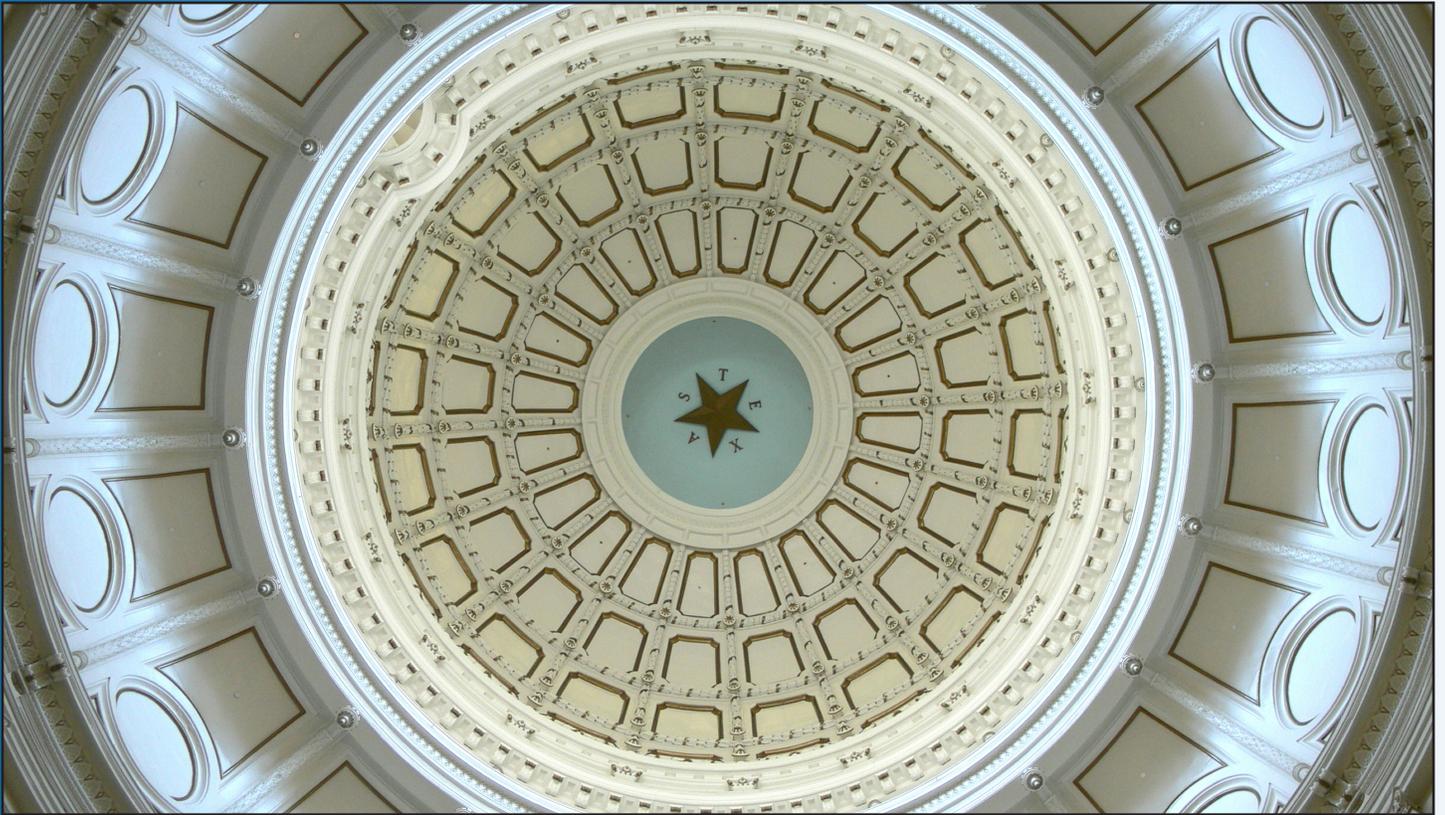


TEXAS HEALTH AND HUMAN SERVICES
INSPECTOR GENERAL



QUARTERLY REPORT
JUNE 2017





PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

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OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH & HUMAN SERVICES COMMISSION

SYLVIA HERNANDEZ KAUFFMAN
PRINCIPAL DEPUTY INSPECTOR GENERAL

I am pleased to submit the third quarterly report for FY 2017 to Governor Abbott, Executive Commissioner Charles Smith, the Legislature, and the citizens of Texas.

The Inspector General's office (IG) posted its highest recoveries to date in FY 17, recovering \$34.9 million in the third quarter, an increase of almost 50 percent over the second quarter. The IG also released its first inspection report; the topic, Opioid Drug Utilization, resulted in multiple recommendations and case referrals.

During the third quarter, the 85th Legislature passed two pieces of legislation, House Bill 2379 and House Bill 2523, which allow the IG to continue to grow its recoveries as well as increasing transparency, and permit the IG to use its peace officers in pursuing retailer fraud in SNAP. The Legislature also directed the IG to work with managed care organizations on several topics, including cost avoidance and waste prevention activities, special investigation units, and the lock-in program.

The office continues to move forward in its goal to become the best state-level IG in the nation by promoting transparency and accountability, and to achieve real results by fighting fraud, waste, and abuse in the delivery of health and human services across Texas. The IG's office looks forward to continuing to work with all of you on this important mission.

Respectfully,
Sylvia Hernandez Kauffman

Dollars recovered

Audit and Inspections

Provider collections (Medicaid and WIC) \$4,599,601

Investigations

Beneficiary collections
(SNAP, TANF, Medicaid, CHIP, WIC) \$20,327,475
Provider collections (Medicaid) \$869,388

Medical Services

Acute care provider collections \$1,708,263
Hospital collections \$6,542,201
Nursing facility collections \$825,080
Voluntary repayments and self-reports \$69,637

Total **\$34,941,645**

Questioned costs

Audit and Inspections

Provider overpayments (Medicaid and WIC) \$9,193,624

Investigations

Beneficiary overpayments
(SNAP, TANF, Medicaid, WIC) \$12,097,760

Medical Services

Nursing facility and hospital overpayments \$6,642,055

Total **\$27,933,439**

Funds put to better use

Audit and Inspections

WIC vendor disqualifications \$16,139

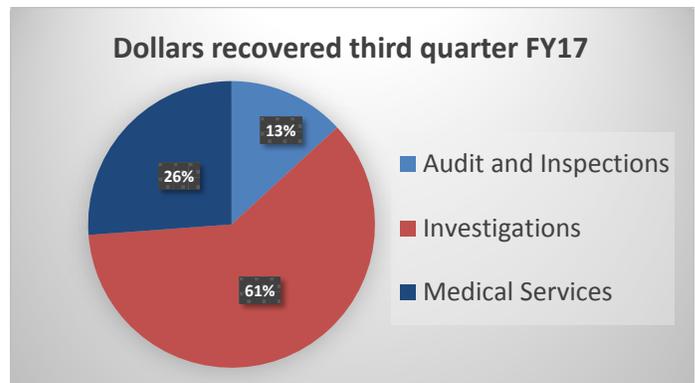
Investigations

Beneficiary disqualifications and
income eligibility matches \$943,768
Other beneficiary data matches \$2,268,788
Medicaid providers ordered
to pay restitution \$8,212,903

Medical Services

Pharmacy Lock-In \$51,075

Total **\$11,492,673**



How we measure results

An investigation, audit, inspection, or review that is performed, managed, or coordinated by the IG can result in:

Dollars recovered: Dollars recovered are overpayments that have been collected based on the results of an investigation, audit, inspection, or review.

Questioned costs (formerly listed as dollars identified for recovery): Questioned costs include overpayments identified for recovery during an IG investigation, audit, inspection or review due to: an alleged violation of a statute, law, regulation, rule, policy, or other authority governing the expenditure of funds or the provision of services; a finding that a cost is not supported by adequate documentation; or a finding that funds were not used for their intended purpose or were unnecessary, unreasonably spent, or wasteful.

Funds put to better use (formerly listed as dollars identified as cost avoidance): Putting funds to better use results in: resources being used more efficiently; an increase in available resources from reductions in inefficient expenditures; or avoidance of unnecessary expenditure of funds for operational, medical, contract, or grant costs.

These measures align with those used by the federal Government Accountability Office.

Overview

Section

1

Overview

Key Legislative Initiatives Passed

The 85th Texas Legislature passed key legislation impacting the work of the Office of the Inspector General:

House Bill (HB) 2379 by Representative Four Price clarified which legal services will stay at the IG and which will be transferred to HHS as a continuing part of the HHS System transformation. Legal functions directly related to the core IG business functions will remain at the IG. Legal services including open records, procurement, contracting, human resources, privacy, litigation support by the attorney general, and bankruptcy will be consolidated with the HHS System.

HB 2379 clarified that the HHS General Counsel is the final authority for legal interpretations related to statutes, rules, and commission policy on programs administered by the commission. It also clarified that the IG has independence on audits, inspections, and investigations.

The bill also addressed how managed care recoveries will be split between the IG and Medicaid Managed Care Organizations (MCOs) and Dental Maintenance Organizations (DMOs). Any funds recovered by an MCO, or through a joint effort between the IG and an MCO, will be split evenly between the MCO and the IG after the federal share is deducted. Any funds identified and recovered solely by the IG will be retained 100 percent by the IG. The IG will provide additional guidance to the MCOs on what information is required for the written notice to the IG on a case of fraud, waste or abuse.

HB 2379 also increased transparency by requiring that a final report for all inspections be available to the public. Like audits and investigations, inspection work papers will remain confidential.

The Medicaid Fraud and Abuse Detection System (MFADS) statute was updated by the bill, allowing for other technologies outside of a “neural network” to be used to identify and deter fraud in Medicaid.

House Bill 2523 by Representative Sarah Davis allows IG peace officers to pursue cases in the Supplemental Nutrition Assistance Program (SNAP) and Temporary Aid to Needy Families

Key quarterly results

- Recovered nearly \$35 million in state and federal funds.
- Completed three Fraud Detection Operations, two for pharmacy and one for durable medical equipment, which led to seven investigations (four full-scale and three preliminary) being initiated.
- Produced first inspection report on opioid drug utilization.
- Issued three audit reports, including an informational audit report on dental service organizations.
- Answered approximately 8,300 calls to the Integrity Line reporting fraud, waste, and abuse.
- Screened more than 18,000 individuals seeking to enroll or validate their enrollment in Texas Medicaid.
- Reviewed 14,195 hospital claims.
- Reviewed 22 nursing facilities.
- Completed 379 Medicaid provider full scale and preliminary investigations cases.
- Excluded 69 providers.

(TANF) programs. This allows the IG to receive and share criminal intelligence with local, state, and federal law enforcement agencies and partner with other law enforcement agencies on fraud task forces. The IG will be able to increase the timeliness of criminal investigations and expedite criminal cases to district attorneys for prosecution, which should increase recoveries and cost avoidance.

Senate Bill 894 by Senator Dawn Buckingham extends the time frame for hospitals to repay overpayments or debts identified in an investigation to 90 days. Hospitals currently have 30 days from the notice to request an appeal, and 60 days from the notice to pay if they do not appeal.

Budget Riders

Article II in the appropriations bill also has multiple budget riders that direct the IG's office to work on several reports and collaborations with managed care organizations:

Rider 160 directs the IG to collaborate with MCOs to expand appropriate use of the Lock-in Program, which restricts an individual's access to a single designated pharmacy, to maximize savings and prevent substance abuse. The IG has already been working with MCO stakeholders to make changes to the Lock-in Program that should assist with this directive.

Rider 167 requires the IG to collaborate with Medicaid and CHIP MCOs to review cost avoidance and waste prevention activities employed by MCOs throughout the state, including strategies to prevent waste, recover overpayments, reduce potentially preventable events, and conduct internal monitoring and audits. The review will also consider the effectiveness of strategies employed by MCOs to prevent waste and the adequacy of current functions. The IG will submit a report to the Legislative Budget Board (LBB) and the governor by March 1, 2018, on its findings and recommendations for performance measures related to cost avoidance and waste prevention activities.

Rider 168 requires the IG to develop recommendations in collaboration with Medicaid and CHIP MCOs for the composition and activities of Special Investigation Units (SIUs). The IG will submit a report to the LBB and governor by March 31, 2018, on its findings and recommendations.

Rider 192 directs the IG to develop a methodology to validate funds recovered through investigations, audits, utilization reviews, and inspections which offset funds which would otherwise be expended by the state. The IG will submit the methodology to the LBB by February 1, 2018.

Stakeholder Outreach

In May 2017, the Deputy IG for Medical Services addressed members of the Texas Association for Home Care and Hospice at their annual conference in Austin. The IG presented an update on Division

of Medical Services (DMS) activities and an overview of the medical records review process and time frames.

Also in the third quarter, the DMS Utilization Review (UR) Unit hosted its quarterly stakeholder meetings for nursing facility and hospital providers. Goals of these meetings are to promote discussion and communication. Providers are updated on IG UR activities and agenda items include responses to questions and education.

IG leadership also met with key lawmakers as the Legislature continued its session, including Senators Dawn Buckingham and Brandon Creighton; and Representatives Richard Raymond, Sarah Davis, John Raney, and Giovanni Capriglione.

Risk Assessment Workgroup

The IG formed a workgroup to consolidate existing IG risk assessments into a single IG collaborative risk methodology. The workgroup, which has met weekly since April, compiled an inventory of almost 200 programs and services within the HHS System and is developing a risk assessment methodology to strengthen the IG's ability to identify potential fraud, waste, and abuse. The workgroup's efforts will lead to recommendations IG leadership can use to meet its strategic goals and maximize its use of available resources to address higher-risk HHS programs, providers, and contractors. In addition to using the risk assessment to address high-risk programs and providers, the IG will also continue to monitor all HHS programs using random sample reviews.

Dental Service Organization Informational Report

In May, the Audit Division issued an informational report on dental service organizations (DSOs), which are management service companies that administer business support services to dentists and dental practices. Although DSOs do not contract exclusively with Medicaid and CHIP providers, studies have shown DSO-supported providers have higher Medicaid and CHIP participation rates than providers not supported by DSOs.

Overview

The informational report identified several areas that may warrant further review, including a federal investigation that led to one DSO (not operating in Texas) being banned from participating in Medicaid for five years.

First Inspection Report Published

The Inspections Division published its first inspection report, “Opioid Drug Utilization: Texas Medicaid Efforts to Reduce Prescription Opioid Abuse and Overutilization,” on May 30, 2017. In 2015, the Texas Medicaid program paid over \$33.3 million to fill opioid pain medication prescriptions for more than 426,000 Medicaid patients.

To conduct the inspection, Inspectors relied upon the federal Centers for Medicare and Medicaid Services (CMS) best practices, and Centers for Disease Control (CDC) recommendations for guidance. The report highlights issues and recommendations related to incorporating the CDC recommendations in pharmacy point-of-sale edits and use of the Prescription Monitoring Program (PMP) database. The PMP, overseen by the Texas State Board of Pharmacy, collects and monitors prescription data for all Schedule II, III, IV, and V controlled substances dispensed by a Texas pharmacy or to a Texas resident from an out-of-state pharmacy. In response to the inspection, HHS Medicaid and CHIP Services Department agreed to recommendations which will help

Fraud, waste, and abuse referrals

Home health agencies / personal attendants	39.2%
Physicians (group or individual)	13.4%
Home health PCS/CCP	6.3%
Dental	5.3%
Pharmacy	4.7%
Nursing home	4.5%
Adult day care	3.5%
Hospital/clinic/surgical center	3.5%
Durable medical equipment	2.6%

These are the top fraud, waste, and abuse allegations by provider type that were received by the IG for the third quarter of fiscal year 2017.

identify and reduce prescription opioid abuse and overutilization. Additional information about the issues and recommendations addressed in the report is in Section 4, Inspections Division.

Texas Fraud Prevention Partnership Generates Cases

The IG continued to strengthen the Texas Fraud Prevention Partnership in the third quarter, meeting with MCOs and DMOs that serve Medicaid clients across Texas. Meetings held with MCO and DMO subject matter experts provided an opportunity to share information on fraud, waste, and abuse schemes and trends occurring in Texas, and provided additional data and information to help focus our fraud detection operations. This data and information sharing supports joint Medicaid program integrity efforts and enhances IG efforts to provide all MCO and DMO Special Investigative Units with the latest tools and best practices for prevention, detection, and investigation of fraud, waste, and abuse in Texas Medicaid.

As part of the TFPP, during the third quarter the IG conducted three Fraud Detection Operations, which are cross-divisional efforts that focus on different areas of potential vulnerability affecting Medicaid expenditures. In March 2017, the fraud detection operation focused on pharmacy providers in the Dallas area; in April 2017, the focus was on durable medical equipment suppliers in Austin and Houston; and in May 2017, the IG conducted another fraud detection operation related to pharmacy providers in multiple regions of Texas.

Fraud detection operations produce valuable



Fraud deterrence: This chart shows a significant drop in pharmacy billing after an IG pharmacy operation.

results including the opening of preliminary and full-scale IG cases; referrals to other divisions within IG for audit, inspection, or medical review; referrals to outside agencies such as MFCU and the Texas Medical Board; and education letters to providers. The operations this quarter led to the opening of four full-scale and three preliminary investigations, five referrals, and two education letters.

The IG Data and Technology division supported three Fraud Detection Operations (FDOs) during this quarter focused on Pharmacy and Durable Medical Equipment services. Though the support often stays behind the scenes, significant cross-team collaboration and analytics work make such an objective, data-driven endeavor possible. Leading up to the FDOs, intelligence and data analysts research claim reimbursement policies, gather input from subject matter experts, and collect information on known provider schemes. Algorithms are developed from the knowledge obtained and applied to vast quantities of claims data, resulting in an outlier list that offers detailed information on suspicious billing patterns. The process of supporting FDOs is a key function of Data and Technology and has shown to be a promising avenue in contributing to the IG's overall mission.

Theory of Constraints Results in Increased Recoveries

Theory of Constraints is a methodology used at the IG to analyze and improve existing workflow processes. During the quarter, process improvement work continued in the General Investigations (GI) and Audit divisions. GI has now fully integrated the referral review process into its business work flow. This process continues to drive the number of quality cases submitted to investigators for full review and has resulted in more focused investigative work on cases that generate improved results. The IG Audit division focused on improvement in report writing by developing a streamlined approach that synchronizes resources with the goal of reducing the number of days needed to produce a draft

report. Target goals have been established and similar streamlining measures are being drafted for the planning and field work phases of the Audit cycle.

Professional Development Guides Staff Improvement

The IG improves organizational effectiveness by promoting individual competency regarding the various HHS services that the IG oversees, the skills necessary to most effectively and efficiently conduct their essential job functions, and IG policies, procedures, and resources.

This quarter, the IG launched a weekly series of HHS Programs and Workplace Skills training sessions. The HHS Programs sessions look at the details of eligibility, services, funding, and provider obligations as related to IG oversight responsibilities. The Workplace Skills sessions focus on improving communication, time management, and productivity. The IG also allocated time and resources in the third quarter on the creation of an improved and expanded New Employee Orientation to be implemented in FY 18. This program will provide new staff with detailed information about the roles and responsibilities of each division and how they interact both with one another and within the greater HHS system; information on what the IG is responsible for overseeing in Texas, including Medicaid, Eligibility Services, and Managed Care; and other relevant operational policies and resources, such as human resource requirements and benefits; IG-wide procedures; and resources to assist with questions around technology, ethics, and the work environment.

Also, during the third quarter of FY 2017, the Division of Medical Services (DMS) Nursing Facility Utilization Reviews (NFUR) staff held new-hire training on May 1-5, 2017. This was a weeklong training for nurses new to the NFUR team and included policy and procedure review, communication exercises for onsite interactions, NFUR computer application walkthroughs, and hands-on medical record review exercises and inter-rater reliability introduction.

Overview

Calls with Other States Support Innovation

The IG continues to hold monthly calls with other states' Medicaid and public assistance program integrity organizations to discuss experiences, successes, and share best practices. The calls focus on Medicaid program integrity efforts that produce the greatest results, and is driving efforts during the "Year of Innovation" at the IG. During this quarter, innovation calls were held with Pennsylvania, Ohio, Michigan,

Wisconsin, Georgia, Tennessee, Minnesota, and Missouri.

Among the best practices implemented from the calls are the use of contractors to monitor improper Medicaid payments that staff can't regularly cover; standardizing the enrollment process for all Medicaid provider types; and creating a Program Integrity Group with stakeholders from across the state Medicaid agency and other related state agencies to discuss program integrity and policy issues.

Medicaid Program Integrity Spotlight: Dental Service Organizations

Section

2

Medicaid Program Integrity Spotlight: Dental Service Organizations

Why the IG Compiled This Report

The IG Audit Division issued an informational report on DSOs on May 31, 2017. Dental service organizations (DSOs) are management service companies that provide or administer business support services to dentists and dental practices. Examples of business support services offered by DSOs include human resources, marketing, facilities maintenance, procurement, and billing. DSOs may be associated with other business models that are sometimes referred to, broadly, as corporate dentistry.

In 2015, an estimated 7.4 percent of dentists in the country were affiliated with a DSO. Dentists who contract with a DSO are responsible for complying with professional standards and are accountable for all clinical decisions, regardless of who handles their business activities. In Texas, dentists are paid for services they provide to eligible Medicaid and Children's Health Insurance Program (CHIP) individuals through the Texas Medicaid and Healthcare Partnership (TMHP) for fee-for-service claims, or by dental maintenance organizations (DMOs) for managed care claims.

Due to the alleged influence DSOs may have on the delivery of services to Medicaid and CHIP populations in Texas, and due to the relative lack of public awareness about DSOs and their operations, the IG is issuing an informational report on DSOs.

What the IG Found

In order to gain an understanding of DSOs and how they support the delivery of dental services provided to Medicaid and CHIP-eligible individuals, the IG Audit Division compiled a broad array of information pertaining to DSOs.

Practice structures: Some DSOs are organized as internal management organizations among dental practices, but most are third-party management companies that contract with dental practices. DSOs are typically organized as corporate or limited liability companies owned by dentists, non-dentists, or private equity investors.

Operations in Texas: As of February 7, 2017, the Texas Secretary of State confirmed 129 DSOs were

registered in Texas, although some of the entities registered as DSOs appeared to be affiliates or subsidiaries of larger parent DSOs. In 2015, an estimated 15 percent of dentists licensed in Texas were affiliated with a DSO. Across all dentist age groups, DSO affiliation rates among Texas dentists exceeded the average national DSO affiliation rates.

Alleged influence on Medicaid and CHIP participation: DSO advocates state DSOs are able to create efficiencies that lower operating costs and therefore increase dental care access for underserved, lower income populations. In 2015, DSO-affiliated dentists had higher Medicaid and CHIP participation rates than dentists not affiliated with a DSO, and participation rates for DSO-affiliated dentists in Texas exceeded the average national DSO participation rates across all dentist age groups.

State payments: HHSC does not contract with DSOs, and therefore does not reimburse DSOs directly for Medicaid and CHIP dental claims. According to DentaQuest, one of two Medicaid and CHIP DMOs in Texas, DSO claims costs represented 10.8 percent of its approximately \$1.8 billion Medicaid costs and 12.5 percent of its approximately \$167 million CHIP costs from 2014 through 2016.

Oversight efforts and investigations: All states prohibit interference by unlicensed persons or entities with dentists' independent judgement, and most states, including Texas, do not permit unlicensed persons to practice dentistry. Concerns regarding DSO influence on the practice of dentistry have led to federal and state investigations, as well as proposed amendments to Texas law to help clarify the context of dental practice ownership.

Read the Full Report

This informational report, which is not an audit report under generally accepted government auditing standards, consists of non-audited information compiled by the IG Audit Division. It is available on the IG website at <https://oig.hhsc.texas.gov/>.

Investigations

Section

3

Investigations

The Investigations Division detects and deters fraud, waste, and abuse through timely, high-quality investigations. It is comprised of five directorates:

- General Investigations investigates allegations of overpayments to recipients of state benefit programs.
- Medicaid Provider Integrity investigates allegations of fraud, waste, and abuse by Medicaid providers.
- State Centers Investigative Team/Electronic Benefits Transfer investigates violations involving State Supported Living Centers staff, State Hospitals staff, and EBT trafficking.
- Internal Affairs investigates employee misconduct and contract fraud within the HHS System.

Each directorate plays an essential role in protecting the safety of residents at state hospitals and state supported living centers, the program integrity of HHS programs, and the appropriate expenditure taxpayer dollars. Over the last few months, the IG performed an in-depth evaluation of all Investigations Division directorates to identify opportunities for workflow efficiency, process improvements, policy enhancements, and training needs. The Investigations Division continues to improve the quality and timeliness of investigations, communication, and employee engagement.

General Investigations

GI staff communicates with HHS AES staff by regularly attending and presenting at regional Texas Works Advisor trainings to help AES

Investigations overpayment results

Period	Overpayment identified	Overpayment collected
FY 17 Quarter 1	\$10,881,932	\$5,461,971
FY 17 Quarter 2	\$9,185,977	\$5,443,064
FY 17 Quarter 3	\$12,097,760	\$21,196,863
FY 17 Total	\$32,165,669	\$32,101,898

Note: Overpayments can be identified and collected in different quarters.

Top GI accomplishments this quarter

- Recovered \$20,301,129 in overpayments.
- Identified \$8,583,078 for recovery.
- Referred 80 cases for prosecution and received 38 court dispositions.

identify fraud, waste and abuse. These meetings occurred in El Paso, Dallas, Grand Prairie, San Antonio, Austin, Pharr, and Fort Worth. GI staff is also available to AES staff to answer questions and provide guidance when a case worker is interviewing an applicant and suspects they are providing false information.

Sample cases completed in this quarter:

- A Supplemental Nutrition Assistance Program (SNAP) and Medicaid fraudulent overpayment of \$60,551 was identified by an AES Texas Works Advisor who suspected the absent parent was living in the home and earning income. The case was referred to the Guadalupe County District Attorney's Office for prosecution as theft.
- A SNAP, Medicaid, and Women, Infants, and Children program (WIC) fraudulent overpayment of \$35,541 was identified through a referral by USDA Food and Nutrition Services, which suspected the recipient was using her sister's address in Texas to collect benefits while she lived in Mexico with her husband and her two children. The case was referred to the El Paso County District Attorney's Office for prosecution as theft.
- A SNAP and Medicaid overpayment of \$87,090 was identified through a referral from an AES Texas Works Advisor who provided information that the recipient was not reporting his correct household income. The case was referred to the Harris County District Attorney's Office for prosecution as theft.

Medicaid Provider Integrity

MPI completed three separate IG Fraud Detection Operations regarding the following

Top MPI accomplishments this quarter

- Opened 482 cases and completed 379 cases.
- Transferred 105 cases to full-scale investigation.
- Referred 154 cases to the Attorney General's Medicaid Fraud Control Unit.
- Ended quarter with 162 open/active full-scale investigations.
- Average case processing time of 28.6 days for preliminary cases.

provider types:

- Pharmacy - March 2017 and May 2017;
- Durable Medical Equipment - April 2017;

These operations led to the opening of four full-scale and three preliminary investigations.

Sample case completed this quarter:

MPI completed an investigation on a pharmacy provider that was transferred to the IG Litigation Division for administrative enforcement and also referred to the Attorney General's Medicaid Fraud Control Unit for criminal investigation.

The investigation discovered that:

- Approximately \$6.7 million in Medicaid payments were made to this pharmacy between 2014 and 2017.
- 96 percent of the billed and paid prescriptions for this pharmacy were allegedly prescribed by one physician.
- During interviews with the alleged prescribing physician, the physician provided a sworn affidavit stating some of the Medicaid patients were not his patients, therefore he would have never written prescriptions. Some of the medications billed by the pharmacy were drugs the physician has never prescribed to any of his patients. Signatures on prescription forms did not belong to the alleged prescribing physician.
- Several Medicaid recipients' parents provided sworn statements identifying several medications that neither they, nor their children, have ever been prescribed or received.

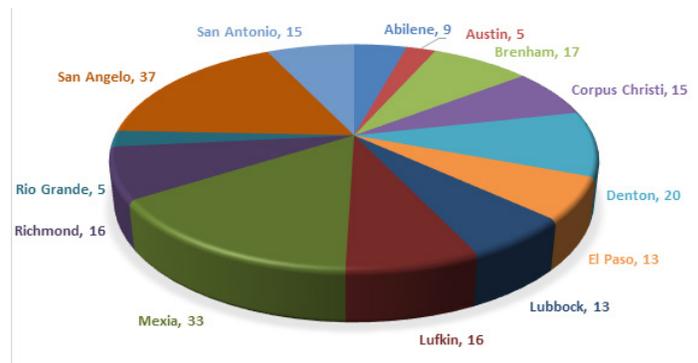
State Centers Investigation Team and Electronic Benefits Transfer

This directorate is comprised of two investigative areas. The Electronic Benefits Transfer (EBT) Unit's main focus is the investigation of SNAP authorized retailers. The State Centers Investigative Team's (SCIT) main focus is criminal investigations at State Supported Living Centers and State Hospitals involving abuse, neglect, and exploitation.

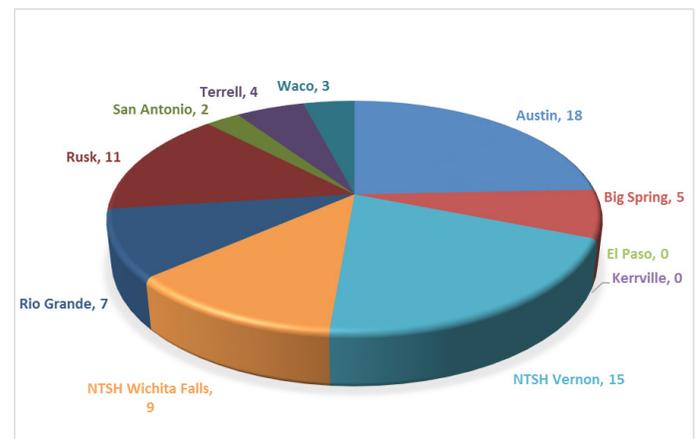
Sample cases completed this quarter:

- A joint EBT investigation involving two separate authorized SNAP retailers in West Texas resulted in 18 felony arrests in which \$22,367 in SNAP benefits were illegally trafficked for \$8,149 in cash. Other agencies participating in this investigation included Texas DPS Criminal Investigations Division; Texas DPS Texas Highway Patrol; United

SCIT investigations completed this quarter for state supported living centers



SCIT investigations completed this quarter for state hospitals



Investigations

States Department of Agriculture OIG; Homeland Security Investigations; El Paso Police Department; El Paso Sheriff's Office; and the El Paso District Attorney's office.

- A State Supported Living Center staff member engaged a client when he intervened in an altercation between two juvenile clients. The juvenile client stated he had redness and swelling on his chest following the intervention. The staff member was interviewed and stated the intervention technique that he used was not an approved technique taught by the facility when dealing with client behaviors. Video surveillance verified that an unapproved intervention technique was used. This case was filed with the county district attorney's office as an assault by offensive contact and enhanced to

Top SCIT/EBT accomplishments this quarter

- Opened 307 cases and completed 313 cases.
 - Presented 19 cases for prosecution.
 - Identified \$83,810 in overpayments and collected \$26,347 in recoupments.
-

a Class A misdemeanor due to the juvenile client being a disabled individual.

Internal Affairs

Internal Affairs conducted 121 investigations, 30 of which had Sustained allegations. The cases involved vital statistics fraud, contract fraud, employee misconduct, privacy breaches, and allegations of perjury and false information.

Audit

Section

4

Audit

The Audit Division conducts risk-based audits of contractors, providers, and HHS programs to reduce fraud, waste, and abuse throughout the HHS System. These audits examine the performance of medical service providers and HHS agency contractors, and provide independent assessments of HHS programs and operations, to name select activities.

Additionally, the Audit Division coordinates all federal government audits, manages the Recovery Audit Contractor (RAC) contract, and serves as the single point of contact with the Centers for Medicare and Medicaid Services for Medicaid Integrity Contractor (MIC) audits and Payment Error Rate Measurement (PERM) activities.

Overpayments identified and collected

This quarter, the Audit Division identified nearly \$9.2 million in overpayments through audits it managed. Additionally, approximately \$4.6 million in overpayments were collected as a result of audits the Audit Division performed, coordinated, or managed. The collected overpayments include overpayments reported by IG Litigation. Audit identified over \$22 million in overpayments for recovery and over \$19.6 million in overpayments have been collected in the first three quarters of fiscal year 2017.

Audit overpayment results

Period	Overpayment identified	Overpayment collected
FY 17 Quarter 1	\$8,552,234	\$9,178,242
FY 17 Quarter 2	\$4,262,601	\$5,855,487
FY 17 Quarter 3	\$9,193,624	\$4,592,823
FY 17 Total	\$22,008,459	\$19,626,552

Note: Overpayments can be identified and collected in different quarters.

Audit reports issued this quarter

The IG issued three reports this quarter. Final audit and informational reports can be accessed on the IG's website.

- Acute Care Utilization Management in Managed Care Organizations: Amerigroup

Top accomplishments this quarter

- Performed, managed, or coordinated audits that resulted in \$9.2 million in overpayments identified for recovery and \$4.6 million in overpayments collected.
- Issued three audit and informational reports.
- Initiated seven audits related to air ambulance providers, pharmacy vendors, pharmacy benefits managers, and hospital cost reports.

Texas, Inc. and Amerigroup Texas Insurance Company.

- Dental Service Organizations: Informational Report
- University of Texas Medical Branch at Galveston Hospital Cost Report

Acute Care Utilization Management in Managed Care Organizations: Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company

The Audit Division completed its audit of Amerigroup Texas, Inc.'s and Amerigroup Texas Insurance Company's (Amerigroup) acute care utilization management. The audit is one in a series of performance audits evaluating the effectiveness of MCO acute care utilization management practices in ensuring that health care services provided are medically necessary and efficient, and comply with state and federal requirements.

Amerigroup is an MCO in Texas, and is contracted to provide Medicaid STAR, STAR+PLUS, and CHIP health care services in most areas of the state. Audit results indicated that while Amerigroup's utilization management program related to prospective utilization review meets many contract, state, and federal requirements, and Amerigroup performs analysis of utilization management data to identify areas of improvement and to monitor program effectiveness, there are opportunities for Amerigroup to improve its utilization management function for acute care prior authorization. The Audit Division recommended that HHS require Amerigroup to strengthen its utilization

management functions related to timeliness of prior authorization determination notifications, data reliability, and staff training.

The HHS Medicaid and CHIP Services Department concurred with the Audit Division's recommendations, and will facilitate Amerigroup's development of a corrective action plan designed to improve its utilization management function.

Dental Service Organizations: Informational Report

Dental service organizations (DSOs) are for-profit management service companies that provide or administer business support services to dentists and dental practices. Due to the alleged influence DSOs may have on the delivery of services to Medicaid and CHIP populations in Texas, and due to the relative lack of public awareness about DSOs and their operations, the Audit Division issued an informational report on DSOs.

DSOs are typically organized as corporate or limited liability companies owned by dentists, non-dentists, or private equity investors, and may be associated with other business models that are sometimes broadly referred to as the corporate practice of dentistry. An estimated 15 percent of dentists in Texas are supported by DSOs, and there were 129 DSOs registered with the state as of February 2017. From fiscal years 2014 through 2016, one Medicaid and CHIP dental maintenance organization (DMO) reported that DSO claims costs totaled approximately \$210.7 million, which represented 10.9 percent of the DMO's \$1.9 billion total Medicaid and CHIP claims costs over the three-year period.

While there are no federal laws specifically regulating DSOs or the corporate practice of dentistry, most states, including Texas, do not permit unlicensed persons to practice dentistry. Concerns regarding DSO influence on the practice of dentistry have led to federal and state investigations, as well as proposed amendments to Texas law to help clarify the context and meaning of dental practice ownership.

The DSO informational report identified several areas of interest that may warrant further review, including a federal investigation that led

to one DSO being banned from participating in the Medicaid program for five years. The Audit Division may add DSOs to its list of potential audit topics in the next iteration of its two-year rolling audit plan.

University of Texas Medical Branch at Galveston Hospital Cost Report

The Audit Division completed its audit of the University of Texas Medical Branch at Galveston's (UTMB) Hospital cost reports. The audit is the first in a series of audits determining whether selected cost centers reported on the hospital cost report are accurate, allowable, and adequately supported according to the Centers for Medicare and Medicaid Services (CMS) and state requirements.

Providers participating in the Medicare program are required by federal and state law to submit information to report costs relating to health care services rendered to Medicare and Medicaid beneficiaries. Cost reports are submitted annually to CMS and are used as a basis for setting certain payment rates. Audit results indicated that the capitalization and depreciation expense cost centers reported on UTMB's hospital cost report for fiscal year 2014 were accurate, allowable, and adequately supported, and that UTMB was in compliance with applicable standards related to its IT system.

The Audit Division did not identify any reportable issues during the audit, and consequently did not offer HHS or UTMB recommendations for improvement.

New audit projects under way

Pharmacy audits

Objective: Determine whether the vendors properly billed the Texas Medicaid Vendor Drug Program and complied with contractual requirements and federal and state regulations, including Texas Administrative Code rules.

Background: The Texas Medicaid Vendor Drug Program provides statewide access to covered outpatient drugs for individuals enrolled in Medicaid, CHIP, the Children with Special Health Care Needs Services program, the Healthy Texas Women program, and the Kidney Health

Care program. The claims to be tested are fee-for-service claims from March 1, 2012, through February 28, 2015.

Hospital cost reports

Objective: Determine whether selected cost centers of the hospital cost report are correct and accurate according to applicable federal and state regulations.

Background: Hospital cost report data is required to confirm the eligibility of a provider to participate in Texas Medicaid or other HHS programs, and is used by HHS to determine Medicaid reimbursement rates. There are currently no other Medicaid audits being conducted of Texas hospital cost reports aside from this series of IG audits and Texas Medicaid and Healthcare Partnership audits of children's hospitals.

Air ambulance

Objective: Determine whether paid fee-for-service claims for air ambulance services of Texas Medicaid enrollees were billed in accordance with state laws, regulations, and the Texas Medicaid Provider Procedures Manual.

Background: In addition to enrolling with Texas Medicaid and obtaining licensure through the Department of State Health Services, air ambulance providers must submit documentation demonstrating medical necessity, the level of service provided, and the mode of transportation used. Air ambulance transport services are covered only if the client's medical condition requires immediate and rapid ambulance transportation that could not have been provided by standard automotive ground ambulance. In fiscal year 2016, fee-for-service claims paid to air ambulance providers totaled approximately \$ 11.5 million.

Pharmacy benefits manager

Objective: Determine whether selected MCOs' delivery of pharmacy benefits through a pharmacy benefits manager (PBM) are in compliance with applicable regulations and guidelines, and whether the services support HHS program objectives and allow for the objective evaluation of PBM performance.

Background: In Texas, pharmacy benefits delivered to Medicaid and CHIP managed care members are processed by PBMs, which are for-profit, third-party administrators of prescription drug programs. All MCOs in Texas subcontract with a PBM to process prescription claims and are responsible for the performance of their PBMs. The PBMs contract and work with pharmacies that dispense medications to Medicaid and CHIP managed care members. In fiscal year 2016, Texas Medicaid paid approximately \$3.7 billion for over 48 million prescriptions.

Audit projects in progress

The following audits are currently in progress. A list of audits in progress and audit topics the IG plans to initiate can be found in the two-year rolling audit plan located on the IG's website.

- Acute care utilization management in MCOs
- Pharmacy audits
- Assessment and evaluation practices at a long-term care nursing facility
- Speech therapy providers
- Durable medical equipment claims
- IT security assessments
- Residential child care facility
- Hospital cost reports
- STAR+PLUS enrollment
- HHS processes for analyzing and preventing eligibility determination errors

Inspections

Section

5

Inspections

The Inspections Division conducts inspections of Health and Human Services programs, systems, or functions focused on systemic issues and provides practical recommendations to improve effectiveness and efficiency to prevent fraud, waste, and abuse, and to ensure the greatest benefit to the citizens of Texas. The Division also conducts inspections of the Women, Infants, and Children program.

First Inspections Report Published

During the third quarter, the Inspections Division published its first inspection report – Opioid Drug Utilization: Texas Medicaid Efforts to Reduce Prescription Opioid Abuse and Overutilization. Opioids are controlled substances commonly prescribed for the relief of pain. Their use, however, comes with significant risk.

The inspection identified issues related to pharmacy point-of-sale edits and made recommendations to address them. The inspection also identified that Texas Medicaid providers could better utilize the Prescription Monitoring Program (PMP) database and made recommendations to address that issue. IG also suggested that recommendations of the federal Centers for Disease Control be incorporated into specific edits. The HHS Medicaid and CHIP Services Department agreed with all recommendations.

The full report is available on the IG’s website at: <https://oig.hhsc.texas.gov/>.

Reports for two other inspections were recently drafted, and address Medicaid pediatric dental sedation, and speech therapy.

Upcoming Inspections

The following inspections are currently in progress:

- Community Attendant Services (CAS)
- Electronic Visit Verification (EVV)
- Medicaid Payments for Deceased Recipients.

Community attendant services

Purpose: Determine if community attendant services (CAS) billed to Medicaid are rendered to consumers in accordance with program requirements. Community attendant services are delivered as part of Medicaid long-term services and supports.

Top accomplishments this quarter

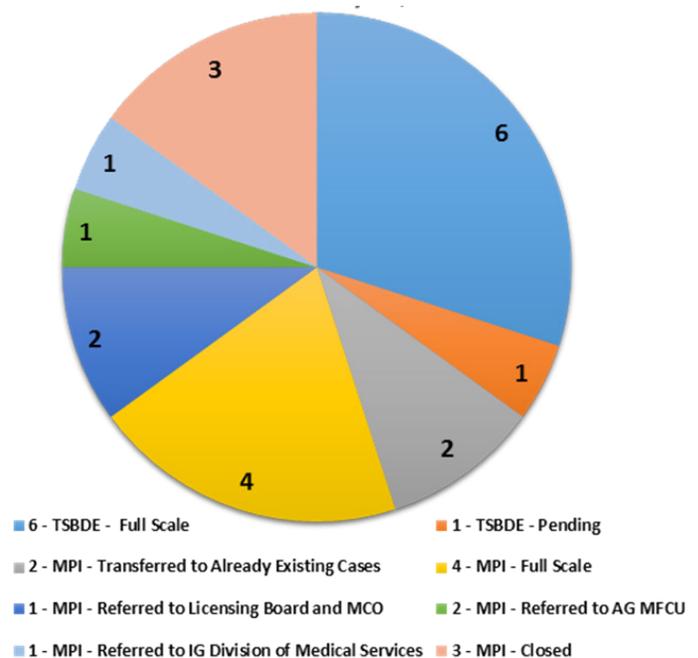
- Published opioid drug utilization report.
- Completed inspections related to Inspector General Medicaid Recovery Process (Suspense Account) and Treasury Offset Program. Reports are pending.
- WIC FPU completed 156 compliance buys, and identified \$16,139 in cost avoidance and \$2,176 in civil monetary penalties.

Objectives: Determine how the Community Support Section of Access and Eligibility Services oversight of the CAS program ensures services are being rendered and properly billed; and determine whether home health agencies are effectively monitoring whether personal attendant services billed are actually provided to consumers.

Electronic Visit Verification

Purpose: Determine the effectiveness of the EVV system at verifying that service visits occur and that confirmation that services were provided can be

Inspection referrals as of May 31, 2017



verified.

Objectives: Determine the effectiveness of the EVV Provider Compliance Plan, and determine the percentage of Medicaid claim details matched with EVV visit data.

Medicaid payments for deceased recipients

This project is a follow-up to a federal inspection.

Purpose: Determine how Texas Medicaid can strengthen processes used to identify and recoup payments made to deceased participants.

Objectives: Determine how Texas Medicaid identifies deceased recipients, and if Texas Medicaid effectively recoups payments for deceased recipients.

Reviews

Section

6

Reviews

The Division of Medical Services conducts claims and medical record reviews on a variety of health and human services, including acute care utilization, hospital utilization, nursing facility utilization, and pharmacy lock-in. The division also provides clinical consultation to the Investigations, Audit, and Inspections divisions on dental, medical, nursing, and pharmacy services.

Medical Services is comprised of three units:

- Clinical Subject Matter Expert
- Record Review, Resolution, and Recovery
- Quality Review

The Clinical Subject Matter Expert (CSME) team includes a physician, dentist, dental hygienist, and pharmacist who provide clinical expertise to IG investigations, audits, inspections, special collaborative initiatives, and IG legal staff. The CSME team also communicates with MCO and DMO compliance departments to educate and to clarify questions regarding clinical documentation and medical/dental policy interpretation.

The Record Review, Resolution, and Recovery team (RRRT) identifies patterns of aberrant billing, performs federally required Surveillance Utilization Reviews, and collects Medicaid overpayments. RRRT nurse analysts research provider billing and review medical records to determine whether claims and services are appropriate. RRRT includes the Research Analysis and Detection (RAD) recovery team, RAD support, and the Targeted Query team which develops and runs targeted data queries to identify acute care billing outliers.

The Quality Review team conducts retrospective utilization review of hospitals and nursing facilities,

Reviews overpayment results

Period	Overpayment identified	Overpayment collected
FY 17 Quarter 1	\$1,198,560	\$11,848,765
FY 17 Quarter 2	\$7,774,899	\$9,458,812
FY 17 Quarter 3	\$6,698,753	\$9,145,181
FY 17 Total	\$15,672,212	\$30,452,758

Note: Overpayments can be identified and collected in different quarters.

Top accomplishments this quarter

- \$6,542,201 recovered from Hospital Utilization Reviews
- \$666,324 recovered from Nursing Facility Utilization Reviews
- \$1,679,200 (fee-for-service Medicaid) RAD dollars recovered
- 14,195 hospital claims reviewed
- 22 nursing facilities reviewed

and administers the pharmacy Lock-In Program. The Utilization Review team performs onsite and desk reviews of hospital claims and nursing facility Minimum Data Set forms for appropriate billing. Lock-In Program staff work with managed care organizations to monitor recipient use of prescription medications and acute care services. Specific indicators will trigger Lock-In Program intervention, locking a recipient into one pharmacy location, and locking a fee-for-service recipient into a single primary care provider.

Lock-in Program MCO Survey

The Lock-in Program at the IG's office works with managed care organizations (MCOs) to monitor recipient use of prescription medications and acute care services, and intervenes by locking a recipient into one pharmacy location (and/or primary care provider for fee-for-service recipients). The Lock-in Program restricts or locks a Medicaid recipient to a designated pharmacy when Medicaid services, including drugs, are dispensed at a frequency or amount that is duplicative, excessive, contraindicated, or when recipient actions indicate abuse, misuse, or fraud. MCOs refer members to the Lock-in Program through the IG's online reporting system. Lock-in Program staff review the referral for indications of abuse, misuse, or fraud. MCOs with a high referral accuracy rate may participate in the IG's Automatic Lock-in Program, under which an MCO applies IG-established lock-in criteria and recommends the lock-in action. The Lock-in Program accepts the referral without additional review and activates the lock.

Since the statewide expansion of Texas Medicaid managed care, the IG has worked with MCOs to streamline the lock-in process. Based on a November 2016 survey of MCOs and a review of other states' lock-in programs, the Lock-in Program updated its lock-in criteria and simplified the process by:

- Creating a single form with a single set of criteria for the 12-month and 24-month lock-in periods (instead of two forms and two sets of criteria) to offer the most opportunities in a given time frame to make referrals to the program.
- Lowering the threshold for the number of unaffiliated pharmacies, prescribers, and prescriptions to allow for the referral of additional clients.
- Allowing MCOs to refer to certain patterns of prescriptions with abuse potential (opioids, benzo sedative hypnotics and/or muscle relaxants), or an excessive morphine equivalent dosing to substantiate overlapping or duplicative opioid treatment. This will allow MCOs to better protect members and leverage data provided by their pharmacy benefit managers.
- Adding criteria for referral when Medicaid clients visit multiple emergency rooms in a 90-day period that resulted in opioid prescriptions to identify possible misuse without restricting access.

Targeted Queries Net Results

In May 2017, DMS collected \$1,244,581 from providers who did not meet Texas Medicaid policy regarding spell of illness based on a targeted query. Texas Medicaid places a 30-day annual limit on inpatient stays for adults per spell of illness. Except for specific diagnoses or transplants, hospital admissions must be separated by at least 60 consecutive days since the previous admissions' last day of discharge.

Other notable recoveries by DMS based on targeted queries during the third quarter included \$265,939 from providers who billed for deceased or ineligible clients, and \$87,877 from providers who billed for outpatient services for clients who

were inpatients. The team also recovered \$21,490 from a therapy provider and \$12,234 from a dental provider for inadequate or substandard documentation.

The DMS research specialists develop and use targeted queries (a scheduled query of data from the Medicaid Fraud and Abuse Detection System) to identify patterns of incorrect billing, such as spell of illness, therapy provided after the date of death, and multiple "once-in-a-lifetime" events for the same recipient.

Also in the third quarter of FY 2017, DMS recovered \$140,823 from an air ambulance transportation provider for:

- Failure to submit requested documentation.
- No prior authorization for nonemergency air transport.
- Duplicate billing.
- Insufficient documentation to verify medical necessity.

Hospital Utilization Reviews

The IG Hospital Utilization Review (HUR) team of registered nurses performs retrospective reviews of paid inpatient claims submitted by Medicaid approved hospitals. Claims are selected for review by a statistically valid random sampling methodology and/or focused case selection and may include:

- Readmissions up to 30 days.
- Ambulatory surgical procedures billed on inpatient claims.
- Questionable admissions or claims coding identified by other entities.
- Admissions identified through HUR review as potential quality of care concerns.
- Diagnosis Related Group (DRG) payments made to freestanding rehabilitation facilities.
- Inpatient claims for admissions to children's hospitals and freestanding psychiatric facilities.
- Day or cost outlier payments.
- Any other DRG or claims submission errors.

The HUR team reviews claims to validate medical necessity for inpatient admission, correct DRG assignment, and quality of care. Ninety-eight percent of these reviews are performed as desk

Reviews

reviews.

In the third quarter of FY 2017, the HUR team reviewed 14,195 inpatient claims submitted by 310 hospitals, and recovered \$6,542,201.

Nursing Facility Utilization Reviews

The Nursing Facility Utilization Review (NFUR) team of registered nurses conducts retrospective, unannounced, onsite reviews of Minimum Data Set (MDS) assessments submitted by nursing facilities to verify that the MDS reflects residents' actual clinical condition and functional capabilities during the time period the assessment was performed and services claimed to have been provided.

During the review, the NFUR team identifies problems, trends, coding errors, and inconsistencies between the submitted MDS and clinical record documentation. In addition to reviewing the MDS and clinical record documentation, the NFUR team interviews staff, conducts observation rounds, and seeks resident and/or family input on the care provided.

The team communicates findings and educates nursing facility staff on identified issues. If potential fraud, waste, or abuse is identified, the

NFUR team will make referrals to the IG Medicaid Provider Integrity unit, IG Chief Counsel, or other external agencies (e.g., professional boards), for further review.

In the third quarter of FY 2017, the NFUR team recovered \$666,324. All dollars relate to fee-for-service reviews.

Utilization Review Stakeholder Meetings

The DMS Hospital Utilization Review Unit held its quarterly nursing facility and hospital stakeholder meetings on March 13, 2017, and April 17, 2017, respectively. To hospital stakeholders, DMS staff presented information on the appropriate billing process for outpatient procedures and introduced a new medical records submission process via secure SharePoint to facilitate paperless reviews.

To nursing facility stakeholders, DMS staff presented and discussed status of onsite reviews; mismatch issues between information submitted on the Long Term Care Medicaid Information form and information submitted on the Minimum Data Set form; and planned revisions to the rules concerning nursing facility utilization review.

Support Services

Section

7

Chief Counsel

The Chief Counsel Division provides dedicated attorneys for the Investigations, Audit, Inspections and Medical Services divisions, and advises the IG on a wide array of complex topics centered on our mission to pursue and take enforcement actions against fraud, waste, and abuse in the state's health and human services system.

Chief Counsel provides close coordination with HHS System legal on a regular basis, including regularly scheduled meetings to foster communication between the attorneys at the IG and the attorneys at the HHS System, and between IG executive leadership and legal experts at the HHS System.

The Chief Counsel Division is comprised of three units:

- General Law
- Litigation
- Special Counsel

The General Law unit is responsible for providing legal support on topics such as Medicaid provider enrollment and other legal questions that impact the mission of the IG. The unit also assists with the process of checking various federal databases to ensure integrity in the Medicaid system, and taking action against providers not eligible to provide services in the Medicaid system.

The Litigation unit is responsible for determining and imposing administrative actions and sanctions based on the enforcement activities of the Investigation and Audit divisions. Following the imposition of certain sanctions, the provider has a right to an informal resolution meeting or an appeal. In those cases, Litigation will conduct the informal meeting and will litigate any appeal before the HHS Appeals Division or the State Office of Administrative Hearings.

The Special Counsel unit provides support to the main functional areas of the IG: Investigations, Audit, and Inspections.

Provider enrollment data matching

42 CFR §455.416(c) and §455.101 require states to match enrollment data to several federal databases containing lists of providers who cannot be enrolled in Medicaid. Chief Counsel, with the support of IG's Fraud Detection and Investigative Strategies and Provider Integrity Research units, developed a data matching process and has, through the first three quarters of FY 17, terminated 23 providers who are ineligible to participate in Medicaid and initiated the removal of another 9 from databases.

Chief Counsel has also initiated the exclusion of three providers/owners/principals who have been excluded by the federal OIG from participation in any federal health care program. Many of the exclusion matches on the federal list have already been excluded in Texas by the Chief Counsel Litigation Section. Chief Counsel will continue to work with the Texas Medicaid & Healthcare Partnership to ensure that providers/owners/principals found on the Death Match Database are excluded.

States are also required to report certain cases to those federal databases. In addition to the 23 terminations discussed above, Chief Counsel reports terminations to the appropriate databases and has reported 64 terminations to the Centers for Medicare and Medicaid Services in the first three quarters of FY 17.

Chief Counsel has had numerous conversations with CMS in furtherance of these projects and has received very positive feedback. In fact, CMS reached out to Chief Counsel for feedback to improve existing databases and the matching process.

Legislative Support

Attorneys in the division helped the IG during the 85th Texas Legislature by crafting draft language, draft bill analysis, and being resource witnesses at legislative hearing and briefings during the session.

The Data and Technology Division supports the IG Audit, Investigations, Inspections, and Operations Divisions by implementing tools, solutions, and innovative data analytic techniques to streamline operations and increase the identification of fraud, waste, and abuse in the Texas Health and Human Services programs. Efforts have continued to implement dashboards across the IG this quarter with the release of dashboards for the Inspections and Audit areas. The dashboards provide timely and relevant information to these business areas, which will improve awareness of critical projects within the IG. Other endeavors related to organizational efficiency are the development of new automated reports for better identifying providers terminated by other states, and for timely information on cases co-identified by IG and MFCU. These automated reports reduce the amount of staff time required to create the reports manually, and offer a greater detail of information than was previously possible.

Projects spanning multiple types of healthcare

claims, SNAP benefits, and agency processes support IG actions, and aid in the identification of processes, entities, and expenditures that may warrant further review. DAT is increasing its focus on managed care encounters, in conjunction with fee-for-service claims, as part of the overall strategy for the development of IG algorithms. These new and revised approaches in IG algorithm development, data analysis, and intelligence efforts have led to the identification of outliers that were reviewed during this quarter for the Fraud Detection Operations related to Pharmacy and Durable Medical Equipment.

Additionally, to expose staff to new methods in analyzing data, several Data and Technology staff attended The University of Texas Summer Statistics Institute, a 4-day course covering the application of various statistical concepts, algorithms and analytics software. Staff also attended training courses to enhance programming language skills and data analysis techniques.

Operations

The Operations Division works to build an infrastructure for the IG that supports enhanced efficiency and effectiveness for investigations, audits, reviews, and inspections; promotes responsibility and accountability; and provides increased communication and transparency both within the organization and to external stakeholders. Operations supports IG policy and procedure development and publication, staff training, contract management, organizational development, budget and fiscal management, business operations and facilities coordination, office administration, and the coordination of strategic planning. Additionally, the Integrity Line (responsible for receiving and processing reports alleging fraud, waste, and abuse within HHS programs) and the Program Integrity Research team (responsible for conducting screenings for providers enrolling in Medicaid, CHIP, and other HHS programs) are housed within Operations.

Program Integrity Research

In this quarter, the Program Integrity Research (PIR) team collaborated closely with HHS's Medicaid/CHIP Services Division) and the Texas Medicaid & Healthcare Partnership to design system enhancements. These improvements to the online enrollment portal are expected to improve the online enrollment experience for providers and incorporate changes to allow new provider types to enroll through the online portal, including Long Term Support Services) and Children's Health Insurance Program providers. Additionally, the team worked closely with the same set of partners to begin the process of streamlining Texas' provider enrollment application to omit questions that provide minimal value in the enrollment process and to eliminate redundancy when possible.

The team has screened more than 18,000 individual providers across approximately 5,800 enrollment applications and conducted over 60 informal desk reviews for providers disputing

Operations

the denial of their enrollment application, all while maintaining a 99 percent compliance rate in meeting the statutorily mandated 10-day timeframe for completing screenings.

In accordance with Affordable Care Act requirements, PIR has nearly completed the retrospective fingerprint process for high-risk providers that enrolled between August 1, 2015, and December 31, 2016. For providers who were notified of the requirements but have not yet complied, termination proceedings will begin in the fourth quarter of FY 2017. Newly enrolling high-risk providers or those wishing to revalidate their enrollment will continue to be subject to fingerprint check requirements upon enrollment.

Integrity Line

During the third quarter of fiscal year 2017, the Integrity Line worked towards optimizing its



Policy and Publications

The Policy and Publications Division provides policy support for IG divisions and coordinates external communication with a variety of stakeholders. The division is comprised of three areas: Policy, Publications and Government Relations.

The Policy team assists other IG divisions with researching Medicaid policy and facilitating communications with HHSC for policy guidance. The Policy team also researches and writes issue briefs on health policy topics relevant to the IG. The Publications team supports the IG by facilitating the publication of IG reports and handling all media inquiries. The Government Relations team provides outreach

interviewing and call documentation processes. As a result, the Integrity Line answered nearly 8,300 calls (a 10 percent increase from the second quarter), entered more than 3,900 referrals, and dropped its average hold time to 1.58 minutes.

The Integrity Line team improved the recorded message and queue routing for callers in an effort to enhance the experience for callers seeking to report fraud, waste, and abuse.

IG University

The Strategic Operations and Professional Development division is finishing development of the core curricula for the IG's strategic training program, IG University. The process began with division and section focus groups determining the foundation for employee and organizational success through a comprehensive training plan. Full implementation of IG University will occur on September 1, 2017. All training within IG University is created with the goal of improving individual and organizational performance.

The IG is committed to strengthening each staff member's knowledge, skills, and abilities in all organizational areas. Periodic review and re-evaluation of the strategic training plan will ensure it addresses current needs, includes relevant material, updates staff on critical issues, and plans for the future.

and communication with legislators, the public, managed care organizations, and other agencies within the HHS System.

In the third quarter, the Policy and Publications division worked on the legislative session, facilitating testimony on the IG budget and legislation impacting the office. As discussed in the overview, the 85th Legislature passed multiple bills that will enhance the work of the IG and improve transparency and recoveries. The Policy team worked with the Audit division and HHSC to recommend liquidated damages resulting from an IG audit of MCO Special Investigative Units and began writing issue briefs and researching Medicaid policy issues for other IG divisions.



PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

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800-436-6184

If you suspect a provider or recipient of state benefits
is committing fraud, waste, or abuse
call the HHS Inspector General Integrity Line

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