the access management process for appropriateness.
- Reconciled potential fraud, waste, and abuse claims reports to source documents.

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

Appendix B: SAMPLING METHODOLOGY

The IG Audit Division examined SIU activities for the period from September 2013 through August 2016. After an initial assessment of risk across SIU activities and contractor performance outcomes, the IG Audit Division performed testing from the population of Christus employees, subcontractors, and providers.

Christus Employee and Subcontractor Training

The IG Audit Division conducted sample testing in order to assess whether Christus employees had attended annual ethics and fraud, waste, and abuse trainings required by Texas Administrative Code. The IG Audit Division selected a simple random sample[16] using a random number generator. The sample size included 50 employees from the total population of 243 Christus staff who were employed at any time during the three-year audit period. Christus utilized five subcontractors during the audit period, and the IG Audit Division reviewed 100 percent of records for these subcontractors to determine whether fraud, waste, and abuse training was provided.

The IG Audit Division evaluated whether Christus employees received required annual ethics and fraud, waste, and abuse trainings by comparing whether the employees in the sample had signed a fraud, waste, and abuse training sign-in sheet to indicate attendance. For subcontractors, the IG Audit Division evaluated documentation submitted by Christus relevant to subcontractor fraud, waste, and abuse training.

Christus Provider Credentialing

The IG Audit Division conducted sample testing to assess whether the provider credentialing process was conducted on a timely basis. The IG Audit Division selected a simple random sample using a random number generator. The sample size included 25 providers from the total population of 75 unique CHIP, STAR, providers enrolled with Christus during the three-year audit period.

The IG Audit Division assessed whether the provider credentialing process was conducted on a timely basis by reviewing sampled providers' credentialing files to verify that the credentialing process was completed prior to their addition to the Christus network, and that re-credentialing was completed at least once every three years thereafter.

[16] Random sampling is a method by which every element in the population has an equal chance of being selected.

The IG Audit Division requested schedules of the total population of providers for the audit period and selected a judgmental sample[17] of 20 percent of the population with a minimum sample size of 25 and a maximum of 50. Where the total population was 30 or less, the IG Audit Division tested 100 percent of the population. Samples reflected an even spread between 2014, 2015, and 2016. This methodology provided sufficient and appropriate evidence to make determinations regarding the test objectives.

Christus SIU Investigations

The IG Audit Division tested both investigations conducted by Christus during 2016 to assess whether SIU investigations were conducted on a timely basis in accordance with statutory requirements and the fraud, waste, and abuse plan. This methodology provided sufficient and appropriate evidence to make determinations regarding test objectives.

The IG Audit Division assessed whether investigations were conducted on a timely basis by determining whether investigations met the time frames required by Texas Administrative Code. The IG Audit Division also assessed whether appropriate records were requested and reviewed, and where applicable, whether overpayments were recovered.

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

Appendix C: Christus Comments

CHRISTUS Health Plan

OUR MISSION "To Extend the Healing Ministry of Jesus Christ"

November 16, 2016

Steve Sizemore, CIA, CISA, CGAP
Audit Director
Texas Health and Human Services Commission
Office of Inspector General
Mail Code 1326
P.O. Box 85200
Austin, Texas 78708-5200

Dear Mr. Sizemore:

CHRISTUS Health Plan ("CHRISTUS" or the "Health Plan") appreciates the opportunity to comment on the report of the Health and Human Services Commission's Inspector General regarding CHRISTUS' Special Investigative Unit ("SIU") activities. CHRISTUS is committed to serving the Medicaid population, and to combating fraud, waste or abuse in the Texas Medicaid program.

We do wish to provide some additional background regarding the period of time following Aetna's transfer of management activities to CHRISTUS in March 2015. HMS had conducted some SIU activities on behalf of Aetna, and there was a contract between HMS and CHRISTUS executed for continuation of those activities. CHRISTUS continued to receive reports from HMS after March 1, 2015. Although they related to earlier time periods, the expected lag time for generation of the reports was not immediately clear to those reviewing the reports. Once it was understood that they were not conducting SIU activities for current time periods, CHRISTUS Associates queried HMS as to what data needed to be submitted to HMS for this purpose. Staffing changes at both HMS and CHRISTUS delayed communications that were needed to clarify the nature of the contract. Once Health Plan Associates understood that HMS was not conducting, and had no obligation to conduct, SIU activities, they proceeded to develop our internal SIU program.

In late September 2015, CHRISTUS began implementing its internal SIU program. The program included conducting regular reviews of provider payments to identify outlier payments or patterns. Under the program, any identified outliers would have resulted in analysis of claims and corresponding medical data. However, no outliers were identified, which did not seem unusual given the small size of the Health Plan. The SIU program also including monitoring of hotline calls and complaints, but no potential fraud, waste or abuse cases were reported.

By July 2016, the Health Plan had developed custom logic within its claims system that was designed to detect anomalies that could indicate billing outside expected norms. In addition, the Health Plan has hired

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CHRISTUS Health Plan

OUR MISSION "To Extend the Healing Ministry of Jesus Christ"

a dedicated SIU investigator. He reviews the reports produced by the claims data analytics, and follows up on potential irregularities identified by that process or by the payment reviews. One such investigation is currently underway.

We believe that our current SIU program fully complies with the Medicaid requirements, but we are using the results of the IG performance review to enhance our process improvement activities, which are ongoing. We remain committed to serving the Medicaid population and ensuring that Medicaid program dollars are used in a manner that provides the greatest benefit to members of the Health Plan, consistent with our mission.

Anita Leal

Anita Leal, Executive Director, CHRISTUS Health Plan

11/16/2016

Date

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Appendix D: REPORT TEAM AND REPORT DISTRIBUTION

Report Team

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

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
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- Jeff Jones, CPA, CIGA, Audit Project Manager
- Babatunde Sobanjo, CGAP, PhD, Auditor
- Netza Gonzalez, MBA, MSM, CISA, CFE, IT Audit Project Manager
- Jude Ugwu, MBA, CFE, CRMA, Auditor
- JoNell Abrams, Auditor
- Angelica Villafuerte, Auditor
- Sarah Warfel, IT Auditor
- Emery Hizon, Auditor
- Lorraine Chavana, Quality Assurance Reviewer
- Scott Miller, Senior Audit Operations Analyst

Report Distribution

Health and Human Services Commission

- Charles Smith, Executive Commissioner
- Cecile Erwin Young, Chief Deputy Executive Commissioner
- Kara Crawford, Chief of Staff
- Gary Jessee, Deputy Executive Commissioner for Medical and Social Services
- Jami Snyder, Associate Commissioner Medicaid and CHIP Services Department
- Tony Owens, Deputy Director, Medicaid and CHIP Services Department Contract and Performance Management
- Karin Hill, Director of Internal Audit

Christus Health Plan

- Anita Leal, Chief Executive Officer
- Gregory J. Ehardt, Chief Compliance and Privacy Officer

Appendix E: IG MISSION AND CONTACT INFORMATION

Inspector General Mission

The mission of the IG 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 IG's mission and statutory responsibility includes:

- Stuart W. Bowen, Jr. — Inspector General
- Sylvia Hernandez Kauffman — Principal Deputy IG
- Christine Maldonado — Chief of Staff and Deputy IG for Operations
- Olga Rodriguez — Senior Advisor and Director of Policy and Publications
- James Crowley — Deputy IG for Investigations
- David Griffith — Deputy IG for Audit
- Quinton Arnold — Deputy IG for Inspections
- Anita D'Souza — Chief Counsel

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To Contact the Inspector General

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