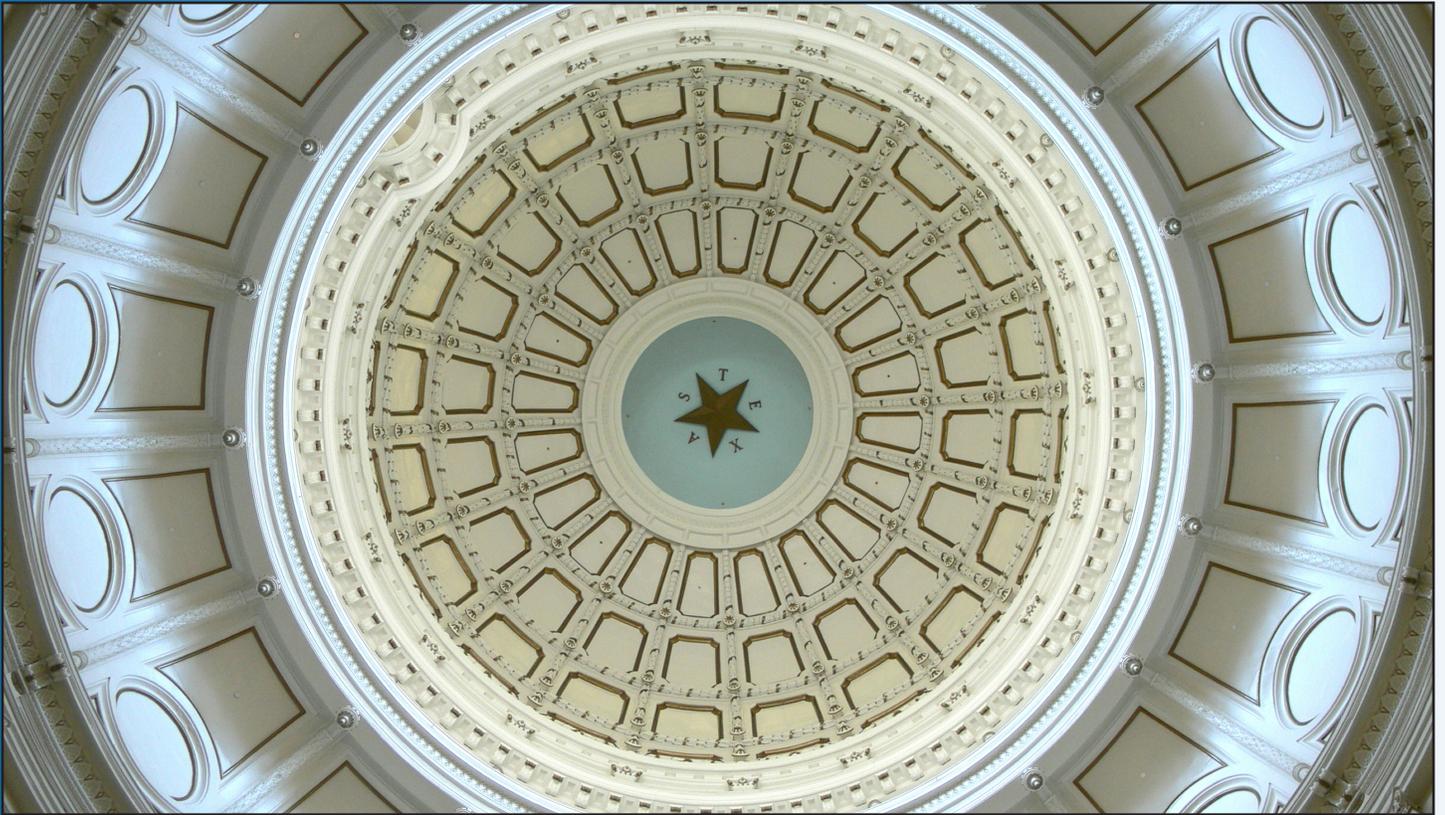


TEXAS HEALTH AND HUMAN SERVICES
INSPECTOR GENERAL



ANNUAL REPORT
FISCAL YEAR 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 Inspector General's annual report for fiscal year 2017 to Governor Greg Abbott, Executive Commissioner Charles Smith, the Legislature, and the citizens of Texas.

The Office of the Inspector General (IG) made great strides in the past year. IG recovered more than \$98 million in fiscal year 2017, a 15 percent increase from fiscal year 2016. Our Inspections Division, new to the IG, released its first two reports, on pediatric dental sedation and opioid drug utilization. The IG issued 41 audits that resulted in 83 recommendations to improve Health and Human Services agency operations and contract oversight. Our office also completed more than 19,000 investigations, and reviewed more than 50,000 hospital claims and 434 nursing facilities. The Texas Fraud Prevention Partnership, a first of its kind state-level public-private partnership, was created, and 10 Fraud Detection Operations were conducted, generating 35 cases and having a noticeable deterrent effect on the subject areas that were investigated. Internal process improvements have boosted efficiency in our Audit and Investigations divisions.

IG is also working to implement legislation passed by the 85th Legislature that allows the office to continue to share in recoveries with managed care organizations (MCOs) and use peace officers in pursuing SNAP retailer fraud. We also are working with MCOs on several legislative reports, on cost avoidance and MCO Special Investigative Units, due in fiscal year 2018.

The IG staff is dedicated to achieving the goal of ensuring fiscal integrity of HHS programs and ensuring the safety and well-being of beneficiaries. The IG will continue to achieve positive, demonstrable results in detecting, preventing, and deterring fraud, waste, and abuse in the delivery of health and human services across Texas in fiscal year 2018.

Respectfully,
Sylvia Hernandez Kauffman

Dollars recovered

Audit and Inspections

Provider collections (Medicaid, WIC) \$23,194,696

Investigations

Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC) \$32,536,769
 Provider collections (Medicaid) \$4,880,011

Medical Services

Acute care provider collections \$5,891,569
 Hospital collections \$27,549,491
 Nursing facility collections \$3,961,925
 Voluntary repayments and self-reports \$297,415

Total \$98,311,876

Questioned costs

Audit and Inspections

Provider overpayments (Medicaid, WIC) \$27,517,314

Investigations

Beneficiary overpayments (SNAP, TANF, Medicaid, CHIP, WIC) \$35,063,588

Medical Services

MCO overpayments identified by IG \$970,569
 Nursing facility and hospital overpayments \$23,509,078

Total \$87,060,549

Funds put to better use

Audit and Inspections

WIC vendor disqualifications \$5,364,338

Investigations

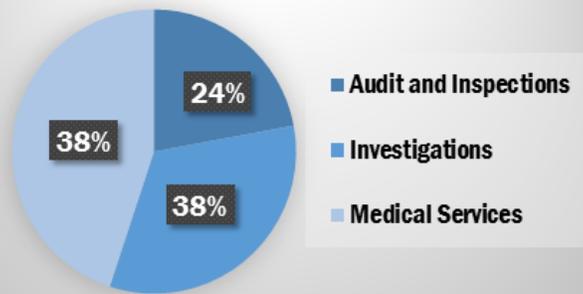
Beneficiary disqualifications and income eligibility matches \$4,327,593
 Other beneficiary data matches \$7,670,801
 Medicaid providers ordered to pay restitution \$29,610,855
 Reclaimed federal share (MPI) \$4,829,585

Medical Services

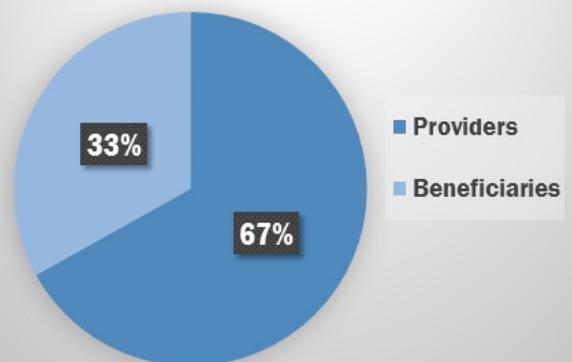
Pharmacy Lock-in \$210,673

Total \$52,013,845

Recoveries by division FY 2017



Recoveries by category FY 2017



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.

Fiscal year 2017 fourth quarter results

Dollars recovered

Audit and Inspections

Provider collections (Medicaid, WIC) \$3,558,047

Investigations

Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC) \$4,457,286
 Provider collections (Medicaid) \$857,596

Medical Services

Acute care provider collections \$2,490,251
 Hospital collections \$4,121,297
 Nursing facility collections \$580,530
 Voluntary repayments and self-reports \$55,563

Total \$16,120,570

Questioned costs

Audit and Inspections

Provider overpayments (Medicaid, WIC) \$5,508,627

Investigations

Beneficiary overpayments (SNAP, TANF, Medicaid, CHIP, WIC) \$8,492,962

Medical Services

MCO overpayments identified by IG \$554,794
 Nursing facility and hospital overpayments \$7,532,640

Total \$22,089,023

Funds put to better use

Audit and Inspections

WIC vendor disqualifications \$0

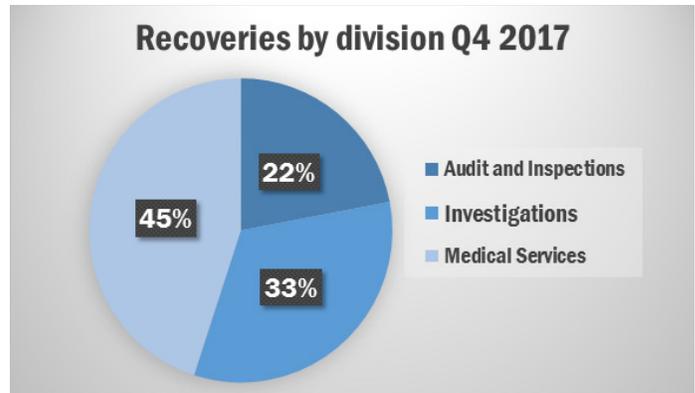
Investigations

Beneficiary disqualifications and income eligibility matches \$918,178
 Other beneficiary data matches \$1,771,470
 Medicaid providers ordered to pay restitution \$8,546,269
 Reclaimed federal share (MPI) \$4,829,585

Medical Services

Pharmacy Lock-in \$137,954

Total \$16,203,456



How we measure results

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

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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.

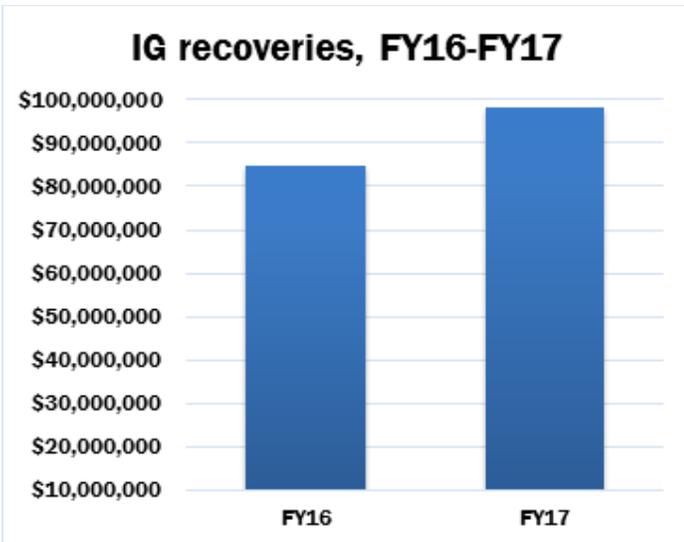
These measures align with those used by the federal Government Accountability Office.

Overview

Section

1

Overview



Fiscal year 2017 recoveries increase

In fiscal year 2017, a strong focus on innovation, process improvement and collaboration enabled the IG to increase its recoveries to \$98 million, a 15 percent increase over fiscal year 2016.

The Audit Division recovered \$23 million, which was 24 percent of the IG recoveries. Investigations recovered \$37 million, which was 38 percent of IG recoveries.

The Division of Medical Services (DMS) completed 50,360 hospital reviews and performed 440 nursing facility reviews. DMS recovered \$37.7 million, which was 38 percent of IG recoveries.

Innovation

Texas Fraud Prevention Partnership created

Beginning in October 2016, the IG held meetings with Managed Care Organizations (MCOs) and Dental Maintenance Organizations (DMOs) to explore the idea of a state-level, public-private partnership that would further efforts to prevent and reduce fraud, waste, and abuse in the Texas Medicaid program. This led to the creation of the Texas Fraud Prevention Partnership (TFPP), a collaboration to exchange information between public and private payers; to share data and analytics with IG; to identify areas of fraud, waste, and abuse in Texas Medicaid; to share trends, schemes, strategies and effective methodologies; and to facilitate best practices between MCOs, DMOs, Texas Health and Human Services, the Office of Attorney General, and IG. In fiscal year

Fiscal year 2017 by the numbers

Provider enrollment screenings completed	86,506
Investigations completed	19,610
MPI referrals to Medicaid Fraud Control Unit	587
MPI referrals to other entities	1,748
IA referrals to district attorneys	63
Fraud Detection Operations completed	10
Hospital claim reviews completed	50,360
Nursing facility onsite reviews completed	434
Settlement agreements executed	41
Medicaid providers excluded	289
Audits completed	41
Inspections completed	2

2017, the IG held ten TFPP meetings which have included executive briefings and subject matter expert meetings with MCOs and separately with DMOs. Success in preventing, detecting, and reducing fraud, waste, and abuse depends on good communication and collaboration between the IG and MCOs and DMOs.

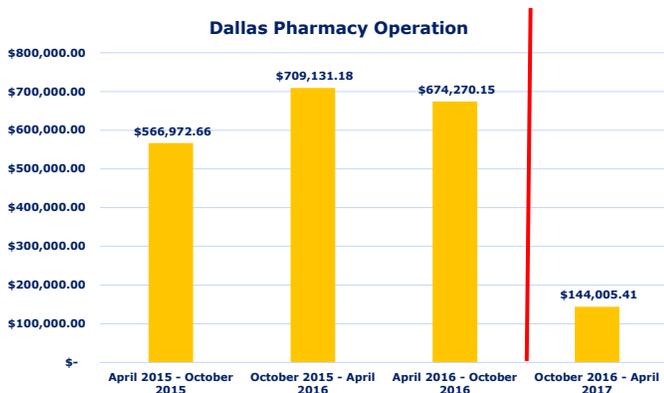
Fraud Detection Operations

A goal of the TFPP is to leverage data forensics and investigative personnel from the IG and MCOs to identify and detect fraud, waste, and abuse. A series of Fraud Detection Operations (FDOs) were conducted using data-driven intelligence to proactively identify areas of potential vulnerability of Medicaid expenditures, to develop high quality cases, and to provide a deterrent effect. The IG conducts these operations as a cross divisional effort using in-depth research and evaluation of internal data along with data provided by MCOs/DMOs through the TFPP.

Leading up to the FDOs, intelligence and data analysts in the IG Data and Technology (DAT) Division research claim reimbursement policies, gather input from subject matter experts, and collect information on potential provider fraud schemes. Algorithms are developed and applied to vast quantities of claims data, resulting in an outlier list that offers detailed information on highlighted

billing patterns.

The 10 FDOs involved the following provider types: pharmacies, durable medical equipment, dental services, and speech and occupational therapy. These 10 operations generated 35 cases; 9 were completed and 6 transferred to the Division of Medical Services and/or Litigation for adjudication. The IG made referrals to the Attorney General’s Medicaid Fraud Control Unit, and state licensure and medical boards. And the IG also analyzed the deterrent effect for entities that have been the subject of these data-driven operations in the field.



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

Inspections Division issues first two reports

In fiscal year 2017, the IG completed its first two inspections. This new division at the IG was fully staffed and engaged with staff across the HHS system and external stakeholders to complete the inspections.

Reports on these two inspections have been published and are available on the IG website (oig.hhsc.texas.gov):

- Pediatric Dental Sedation
- Opioid Drug Utilization

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. During the year, IG held calls with Pennsylvania, Ohio, Michigan, Wisconsin, Georgia, Tennessee, Minnesota, and Missouri.

Best practices identified from the calls include 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.

Litigation secures \$5.7 million settlement

The IG litigation team, working closely with our Medicaid investigators in San Antonio, secured a \$5.7 million settlement from a pediatric provider based on referrals from several MCO SIUs. IG investigative staff identified a provider’s improper unbundling of labor and delivery charges from global hospital charges. Instead of billing just the hospital for newborn hearing screenings, the provider also billed MCOs, resulting in unauthorized double compensation.

Strengthening IG infrastructure

In addition to bringing innovative ideas to the IG, the office focused on continuing to improve its core processes.

Risk assessment workgroup

The IG initiated a project to coordinate and consolidate existing processes for identifying high-risk HHS programs, providers, and contractors. The goal is to establish a framework of continuous risk assessment by creating a strategy for defining the areas of risk the IG will focus on in a given time period. In fiscal year 2017, the workgroup compiled an inventory of the HHS programs and services the IG oversees, and started to develop a risk assessment methodology that can be used to prioritize the work of each division.

Throughout fiscal year 2018, the workgroup will meet to further evaluate and improve its risk assessment processes and tools. The workgroup also will make recommendations to IG leadership about which IG division may be best suited to address specific risk areas.

Theory of Constraints improves efficiency

The IG has applied the Theory of Constraints organizational method to increase efficiency and promote accountability to boost outcomes. Investigations has integrated a referral review process to its workflow, creating higher-quality

Overview

cases submitted to investigators for full review. The result is more focused investigative work that generates improved results. Audit developed a report writing approach that reduces the number of days to produce a draft version, and similar processes are being drafted for the planning and field work phases of audits.

IG expands use of Recovery Audit Contractor

In the second quarter of fiscal year 2017, HHS approved the permanent transfer of responsibility for contract management of the Recovery Audit Contractor (RAC) to the Audit Division. With Audit oversight, the RAC has primarily been conducting two types of complex reviews, which involve claims data elements that cannot be validated through automation and require medical record reviews by qualified personnel. The reviews resulted in the identification of \$23.7 million in questioned costs and the collection of \$20.5 million in fiscal year 2017. Audit coordinated approval of two additional complex reviews and the introduction of automated reviews, which involve claims data elements that can be analyzed using algorithms based on Medicaid policy and rules. The expanded utilization of the RAC is expected to lead to an increase in identified questioned costs and collections starting in the first quarter of fiscal year 2018.

Fraud, waste, and abuse referrals

Home health agencies / personal attendants	42.4%
Physicians (group or individual)	13.8%
Dental	7.6%
Pharmacy	5.2%
Nursing facility	4.7%
Therapy (PT, OT, ST)	4.1%
Home health (PCS/CCP)	3.5%
Durable medical equipment	3.1%
Hospital	2.9%
Adult day care	2.3%

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

WIC inspections strengthened

The Women, Infants and Children (WIC) Fraud Prevention Unit, which monitors WIC vendors through in-store evaluations, covert compliance buys, and invoice audits, implemented new practices after meeting with Texas retail industry leaders. The WIC team modified the on-site inspection process by adding a transaction to the regular inspection of a store's internal operations. This allows WIC inspectors to give immediate feedback to a retailer. In addition, WIC uses a new data-driven methodology that helps identify vendor anomalies that may indicate benefits trafficking. This new Inspections Division methodology is the result of a collaboration with the IG General Investigations Division, United States Department of Agriculture (USDA) Food and Nutrition Service, and the USDA Office of the Inspector General.

During fiscal year 2017, the unit conducted 254 compliance buys and 130 in-store evaluations. The IG closed 257 cases during the fiscal year with \$50,592 identified as funds put to better use. The unit also assessed 11 civil monetary penalties totaling \$17,438 for three vendors with first-time violations.

Dashboards, automated reports boost accountability

During the past fiscal year, IG has implemented dashboards for the Investigations Medicaid Program Integrity Intake Unit, Audit, Inspections, and Integrity Line. The dashboards provide timely and relevant information to the business area, which allows for tracking of performance metrics and completion timelines.

Additionally, the IG completed 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 the Attorney General's Medicaid Fraud Control Unit. These automated reports reduce staff time required to create the reports manually, and offer more of information than previously possible.

Lock in Program process simplified

The IG's Lock-in Program works with MCOs to monitor recipient abuse of prescription medications and acute care services. 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. 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 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.

Collaboration

Fiscal year 2017 also included an emphasis on collaboration across the HHS system and with external stakeholders.

The IG works with its colleagues in the HHS System to develop programs and practices that help reduce fraud, waste, and abuse. The IG meets monthly with HHS Access and Eligibility Services to coordinate fraud prevention activities and to develop an HHS anti-fraud plan. Investigations attends State Supported Living Center quarterly meetings and new employee orientations across the state. Investigations also presented at four Department of Family and Protective Services investigator trainings.

DMS regularly consults with HHS Medicaid and CHIP Services (MCS) staff on legal, policy, and recipient issues. The Hospital Utilization Review team worked with MCS to clarify certain procedure codes. Lock-in Program staff routinely confers with HHS Health Plan Management staff on program activities. The Research, Analysis, and Detection (RAD) team meets with MCS quarterly to discuss provider concerns, record review findings, and

recommend policy changes. RAD also meets with MCS Quality Oversight monthly to discuss utilization review results.

DAT regularly meets with HHS data analytics and technology counterparts to ensure that lines of communication and information sharing are open and available. Through these interactions, the division can gather programmatic trends and technological innovations to incorporate into its methodologies and systems.

The IG engages with external stakeholders through quarterly meetings, including Nursing Facilities, Hospitals, Special Investigative Units (SIUs), and TFPP participants. IG staff met regularly with legislators before, during, and after the ongoing legislative session, as well as key stakeholder groups and HMO leaders. IG staff also spoke at several conferences, including the National Association of Medicaid Provider Integrity conference.

The IG hosted a stakeholder symposium at the University of Texas Rio Grande Valley in February which drew a full house of providers. Panels featured legislators, HHS and IG staff, and several MCO executives.

IG University enhances training

Throughout fiscal year 2017, the IG continued to improve its training and professional development programs.

The Professional Development Team has worked with all areas to develop a robust IG University training curriculum. It includes core courses and content necessary to arm the IG staff with the skills and knowledge to effectively combat fraud, waste, and abuse and conduct sound oversight of HHS services for which the IG is responsible. The IG deployed a tracking tool for staff to document the training they present and receive, which will allow managers oversight and assist with staff development.

During fiscal year 2017, the IG developed and conducted more than 60 trainings and facilitations, using technology to reach staff in regional offices across the state. Training topics included: An Overview of Managed Care Organizations (MCOs); Long Term Services and

Overview

Supports (LTSS); Electronic Visit Verification (EVV); and training to help staff better understand the HHS services that the IG oversees, such as Medicaid Women, Infants, and Children (WIC), Temporary Assistance for Needy Families (TANF),

and Supplemental Nutrition Assistance Program (SNAP). Additionally, the IG provided or facilitated a diverse array of workplace skills and leadership trainings.

Medicaid Program Integrity Spotlight: Acute Care Utilization Management

Section

2

Medicaid Program Integrity Spotlight: Acute Care Utilization

Why the IG conducted this audit series

At approximately \$30 billion a year, the Medicaid program and Children’s Health Insurance Program (CHIP) constitute over 29 percent of the total Texas budget. Approximately 88 percent of individuals enrolled in Medicaid or CHIP are members of a managed care organization (MCO).

MCOs are required to perform utilization management to ensure that members receive appropriate health care services, and that state and federal funds spent on managed care are used appropriately. Utilization management includes review of provider requests for members’ current and future medical needs, and previously provided services for medical necessity, appropriateness, timeliness, effectiveness, and compliance with state and federal requirements.

The IG Audit Division conducted four audits of acute care utilization management in MCOs to evaluate the effectiveness of MCO acute care utilization management practices in ensuring that health care services provided are medically necessary, efficient, and comply with state and federal requirements.

What the IG reported

The results of IG Audit Division reports included in a series of four acute care utilization management audits can be summarized in four primary observations:

- MCOs face challenges in complying with different prior authorization processing requirements included in the Uniform Managed Care Contract (UMCC) and Texas Insurance Code (TIC).
- MCOs perform various analyses of utilization management data.
- MCOs assess and monitor personnel performance, but do not always ensure Texas-specific training is completed.
- The Medicaid and CHIP Services Department (MCS D) and audited MCOs are taking actions to address the findings identified in the audit reports.

Inconsistent prior authorization processing requirements: Each MCO is required by UMCC

and TIC to notify requestors of prior authorization determinations within specific timeframes. There are two TIC sections that apply to MCOs – one for utilization review agents and another for health maintenance organizations. Neither rule aligns with the other or with the UMCC.

MCS D expressed its intention to discuss the discrepancy between notification timeframe requirements with TDI and update contractual time frames for prior authorization requests if appropriate.

MCOs perform various analyses of utilization management data: MCOs were analyzing utilization management data to help ensure appropriate utilization of resources. This included tracking utilization of services, monitoring providers to promote appropriate practice standards, and interacting with other programs, such as case management, disease management, compliance, quality improvement, credentialing, and fraud and abuse programs.

Texas-specific training requirements are not always met: The IG Audit Division reviewed the four audited MCOs’ training records related to acquired brain injury treatment and found they were aware of the TAC requirement. Noncompliance with the requirement arose when an MCO employed non-Texas personnel, as the Texas-specific training was not included in the employees’ training curriculum.

Actions to address audit issues: The IG Audit Division also noted issues specific to the MCOs’ prior authorization processes, including unreliable electronic data for measuring timeliness, lack of supporting documentation, appeals processes that did not comply with all requirements, and some requests incorrectly denied for not being a covered benefit. To address these issues, the MCOs submitted corrective action plans to MCS D, and will update MCS D monthly detailing the status of each action plan.

Read the full report

This informational report, as well as the four individual acute care management audit reports, is available on the IG website at <https://oig.hhs.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 (GI) investigates allegations of overpayments to recipients of state benefit programs.
- Medicaid Provider Integrity (MPI) investigates allegations of fraud, waste, and abuse by Medicaid providers.
- State Centers Investigative Team (SCIT) and Electronic Benefits Trafficking (EBT) investigates violations involving State Supported Living Centers staff, State Hospitals staff, and EBT trafficking.
- Internal Affairs (IA) 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 of taxpayer dollars.

General Investigations

GI provided regional Texas Works Advisor trainings to assist HHS Access and Eligibility Services (AES) with identifying fraud, waste and abuse. GI successfully completed regional employee development training for about 90 GI personnel to improve skills and update staff on current program policies and procedures. This training included: Modified Adjusted Gross Income (MAGI) worksheet updates; program specific Texas Works policy refresher; Women,

Investigations overpayment results

Period	Overpayment identified	Overpayment collected
FY 17 Quarter 1	\$9,650,227	\$5,461,971
FY 17 Quarter 2	\$8,252,754	\$5,443,064
FY 17 Quarter 3	\$8,667,644	\$21,196,863
FY 17 Quarter 4	\$8,492,962	\$6,172,504
FY 17 Total	\$35,063,587	\$38,274,402

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

Top GI accomplishments this quarter

- Recovered \$4,438,918 in overpayments.
- Identified \$8,342,132 for recovery.
- Referred 40 cases for prosecution and received 26 court dispositions.

Infants, and Children (WIC) Social Media Investigations; Texas Integrated Eligibility Redesign System (TIERS) Navigation; Long-Term Care Investigations; and household composition calculation.

An example of a case completed this quarter by GI staff:

A Supplemental Nutrition Assistance Program (SNAP), Medicaid, and CHIP beneficiary failed to report facts that rendered her ineligible to receive benefits. Her husband's additional income placed her family over the threshold to qualify for benefits. The beneficiary received \$64,918 in overpayments identified as fraudulent. The case was referred to the Lee County District Attorney's office for prosecution.

Medicaid Provider Integrity

MPI was part of an IG cross-divisional investigation planning workgroup. The workgroup will finalize a plan that identifies the potential program violations to be investigated, evidence necessary, and ultimately results in the appropriate resolution of the investigation.

Additional cross-division coordination included the successful completion of Investigations Development training. This training focused on developing core investigative skills, including interview techniques, evidence gathering, surveillance techniques, fraudulent identification recognition, social media investigations, report writing, courtroom demeanor, and mock trial.

An example of a case completed by MPI staff this quarter:

MPI completed an investigation on a durable medical equipment (DME) provider that was transferred to the IG Litigation Division for administrative enforcement and also referred the case to the Attorney General's Medicaid Fraud Control Unit for criminal investigation.

Top MPI accomplishments this quarter

- Completed 366 cases.
- Transferred 61 cases to full-scale investigation.
- Referred 140 cases to the Attorney General's Medicaid Fraud Control Unit.
- Ended quarter with 156 open/active full-scale investigations.
- Average case processing time of 29.33 days for preliminary cases.

The following are facts gathered during the investigation:

- MPI sent copies of the prescriptions for the durable medical equipment/supplies to the originating physicians for verification of authenticity.
- Physicians verified the DME provider added additional items to the prescriptions after the physicians signed the documents. The manipulation to the prescriptions benefitted the DME provider by either justifying their inappropriate billing or allowing the provider to bill at a higher rate.
- Interviews conducted with the provider exposed an employee who admitted to altering the documents at the direction of the business manager.

State Centers Investigative Team and Electronic Benefits Transfer Trafficking

The Electronic Benefits Transfer (EBT) Trafficking Unit's main focus is to investigate SNAP authorized retailers. The State Centers Investigative Team (SCIT)'s main focus is to investigate abuse, neglect, and exploitation at State Supported Living Centers and State Hospitals.

During the quarter the directorate opened 317

Top SCIT/EBT accomplishments this quarter

- Collected \$13,700 in recoupments and identified \$129,010 in overpayments.
- Opened 317 investigations and completed 324 investigations.
- Presented eight cases for prosecution.

investigations, completed 324, and presented 8 cases for prosecution.

Examples of cases completed by SCIT/EBT staff this quarter:

The EBT Trafficking Unit received an allegation that a retailer was illegally purchasing SNAP benefits from SNAP beneficiaries. The owner used the SNAP benefits to stock the store. The EBT unit conducted multiple undercover operations in which investigators trafficked SNAP benefits for cash. The investigation also discovered that the owner and employees violated the Food Nutrition Services regulations by allowing the purchase of hot plated foods. The case was referred to the Harrison County district attorney for felony prosecution for illegal use, possession or transfer of EBT. As a result of the investigation, the IG identified eight recipients as having inappropriately used their benefits at this retailer. The Administrative Disqualification Hearing process was initiated on each of the eight recipients, which resulted in combined identified overpayment amounts of \$31,354. Criminal prosecution of the owner is pending.

IG initiated a State Supported Living Center investigation based on allegations that an employee made false medical entries for client assessments. The employee pleaded guilty to tampering with a government record and was placed on deferred adjudication, ordered to pay \$4,000 in fines and \$328 in court costs, and required to complete 250 hours of community service. The employee also is not allowed to be a nurse or seek a nursing license while on probation.

Internal Affairs

IA conducted 99 investigations, 9 of which were determined as sustained. The cases involved vital statistics fraud, contract fraud, employee misconduct, privacy breaches, theft, and benefit fraud.

The IA Vital Statistics Fraud Unit (VSFU), in conjunction with Texas Department of Public Safety (DPS), monitors and flags birth records of reported missing children under age 11. These birth records are flagged "not to issue" as DPS has classified the record holders as missing children for

Investigations

law enforcement purposes to prevent removal of a child from the country or an attempt to re-establish the child in a new area. Along with this flag is a request for the local or county officials to provide any information of any attempt to obtain a copy of the flagged record. This quarter, VSFU placed flags for 97 missing children based on information obtained from DPS through the VSFU Missing Children Database.

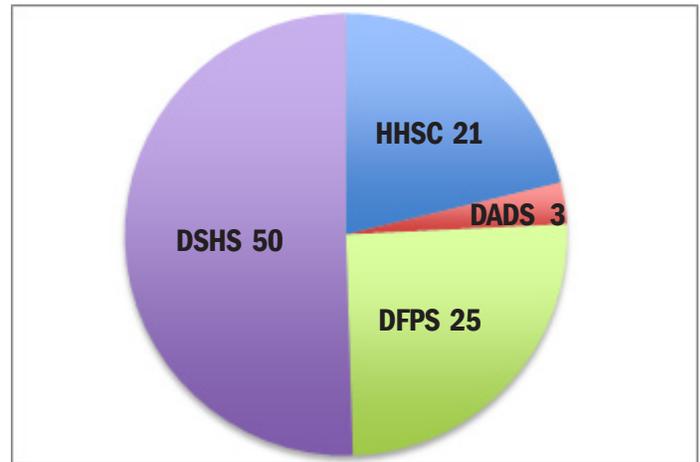
During this quarter, IA improved the intake process by:

- Refining the complaint intake form
- Providing additional referral methods including a secure email address and website contact information
- Implementing a complaint reconciliation process
- Improving the existing case review and approval process.

An example of a case completed this quarter by IA staff:

An employee misconduct investigation involving a community care worker with the Department of Aging and Disability Services was conducted

Completed IA investigations by agency



for the unauthorized disposal of Protected Health Information. The employee confessed that he violated established HHS Work Rules pursuant to protecting state property, and the proper disposal of Protected Health Information/Personally Identifiable Information/Health Information Portability and Accountability Act information. IG closed the case with a sustained finding.

Audit

Section

4

Audit

The IG 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.

Additionally, Audit 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 (CMS) for Medicaid Integrity Contractor (MIC) audits and Payment Error Rate Measurement (PERM) activities.

Overpayments identified and collected

This quarter, Audit identified more than \$5.5 million in overpayments for recovery through audits it managed. Additionally, IG collected approximately \$3.5 million of overpayments as a result of audits the division performed, coordinated, or managed.

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 Quarter 4	\$5,508,627	\$3,545,295
FY 17 Total	\$27,517,086	\$23,171,847

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

Audit reports issued this quarter

Audit issued eight reports this quarter. Final audit and informational reports can be accessed on the IG website (oig.hhsc.texas.gov).

Audit Spotlight: Acute Care Utilization Management in MCOs

Audit completed its series of performance audits evaluating the effectiveness of managed care organization (MCO) acute care utilization management practices. MCOs are required to perform utilization management to ensure that

Top accomplishments this quarter

- Performed, managed, or coordinated audits that resulted in \$5.5 million in overpayments identified for recovery and \$3.5 million in overpayments collected.
- Issued eight audit and informational reports.
- Initiated 11 performance, provider, and IT audits.

Outcomes of completed audits

6 Provider audits related to pharmacy providers, speech therapy providers, and hospital cost reports. One pharmacy provider audit identified errors related to noncompliance with record retention requirements, which resulted in questioned costs expected to be collected in the first quarter of fiscal year 2018.

1 IT audit related to security controls over confidential HHS system information. IG identified the need for increased HHSC and MCO collaboration to ensure the security of confidential information processed and stored by MCOs meets state and federal IT security standards.

1 Informational report summarizing the results of a series of performance audits of acute care utilization management in MCOs.

members receive appropriate health care services, and that state and federal funds spent on managed care are used appropriately.

The division conducted audits of acute care utilization management in four MCOs, and issued six audit and informational reports. Audit found challenges MCOs face in complying with different contractual and statutory prior authorization processing requirements, performing utilization management data analyses, and meeting and documenting Texas-specific training requirements for utilization management personnel.

These audits prompted a proposal for a joint HHS initiative to establish consistent timeliness requirements for notice of prior authorization determinations. In addition, the HHSC Medicaid and CHIP Services Department (MCSDD) and the audited MCOs are taking corrective actions to address audit recommendations designed

to strengthen MCO utilization management functions.

New audit projects under way

Audit initiated the following audits this quarter. A list of initiated audits and audit topics the Audit Division plans to initiate can be found in the two-year rolling audit plan located on the IG website.

MCO special investigative units' performance

Objective: Determine the effectiveness of selected MCO special investigative units' (SIU) performance in detecting and investigating fraud, waste, and abuse, and in reporting reliable information on SIU activities, results, and recoveries to HHSC.

Background: In fiscal year 2017, MCOs received more than \$20 billion of federal and state funds from the state in capitated services. State law requires MCOs to establish or contract with a qualified entity to investigate suspected fraud or abuse by MCO members or their participating providers. MCSD administers MCO contracts and maintains oversight responsibility over MCOs. The IG approves annual SIU fraud, waste, and abuse compliance plans submitted by MCOs.

Medical Transportation Program vendor performance

Objective: Determine whether contractors used funds as intended; contractor performance was in accordance with contract requirements; and the managed transportation organization (MTO) service delivery methodology, as designed, is cost effective and achieving its intended purpose.

Background: The Medical Transportation Program (MTP) is responsible for providing nonemergency medical transportation (NEMT) services to eligible Medicaid, Children with Special Health Care Needs Services program, and Transportation for Indigent Cancer Patients program clients who have no other means of transportation. Effective September 2014, HHSC implemented a new NEMT service delivery model that transitioned from Transportation Service Area Providers to MTOs, which are contracted vendors that provide NEMT services to MTP-eligible clients.

Pharmacy providers

Objective: Determine whether selected pharmacy 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 the period of March 1, 2012, through February 28, 2015.

Durable medical equipment claims

Objective: Determine whether selected durable medical equipment (DME) providers billed and were paid for services and supplies in accordance with applicable state and federal regulations and guidelines.

Background: DME is medical equipment or appliances manufactured to withstand repeated use, ordered by a physician for use in the home, and required to correct or ameliorate a client's disability, condition, or illness. Medicaid covers DME products and supplies certified by a physician as medically necessary for a beneficiary's home health needs.

Hospital cost reports

Objective: Determine whether amounts for selected cost centers reported on the hospital Medicare cost report were accurate, allowable, and adequately supported, in accordance with applicable CMS and state requirements.

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 HHSC to determine select 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.

IT security assessment

Objective: Assess the design and effectiveness of

selected security controls over confidential HHS system information stored and processed by a selected MCO.

Background: MCOs process and store protected health information for Medicaid recipients. Audit will examine the IT controls supporting security activities for a selected MCO. Work may include detailed tests of security activities, supporting technologies, data and transaction logs, and site visits to locations where key activities are performed or data is stored.

MCO speech therapy providers

Objective: Evaluate selected MCO speech therapy providers' compliance with prior authorization and reauthorization requirements, criteria for determining when discontinuation of therapy is appropriate, and applicable licensure and certification requirements.

Background: The IG included speech therapy provider audits on its audit plan after the CMS MIC contractor expressed interest in determining whether speech therapy services are provided by someone other than licensed therapists or by someone under the supervision of a licensed therapist. In fiscal years 2014 and 2015, approximately \$745 million in state funds were spent on speech therapy services in Texas.

Therapy services at a long-term care nursing facility

Objective: Determine whether services at a selected long-term care nursing facility are provided consistent with physician orders, in accordance with resident assessments and evaluations, and in compliance with applicable requirements; and assess the accuracy of therapy related payments and reimbursements, and the completeness of supporting documentation.

Background: Long-term care nursing facilities joined the managed care environment in March 2015. The audit will verify whether services are medically necessary, and are provided and billed in accordance with physician orders, state rules and

Medicaid requirements, and the level of care for authorized and eligible services.

Home and community-based services providers

Objective: Determine whether fee-for-service claims submitted by and paid to a selected home community-based services (HCS) provider were billed and documented in accordance with applicable state laws, regulations, contracts, and guidelines.

Background: The HCS program, which is the largest of six Texas Long-Term Service and Supports (LTSS) waiver programs, provides individualized services and supports to consumers with intellectual disabilities who are living with their family, in their own home, or in other community settings, such as small group homes. In fiscal year 2015, HCS expenditures totaled \$1.1 billion, which comprised approximately 25 percent of LTSS expenditures totaling \$4.4 billion.

Audit projects in progress

The following projects from the fiscal year 2017 audit plan are currently in progress. A list of audits in progress can be found in the two-year rolling audit plan located on the IG website.

- Pharmacy providers
- Therapy services at long-term care nursing facilities
- MCO speech therapy providers
- DME claims
- IT security assessments
- Residential child care services contractor
- Hospital cost reports
- STAR+PLUS enrollment
- HHSC processes for analyzing and preventing eligibility determination errors
- MCO SIU performance
- Managed care pharmacy benefits managers' compliance
- MTP vendor performance
- HCS providers
- Air ambulance providers

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 to ensure the greatest benefit to the citizens of Texas. The division also conducts inspections of the Women, Infants, and Children program.

Pediatric dental sedation report published

During the fourth quarter, Inspections published the division's second report, Pediatric Dental Sedation Inspection: Medicaid Dental Providers. This report details the inspection of Texas Medicaid dental providers to determine if dental sedation procedures performed on Medicaid pediatric patients are medically necessary and meet the standard of care. It also evaluates the form currently used to justify general anesthesia without prior authorization.

The inspection identified several issues and the division made recommendations to remedy concerns. The form currently used to justify general anesthesia can be manipulated to bypass prior authorization. Therefore, the IG recommended that prior authorization be required for all level IV general anesthesia procedures and that prepayment review be established to address situations related to medical emergency and other appropriate circumstances. Some dental records lack documentation to support medical necessity and standard of care. In response, dental maintenance organizations (DMOs) should be required to educate dental providers about dental records documentation in accordance with the Texas Administrative Code (TAC). In addition, some offices lack equipment required by TAC. The division recommended that DMOs be required to educate providers who conduct dental sedation procedures about TAC requirements for sedation equipment.

The Medicaid and CHIP Services Division agreed with all recommendations. The full report is available on the IG website (oig.hhsc.texas.gov).

More Inspections results forthcoming

The division is working on reports related to

Top accomplishments this quarter

- Published Pediatric Dental Sedation: Inspection of Medicaid Dental Providers report.
- Completed 18 compliance buys and closed 30 cases in WIC Fraud Prevention Unit.

Medicaid speech therapy services and one that addresses procedures to maximize recovery of Supplemental Nutrition Assistance Program overpayments through the Treasury Offset Program.

The following inspections introduced in previous quarterly reports are in the execution phase: Medicaid Payments for Deceased Recipients, Multiple Medicaid Identification Numbers, and Electronic Visit Verification. In addition, Duplicate Capitation Payments to Managed Care Organizations, and Long-term Services and Support Community Attendant Services are in the inspection preparation phase.

WIC unit investigates benefits trafficking

The WIC Fraud Prevention Unit (FPU) introduced a new investigative process focused exclusively on the trafficking of WIC benefits. Trafficking is the act of selling or exchanging the benefit for cash or for any other unauthorized items. The WIC FPU created a new data driven model based on WIC specific data queries to identify vendor transaction anomalies that may be indicators of trafficking.

After launching a series of coordinated investigations, the WIC FPU observed a trend of trafficking facilitation. Currently, facilitation of trafficking is not a WIC program violation. The WIC FPU submitted a policy change proposal to the WIC program requesting that a new violation be developed for the facilitation of trafficking of WIC benefits. WIC FPU efforts resulted in a civil monetary of penalty of \$11,000 against one vendor for trafficking violations.

The WIC FPU continues to refine its trafficking program and is in the process of redefining data analytics to better identify those vendors whose behavior indicates possible trafficking of WIC benefits.

Medical Reviews

Section

6

Medical 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 managed care organization (MCO) and dental maintenance organization (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 develops and runs targeted data queries to identify acute care billing outliers.

The Quality Review team conducts retrospective

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 Quarter 4	\$554,794	\$7,171,099
FY 17 Total	\$16,227,006	\$37,623,857

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

Top accomplishments this quarter

- \$4,121,297 recovered from Hospital Utilization Reviews
- \$483,552 recovered from Nursing Facility Utilization Reviews
- \$96,978 received in nursing facility settlements
- \$2,469,272 (fee-for-service Medicaid) Acute Care Surveillance (ACS) dollars recovered
- \$554,794 ACS MCO overpayments identified
- 12,525 hospital claims reviewed

utilization review of hospitals and nursing facilities, and administers the pharmacy Lock-in Program. The Utilization Review team performs on-site and desk reviews of hospital claims and on-site reviews of nursing facility Minimum Data Set (MDS) forms for appropriate billing. Lock-in Program staff work with MCOs 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 in the case of a fee-for-service recipient, a single primary care provider.

Nursing Facility Utilization Review completes managed care review

On March 1, 2015, HHS implemented Senate Bill 7, 83rd Legislature, 2013, mandating statewide transition of nursing facility services for most clients age 21 and older from traditional fee-for-service Medicaid to STAR+PLUS.

With the transition of Texas Medicaid nursing facility residents into managed care, the IG evaluated MDS assessment coding by nursing facilities in managed care, applied existing IG utilization review processes to ensure they align with the existing managed care environment, and gathered information from nursing facility staff regarding their experience with the transition. This evaluation was conducted in the first quarter of fiscal year 2017 and release of the final report, including recommendations based on findings, is expected during fiscal year 2018.

Hospital Utilization Review completes managed care pilot

In February 2017, the IG Hospital Utilization Review (HUR) Unit completed a pilot review to test existing utilization review processes in the managed care service delivery model. Through the pilot, the HUR team reviewed a sample of fee-for-service claims and managed care encounters submitted by a large acute care hospital from March 1, 2012, through August 31, 2015. The objective was to compare fee-for-service and managed care claims related to medical necessity determination, diagnosis coding validation using federal coding guidelines, and quality of care screening. During the time period tested, the HUR team identified encounter data from four managed care organizations.

The HUR reviewers did not identify any quality of care concerns in the managed care cases and found a lower incidence of errors in managed care records as compared to fee-for-service. However, documentation errors were identified as a concern under both delivery models. For example, the HUR team found that 10.74 percent of reviewed fee-for-service records did not document medical necessity for inpatient level of care, compared to 4.29 percent of MCO records reviewed. MCO admissions were prior authorized, and IG physician consultants confirmed lack of medical necessity to justify inpatient admissions due to a variety of reasons.

The pilot review also identified instances where the diagnosis related group (DRG) assignment was not supported by the diagnosis(es) reflected in the medical record. For these instances, the diagnosis was either not documented by the attending provider, or documentation was not found in the medical record that the diagnosis was observed, evaluated, treated, or required follow-up. In fee-

for-service, these types of errors were found in 7.49 percent of records reviewed compared to 5.62 percent of managed care records reviewed. This pilot assisted the IG Utilization Review team when analyzing its claim selection criteria for managed care claim submissions during fiscal year 2018.

Hospital Utilization Review DRG revision process modified

Senate Bill 207, 84th Legislature, 2015, modified the process for reviewing DRG claims. The DMS HUR team convened a workgroup to develop a revised process based on the SB 207 mandate to adhere to federal coding guidelines. The workgroup communicated its activities during hospital stakeholder meetings which served as a forum for stakeholder input and discussion.

Under the new review process, DMS HUR follows federal coding guidelines for ICD-9 and ICD-10 and refers to the coding clinics as necessary. Also, DMS HUR revised provider notifications to include education based on the coders' review of the medical record documentation. Hospitals with reviews pending completion under the previous methodology with DRG change notifications issued on or after September 1, 2015 (SB 207 effective date) were provided an opportunity to request a second review under the revised DRG review process.

The new process allows nurse reviewers to discuss medical record documentation with the coders, and coders perform a final review of the record when coding questions remain. Review results are evaluated and nurse reviewers are educated to ensure consistency in applying the new review approach. Since implementing the new process, DMS HUR has identified fewer coding errors.

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 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 IG attorneys and HHS System attorneys, and between IG executive leadership and legal experts at the HHS System.

Chief Counsel is comprised of three units:

- General Law
- Litigation
- Special Counsel

The General Law and Special Counsel units are responsible for providing legal support to the main functional areas of the IG (Investigations, Audit and Inspections) and on topics such as Medicaid provider enrollment and other legal questions that impact the mission of the IG. The General Law 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. When certain sanctions are imposed, 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.

Legal support

Chief Counsel provided general legal support to all areas of the IG to further the mission of the IG through investigations, audit, inspections and reviews and for implementation of legislative directive.

Legislative implementation

Attorneys in the division helped the IG implement various pieces of legislation passed by the 85th Texas Legislature.

Data and Technology

The Data and Technology Division (DAT) continues to support 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. The division is comprised of these units:

- Data Research Unit
- Data Intelligence Unit
- Fraud Analytics Unit
- Statistical Analysis Unit
- Data Operations staff

These units have made significant strides in improving support through targeted selection of areas most at risk of fraud, waste, and abuse.

During the fiscal year, in an effort to introduce staff to new methods in analyzing data, several

DAT staff attended The University of Texas Summer Statistics Institute. Staff also attended various training courses to enhance programming language skills, data analysis, and intelligence research techniques.

Support for IG divisions

DAT helps Investigations by identifying outliers to help focus investigative actions, and identifies areas of interest that may warrant further review. Through collaboration with members of Investigations the team clarifies details pertaining to the data, processes, and regulations within the Medicaid program. DAT also provides critical support for Fraud Detection Operations.

The DAT team also confers with members of Inspections to explain aspects of the data and related processes within Medicaid to refine the

focus of Inspections during the planning stage of projects.

Support for Audit includes discussing categories of Medicaid services and the underlying data,

providing structured information for review, and assisting in the development of a sample methodology and related samples.

Operations

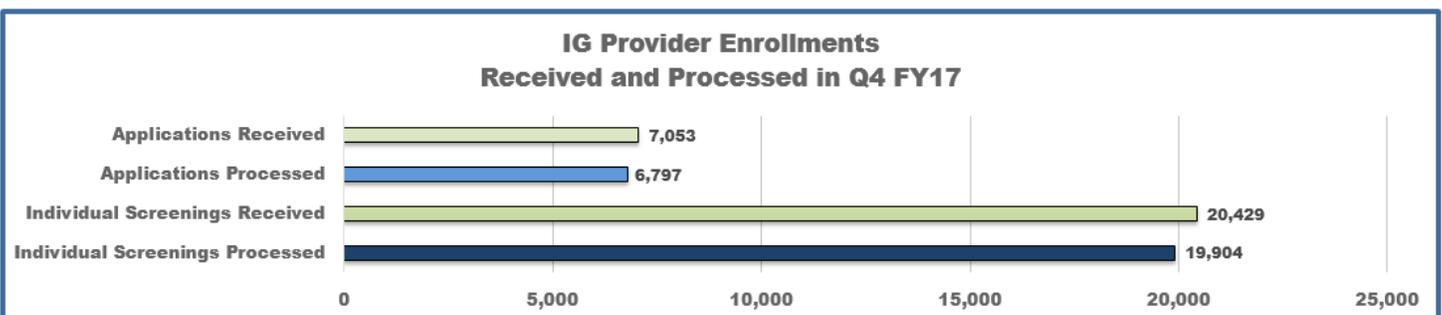
The Operations Division works to build an infrastructure for the IG that supports enhanced efficiency and effectiveness for investigations, audits, reviews, and inspections; promotes responsibility and accountability; and provides increased communication and transparency both within the organization 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 Provider Enrollment Integrity Screenings team (responsible for conducting screenings for providers enrolling in Medicaid, Children’s Health Insurance Program (CHIP), and other HHS programs) are housed within Operations.

In the fourth quarter of fiscal year 2017, the IG Operations Integrity Line answered 7,874 calls reporting fraud, waste and abuse or otherwise seeking assistance. In addition, the IG Operations Provider Enrollment Integrity Screening team conducted screenings for nearly 20,000 individuals (representing more than 6,700 provider applications) seeking to enroll or revalidate their

Texas Medicaid and/or CHIP enrollment.

CHIP provider enrollment

As a result of the 21st Century CURES Act, enacted by Congress in December 2016, and the updated CMS Managed Care Rules adopted thereafter, all CHIP providers are required to be enrolled with each state’s Medicaid agency by January 1, 2018. Historically, providers who exclusively served the CHIP population but not the Medicaid population have been largely credentialed through managed care organizations for the provision of services, but not through the state’s enrollment process. With this change, more providers will be coming through the IG’s Provider Enrollment Integrity Screenings (PEIS) team at enrollment and revalidation to ensure that these providers undergo the same degree of safety and fraud prevention screenings required for both Medicaid and CHIP providers in the Affordable Care Act (ACA). In preparation for the impending enrollment wave, the IG has worked closely with the HHS Medicaid/CHIP Services Division and the Texas Medicaid & Health Partnership (TMHP) contractor to develop communications and outreach efforts to this population, implement system enhancements and business processes to accommodate this new provider group, and institute tracking mechanisms to monitor and report upon this unique population throughout



Operations

the process. As the deadline nears, the IG expects to receive a large number of CHIP applications to screen in a short timeframe and is working to

promote staffing to support the additional provider volume.

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 facilitates the publication of IG reports and handles all media inquiries. The Government Relations team provides outreach and communication with legislators, the public, managed care organizations, and other agencies

within the HHS System.

In the fourth quarter, the Policy and Publications Division worked with other IG divisions on implementing bills passed during the 85th Legislature. These bills will enhance the work of the IG and improve transparency and recoveries. The Policy team published issue briefs and researched Medicaid policy issues for other IG divisions.

The Communications team launched the redesign of the IG website. The new look is more in line with other HHS agencies and provides easier access to the fraud reporting form and provider exclusions check form, the most frequently visited pages on the site, and provides space on the home page for news items and other announcements.



PROFESSIONALISM
PRODUCTIVITY
PERSEVERANCE

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To report fraud, waste, or abuse

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

800-436-6184

