Quarterly Report

Quarter 2

Fiscal Year 2019

Inspector General

Texas Health and Human Services

Office of Inspector General

Texas Health & Human Services Commission

Sylvia Hernandez Kauffman
Inspector General

I am pleased to present the second quarterly report for fiscal year 2019, summarizing the excellent work this office has performed during this period, to Governor Greg Abbott, Executive Commissioner Dr. Courtney Phillips, the Texas Legislature, and the citizens of Texas.

During this quarter, the OIG recovered nearly $97.7 million, continuing the strong results achieved in the first quarter ($95 million). In addition, nearly $42 million was identified for future recovery, and $36.4 million was saved in cost avoidance.

This quarter also saw the start of the 86th Texas Legislature. The OIG is working closely with Texas Health and Human Services to monitor and review legislation that would affect this office, and provide our insight on bills as they move through the legislative process. We will work with the appropriate committees in the House and Senate to assure that the OIG has the tools and processes to help us in our mission to detect, prevent, and deter fraud, waste, and abuse in the delivery of services to Texans.

The OIG is committed to protecting the integrity of Texas health and human services programs, making sure that funds dedicated to providing services to those who need them are spent only for their intended purpose. That commitment includes holding ourselves to the highest standards of ethics and professionalism in all we do. I'm honored to serve with the OIG team as we work to achieve that mission every day.

Respectfully,
Sylvia Hernandez Kauffman

Quarter 2 results

Dollars recovered

Audit	
Collections	$2,565,306
Inspections	
WIC collections	$8,720
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$3,570,111
Voluntary repayments by beneficiaries	$86,455
Peace Officers	
EBT Trafficking team collections	$44,493
Medicaid Program Integrity	
Provider collections	$2,695,435
Acute care provider collections	$4,020,258
Hospital collections	$3,587,522
Third Party Recoveries	
TPR recoveries	$81,117,471
Total dollars recovered	**$97,695,771**

Dollars identified for recovery

Audit	
Provider overpayments	$20,174
Inspections	
Durable medical equipment inspection	$279,862
WIC vendor monitoring	$27,300
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$9,388,843
Peace Officers	
EBT trafficking	$409,714
Medicaid Program Integrity	
MCO identified overpayments	$8,062,830
Medical Reviews	
Acute care providers	$323,434
Hospitals	$9,445,960
Nursing facility overpayments	$355,880
Third Party Recoveries	
RAC audits	$13,413,292
Total dollars identified for recovery	**$41,727,288**

Cost avoidance

Inspections	
Vendor disqualifications	$1,818,784
Benefits Program Integrity	
Client disqualifications	$1,500,965
Medicaid Program Integrity	
Medicaid provider exclusions	$2,445,367
Medical Reviews	
Pharmacy Lock-In	$1,357,679
Third Party Recoveries	
TPR	$29,289,265
Peace Officers	
Disability Determination Services	$656,731
Total cost avoidance	**$37,068,791**

How we measure results

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

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

Dollars identified for recovery: Dollars identified include overpayments identified for recovery during an OIG investigation, audit, inspection or review for: 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.

Cost avoidance: Cost avoidance 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.

OIG peace officer recoveries

Dollars recovered	$44,493
Dollars identified for recovery	$409,714
Cost avoidance	$656,731
Completed cases involving OIG peace officers	278

Trends

Medicaid Program Integrity

The Medicaid Program Integrity (MPI) Division's provider field investigations initiated 76 investigations related to 13 provider types during the quarter. In addition to investigating complaints related to physicians, dental providers, hospitals, and other provider types, MPI has identified a number of attendant cases with strong evidence of billing for services not rendered. These include cases where attendants clocked in for personal care services while a client was hospitalized, while the attendant was incarcerated, or when the attendant was employed in another job. These cases have been referred to the Office of Attorney General's Medicaid Fraud Control Unit.

Top provider types under field investigation

- Dental
- Personal care attendants
- Therapy-counseling
- Home health agency
- Hospital
- Pharmacy
- Physician (individual/ group/clinic)
- Durable medical equipment
- Managed care organization
- Lab/radiology/X-ray

In a case worked by MPI, the OIG reached a settlement in December with a licensed professional counselor in Bertram for $104,000. An investigation resulted in allegations that the provider billed Medicaid for counseling services that were provided in settings that were improper and were not for the length of time claimed in the billings.

Benefits Program Integrity

The Benefits Program Integrity (BPI) Division opened 3,541 investigations involving some form of benefit recipient overpayment or fraud.

- **Household composition:** Seventy-eight percent of all investigations opened involved unreported income (31 percent) or an issue with the reported household composition (47 percent). Household composition cases usually deal with an unreported household member who has income but could also include reporting a household member that does not actually live in the household. Both instances cause the household to receive more benefits than they are entitled to.

BPI completed 436 investigations where fraud was found and were referred for either prosecution (37) or an administrative disqualification hearing (165), or waiver signed (234) with the client agreeing with the finding and repaying the overpayment.

Cases worked by BPI this quarter include:

- The Travis County District Attorney prosecuted a Supplemental Nutrition Assistance Program (SNAP) client for failing to report her correct household members and income. The client was charged with Securing Execution of a Document by Deception. She was placed on 10 years' deferred adjudication, required to pay $120,591 in restitution and was permanently disqualified from SNAP.
- The spouse of an Edinburg SNAP client was ordered to pay $44,238 in restitution and given 10 years' probation after pleading guilty to submitting falsified applications about the composition of the household to HHSC between February 2013 and April 2016.
- A Wichita County client was ordered to pay $50,545 in restitution and given 10 years' probation for lying about her household composition to obtain Medicaid for herself. The woman in Wichita County admitted that she made false statements that her son was living in the household when he was not in order to obtain SNAP, TANF and Medicaid benefits between January 2012 and October 2016.

Type of complaints received by MPI

Personal care attendant	46%
Physician (individual, clinic, or group practice)	15%
Dental	8%
Home health agency	8%
Durable medical equipment	4%
Pharmacy	3%
Nursing facility	3%
Adult day care	2%
Hospital	2%
Lab/radiology/X-ray	1%

EBT Trafficking Unit

This quarter, the Electronic Benefits Transfer (EBT) unit completed 31 investigations and presented another 25 investigations for either administrative disqualification hearings (12) or prosecution (13).

Trends identified by the unit include:

- **Funding illegal activity:** The EBT Trafficking Unit identified a recent trend regarding the selling of Supplemental Nutrition Assistance Program (SNAP) benefits cards to fund illegal activity. The unit is identifying a case where non-participants have illegally purchased the cards from SNAP recipients, who are exchanging their benefits cards for cash to pay for illegal gaming such as slot machines.
- **Purchasing SNAP cards:** In addition, the unit continues to see smaller convenience stores and restaurants across the state buying SNAP cards from recipients. The owners or designees of those businesses then go to larger retail stores and use the illegally purchased SNAP cards to buy merchandise to stock their businesses. The EBT Trafficking Unit continues to address the problem by working with large retail chains to identify customers who are using multiple SNAP cards to make purchases.

One case worked by the EBT Trafficking Unit involved allegations of SNAP recipients receiving unauthorized refunds provided by a retailer in Dallas. The investigation, which involved 41 recipients who received $1,000 or more for their SNAP benefits, resulted in identified recoveries of $165,236. The district attorney's office indicted 26 recipients, with 15 cases pending indictment. The other recipients involved in the fraudulent scheme are being handled through the administrative disqualification hearing process.

Internal Affairs

The Internal Affairs (IA) Division received 90 complaints in the second quarter alleging employee misconduct related to the delivery of health and human services, contract fraud, and other issues. IA investigated 51 percent of those complaints with the remaining referred to the appropriate business areas including the HHSC Office of the Ombudsman, DFPS Office of Consumer Relations, and the Texas Office of Attorney General. Of those investigated, 9 percent were referred for prosecution.

- **Falsifying information:** IA experienced an increase in complaints involving the alleged falsification of information across HHS, Department of Family and Protective Services, and Department of State Health Services. The majority of these cases were not sustained because there was no evidence of criminality; one was referred to the local DA for criminal prosecution.
- **Privacy Breach:** In partnership with the HHS Privacy Office, IA investigations related to privacy incidents/ breaches saw a decrease from 19 in the first quarter of fiscal year 2019 to 4 this quarter. These cases involve compromised confidential personal identification and Health Insurance Portability and Accountability Act information.

State Centers Investigations Team

The OIG's State Center Investigations Team (SCIT) opened 183 investigations and completed 194 investigations in the second quarter, with an average completion time of 31 days. This compares to 185 opened investigations and 180 completed investigations in the first quarter of fiscal year 2019. In the second quarter of 2018, SCIT opened 181 investigations and completed 181 investigations.

Type of complaints received by IA

Falsifying information/documents	31%
Unprofessional conduct	22%
Perjury	7%
Abuse/neglect	6%
Vital records fraud	6%
Unauthorized release of information	4%
Theft	4%
Privacy breach	4%
Hiring practices	3%
Phishing scam	3%

Rule proposals

Nursing facility utilization reviews

As of January 1, amendments to amendments to 1 TAC §371.214(n)(1) have been published in the Texas Register and adopted that replace the requirement that the OIG conduct onsite utilization reviews of all nursing facilities every 15 months. The new rule establishes a process whereby the OIG conducts a comprehensive review of all nursing facilities on an annual basis. This comprehensive annual review considers factors such as length of time since the last review, previous review results, complaints, and referrals in order to prioritize nursing facilities for onsite utilization reviews.

Closing investigations amendment

Proposed amendments to 1 TAC §§371.1305, 371.1307, and new rule 1 TAC §371.1312, related to closing investigations, were presented to the Medical Care Advisory Committee and the HHSC Executive Council in February and are expected to be published in the Texas Register for formal comment in March. These rules outline the criteria for opening, prioritizing, and closing preliminary, full-scale, and recipient investigations. The amendments and new rule clarify for MCOs and Texas Medicaid providers the criteria the OIG uses to close these investigations. This rule provides greater transparency into the office's investigative processes.

HB 2379: MCO referrals and recoveries

Proposed amendments to 1 TAC §353.502, §353.505, and §371.1311 related to HB 2379 were presented at the Medical Care Advisory Committee and HHSC Executive Council meetings in February and are expected to be posted in the Texas Register for formal comment in March. The OIG has proposed changes to the rules regarding provider overpayments and the MCO recovery process. The proposed amendments would align the rules with HB 2379 (85th Legislative Session) and update changes to MCO referral procedures. In fiscal year 2018, the MCOs reported recoveries of $3.89 million. These recoveries will be split between MCOs and OIG per the requirements of HB 2379.

In March 2019, the OIG is sending notifications to MCOs of the distribution of funds from MCO-identified cases the OIG investigated, as well as requests for payment from MCOs for MCO-identified cases the MCOs investigated, in accordance with HB 2379.

Policy recommendations

Audit

The OIG recommended that HHSC Medicaid and CHIP Services, through its contract oversight responsibility, should monitor UnitedHealthcare Community Plan of Texas, L.L.C.'s (UnitedHealthcare's) correction of coding errors in its encounter data and require UnitedHealthcare to put corrective actions in place to strengthen its current and future encounter data reporting. This recommendation comes after the OIG initiated an audit of durable medical equipment (DME) and supplies provider Longhorn Health Solutions, Inc. (Longhorn) to determine the reliability of UnitedHealthcare sub-capitated encounter data and claims-based encounter data.

The audit identified sub-capitation encounter data reported by UnitedHealthcare that was coded incorrectly. Because of the coding errors, encounter data for Longhorn's sub-capitated agreement DME and supplies activity, part of approximately 133,557 encounters reported by UnitedHealthcare, could not be distinguished from encounter data for Longhorn's claims-based DME and supplies activity.

For more information, the complete audit report can be found on the OIG website at http://oig.hhsc.texas.gov/

Agency highlights

Sylvia Hernandez Kauffman confirmed as inspector general

Governor Abbott reappointed, and the Texas Senate confirmed, Sylvia Hernandez Kauffman as inspector general for Texas Health and Human Services (HHS) for a term set to expire February 1, 2020. IG Kauffman is the first woman confirmed by the Senate to lead the OIG.

In her appearance before the Senate Nominations Committee, IG Kauffman discussed the goals she would like to see met during her tenure, which include strengthening managed care and contract oversight; strengthening fraud prevention efforts; continuing to require rigor and professionalism from the OIG team; and further developing a community of key partners that will help strengthen the OIG's oversight of Medicaid.

"Our office is looking at issues such as care coordination, administration of services, and contract oversight, and is recommending corrective actions plans and liquidated damages for contract non-compliance, when appropriate," Kauffman said. "I have formed a research and innovation team to help the OIG adapt to this rapidly changing environment. I want my OIG team to be dynamic and agile so it has the ability to evolve as the delivery of healthcare evolves."

Another key area where IG Kauffman told the committee the office is focusing is on the prevention of fraud. She has expanded the Texas Fraud Prevention Partnership to further the OIG's work with managed care organizations, HHSC, and the Office of Attorney General, as well as healthcare provider associations.

Legislative session

The 86th Session of the Texas Legislature is under way. The OIG requested funding for 10 BPI staff to investigate allegations of client overpayments in state health and human services programs. In fiscal year 2018, each BPI investigator recovered on average more than $425,000 due to client fraud, client error, or agency error. More investigators will protect the integrity of the Texas Medicaid system by ensuring accurate client eligibility, increasing taxpayer dollars identified for recovery, and recovering additional taxpayer dollars.

The OIG is also requesting funding to remediate the Automated System for the OIG (ASOIG). ASOIG is used to track the stages of a client referral through the investigations process in real-time. Launched in 2007, ASOIG is inefficient and is no longer capable of supporting the work of the OIG. Remediating the existing system will save time, increase efficiency and functionality, and provide for better data access and manageability, allowing investigators to review more cases.

Senator Juan "Chuy" Hinojosa filed Senate Bill 1483 relating to the proof required to impose payment holds in certain cases of alleged fraud by Medicaid providers. When the OIG receives an allegation of fraud or abuse against a provider, it must conduct a preliminary investigation. If an allegation of fraud is credible, the OIG must suspend all Medicaid payments to the provider or document a good cause exception not to suspend. The case must also be referred to the Office of the Attorney General Medicaid Fraud Control Unit or other appropriate law enforcement agency. SB 1483 clarifies that the hold may be placed when there is a threat to the integrity of Medicaid due to an ongoing significant financial risk to the state that may result in the loss of $100,000 or more or high probability that a serious threat to the health or safety of a recipient exists or may develop as a result of the provider's conduct.

Quarter 2 data

Audit reports issued	6
Audits in progress	25
Inspections reports issued	4
Inspections in progress	7
Investigations completed (BPI, IA, Peace Officer)	3,831
Investigations opened	3,783
Medicaid provider investigations completed	
Preliminary	453
Full-scale	63
MPI cases transferred to full-scale investigation	76
MPI cases referred to Medicaid Fraud Control Unit	82
Hospital claims reviewed	6,257
Nursing facility reviews conducted	105
Medicaid and CHIP provider enrollment screenings performed	28,896
Medicaid providers excluded	80
Fraud hotline calls answered	6,571

OIG notifying MCOs on distribution of recoveries from MCO-identified cases

In March 2019, the OIG is sending notifications to MCOs of the distribution of funds from MCO-identified cases the OIG investigated, as well as requests for recoupment dollars from MCOs for MCO cases referred to the OIG on or after September 1, 2017, in accordance with HB 2379. The OIG identified 76 cases where the referring MCO must remit 50 percent of their recoveries to the OIG.

In February 2019, OIG notified MCOs of their potential share of OIG recoveries under HB 2379 that resulted from an MCO-identified case. In March 2019, the OIG will notify the MCOs of the OIG's determination of their final share. The MCOs will then have 30 days to contact the OIG about any questions or concerns regarding the determination.

OIG finalizes its own Managed Care Blueprint and Transition Plan

The OIG has prioritized modernizing business functions to reflect Texas' Medicaid managed care model and the evolving relationship among the OIG, HHS, MCOs, providers, and clients. The OIG has developed the Managed Care Blueprint to guide improvements made during the business process transition. The blueprint outlines the OIG's advancement of its core functions in managed care supporting program integrity and protecting Texans. It's accomplished by continuing to develop four pillars:

- Equip the OIG with structure, tools, and processes that bolster and improve work in managed care.
- Cultivate and promote specialized knowledge and expertise on managed care.
- Optimize a data-driven approach rooted in the OIG's mission and focused on protecting Texans receiving health services via managed care.
- Strengthen relationships that support the OIG's mission and core functions within a managed care delivery system.

The OIG Managed Care Transition Plan for fiscal year 2019 outlines the initiatives in which the OIG is engaged to develop its work in managed care:

- Tailor recovery process to the managed care environment.
- Operationalize utilization review in managed care by identifying data-driven approaches from other states.
- Create and implement a comprehensive Managed Care Professional Development Plan, which includes development and coordination of educational and managed care reference materials and trainings, and cultivation of subject matter expertise.
- Continue identification of concepts for audits and inspections based on risk and data analysis, and feasibility.
- Enhance collaboration with MCOs to identify and prevent fraud, waste, and abuse (FWA).
- Distinguish the OIG's role in managed care, communicate OIG work streams and scope in managed care, create opportunities to collaborate with other areas of HHSC, and provide education that encourages continued collaboration with the OIG to identify and prevent potential FWA.
- Expand the application of data analytics and capacity of technologies and resources available to the OIG.

Liquidated damages identified by OIG

The OIG is holding accountable managed care organizations (MCOs) and dental maintenance organizations (DMOs) found to be non-compliant with program integrity requirements in their contracts. When found non-compliant, the OIG recommends to HHSC that

Recommended liquidated damages

	Q3 FY 2016	Q1 FY 2017	Q2 FY 2017	Q3 FY 2017	Total
Special Investigative Unit recommendations	$73,000	$792,800			$865,800
Request for information recommendations				$17,500	$17,500
Total	$73,000	$792,800	$659,972	$17,500	$1,543,272
Total collected	$73,000	$792,800	$659,972	$17,500	$1,543,272

Notes

1. SIU Audit LDs were assessed by HHS in different quarters based on when the reports were finalized.
2. No LD recommendations were made by the OIG for the fourth quarter of fiscal year 2016.

it assess MCOs liquidated damages (LD). The OIG works with Texas Medicaid to apply a methodology in line with the remedies used for other types of damages. Contract non-compliance where the OIG has recommended LDs include the lack of effectiveness of MCO special investigative units (SIUs) and MCOs delivering untimely and/or inaccurate documents when requested.

The chart on page 6 illustrates the identified LD Texas HHS collected thus far for non-compliance following recommendations from the OIG.

MPI better tracking home health agencies and workers

The Medicaid Program Integrity Division (MPI) is focusing on home health agency workers (attendants) billing for hours while not on duty. In the second quarter of fiscal year 2019, MPI had 27 attendant care cases develop into full-scale investigations and transferred 17 attendant care cases to OIG Litigation for possible exclusion from participating in Texas Medicaid.

At the end of the second quarter, Litigation had 29 open cases for possible exclusion related to attendant care.

WIC Vendor Monitoring Unit increases recoveries

The Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) completed 118 compliance buys, 152 on-site store reviews, and closed 199 cases in the first two quarters of fiscal year 2019.

A compliance buy is a covert in-store inspection in which an inspector poses as a WIC client or proxy and uses a WIC Electronic Benefits Transfer (EBT) food card to transact a purchase. The inspector does not reveal to store personnel that they are a state agency representative during the visit.

An on-site store review is an assessment of the store's WIC operations in which the inspector identifies him/herself to store personnel. The review includes verifying prices are prominently displayed for all WIC food items examining adequacy of stock levels; ensuring adherence to labeling and vendor incentive item restrictions. The review concludes with the inspector reviewing findings with store management. Violations may be noted, but no penalties are imposed

During this same period, the VMU also recovered $60,348 and collected $29,695 in civil monetary penalties. As a comparison, in the first two quarters of fiscal year 2018, the VMU recovered $740 and collected $12,617 in civil penalties. In the first two quarters of fiscal year 2019, the VMU has also assessed disqualification cost avoidance of $5.3 million, already exceeding the largest annual amount recorded in recent years.

Completed reports

Audit

UnitedHealthcare Encounter Data: Records of Provider Services Delivered Under a Sub-Capitated Agreement Were Coded Incorrectly. The OIG initiated an audit of durable medical equipment (DME) and supplies provider Longhorn Health Solutions, Inc. (Longhorn). Part of the audit includes testing authorization of certain supplies delivered under a sub-capitated agreement to members of UnitedHealthcare Community Plan of Texas, L.L.C. (UnitedHealthcare); UnitedHealthcare also uses Longhorn as a claims-based DME provider outside of the sub-capitation agreement, in which UnitedHealthcare reimburses Longhorn for claims submitted for payment. One of the objectives for this part of the audit was to determine the reliability of UnitedHealthcare sub-capitated encounter data and claims-based encounter data.

The OIG found that sub-capitation encounter data reported by UnitedHealthcare was coded incorrectly. Because of the coding errors, encounter data for Longhorn's sub-capitated agreement DME and supplies activity could not be distinguished from encounter data for Longhorn's claims-based DME and supplies activity, resulting in these transactions being misclassified in HHSC's financial reports. UnitedHealthcare, however, indicated it will complete a project to correct the encounter data.

Audit of Metscript Pharmacy No. 2 Vendor Drug Program Claims. The OIG audited Metscript Pharmacy No. 2 (Metscript) Vendor Drug Program (VDP) claims to determine if Metscript properly billed VDP for Medicaid claims submitted and complied with contractual Texas Administrative Code requirements between September 2013 through August 2016. The results indicated no exceptions for the claims tested.

Audit of Epic Pediatric Therapy: A Texas Medicaid Speech Therapy Provider. The OIG conducted an audit of Epic Pediatric Therapy (Epic) to determine whether Epic properly billed FirstCare Health Plans (FirstCare) for Medicaid claims submitted and complied with requirements contained in its agreement with FirstCare and the FirstCare Provider Manual, as well as state rules and guidelines.

Epic submitted 5 speech therapy claims with incorrect procedure codes, resulting in $174 reimbursed in error. The OIG recommended that Epic ensure all Medicaid claims submitted contain correct procedure codes and submit to the state of Texas the overpayment of $174. Epic indicated in its management response that it plans to complete corrective actions by September 2019.

Audit Of Cook Children's Medical Center Teddy Bear Transport: A Texas Medicaid Air Ambulance Provider. The OIG conducted an audit of air ambulance provider Cook Children's Teddy Bear Transport (Teddy Bear Transport), a division within Cook Children's Medical Center, to determine whether paid Medicaid claims and managed care claims for air ambulance services and their associated ground transport were billed according to state rules and guidelines and contractual requirements.

During the audit period, Teddy Bear Transport submitted claims for 238 air ambulance claims for which it received reimbursements of $1,893,046, and 141 ground ambulance claims for which it received reimbursement of $85,824. Teddy Bear Transport did not bill the correct mileage for 15 of 238 air ambulance claims. In addition, Teddy Bear Transport did not ensure that prior authorization had been obtained by the referring medical provider before delivering and billing for one fee-for-service out-of-state-transport service. These 16 claims resulted in $19,521.50 reimbursed in error.

The OIG recommended that Teddy Bear Transport ensure claimed mileage is accurate, that it obtains prior authorization for out-of-state transports, and that it return overpayments of $19,521 to the state of Texas.

Bethesda Lutheran Homes And Services: A Texas Medicaid Home And Community-Based Services Program Provider. The OIG completed an audit of Bethesda Lutheran Homes and Services (Bethesda Lutheran) to evaluate whether fee-for-service claims submitted by and paid to Bethesda Lutheran were authorized, documented, and billed according to the home and community-based services provider agreement and state rules and guidelines. Bethesda Lutheran did not accurately calculate units of service from times documented on 41 or 395 daily claims, resulting in $478 reimbursed in error, which the OIG recommended it return to the state of Texas. Bethesda Lutheran indicated that it plans to complete corrective actions to avoid further errors.

Inspections

Automated Monthly Social Security Number Verification: Inspection of HHSC Access and Eligibility Services' Process for Addressing Non-Verified Social Security Numbers for Texas Medicaid Clients. The OIG conducted an inspection to determine if HHSC Access and Eligibility Services (AES) properly addresses non-verified Social Security numbers (SSNs) to prevent ineligible client enrollment in Texas Medicaid.

The OIG found that HHSC AES has an effective process for verifying SSNs upon enrollment. The OIG observed there were 76,501 SSNs that were not verified in June 2018 due to validation rules governing the automated monthly SSN verification interface process.

The OIG noted three opportunities for improvement: 1) Review the Texas Department of Family and Protective Services (DFPS) front-end eligibility process for enrolling foster care clients in Medicaid and their transition into the adoption assistance program; 2) Review the validation rules governing the automated monthly SSN verification interface process to identify if changes are necessary; and 3) Develop a collaborative communication process between AES and DFPS to address the non-verified SSNs related to foster care and adoption assistance clients.

Durable Medical Equipment: Inspection of Power Wheelchairs. The OIG conducted an inspection to determine if documentation requirements are being met when Medicaid clients receive power wheelchairs from durable medical equipment (DME) suppliers, including whether DME suppliers met documentation requirements for prior authorizations and whether clients received power wheelchairs as prescribed.

The OIG found documentation standards in the Texas Administrative Code for fee-for-service claims, however, there are no documentation standards for MCOs when Medicaid clients receive power wheelchairs from DME suppliers. The Uniform Managed Care Contract allows each MCO to set their own standards for DME suppliers. MCOs have the discretion to require a prior authorization for power wheelchairs. Due to the cost of power wheelchairs, all nine of the MCOs sampled require prior authorizations.

The OIG observed that not all power wheelchairs were received as prescribed or used by clients in nursing facilities; and a review of prior authorization and supporting documentation identified incomplete or inadequate information.

Pharmacy Benefit Managers: Inspection of Program Integrity Activities. The OIG conducted an inspection to determine the program integrity activities pharmacy benefit managers (PBMs) use to detect fraud, waste, and abuse (FWA) of Medicaid-funded prescriptions. The objective of the inspection was to determine how PBMs detect overbilling, unauthorized refills, and unauthorized prescription drug substitutions.

The two PBMs selected by OIG rely on three program integrity activities to detect FWA in overbilling, unauthorized refills, and unauthorized drug substitutions in Medicaid-funded prescriptions. Those activities are: Edit Checks of Submitted Prescription Claims; Daily Prepayment Review of Covered Prescription Claims: and Audit of Paid Prescription Claims. These specific activities are not required in the managed care contract. Therefore, any observations made are not an indication of non-compliance with rules, statutes, HHSC guidance, or contract requirements.

The OIG observed that selected PBMs are unable to provide complete results of their prepayment review process.

Personal Care Services: Inspection of Attendant Background Checks. The OIG conducted an inspection to determine if home health providers obtain and evaluate background information on attendant care personnel to ensure client safety. The inspection focused on whether home health providers have policies and procedures to ensure required criminal history and exclusion checks are performed and whether home health providers document and evaluate attendant care personnel's criminal history to ensure they have not been convicted of an offense that excludes them from employment.

The OIG found that all 12 inspected home health providers had policies and procedures in place to perform the required background checks. However, home health providers did not consistently document that they performed the required background checks. Of the 229 attendant records reviewed at the provider's office, 25 percent were missing at least one of the required background checks, or the background checks were performed only after the attendant provided direct client services.

The OIG made three observations: 1.) Seven percent of attendant records were missing the required Texas Department of Public Safety criminal history, and seven percent of the background checks were performed after attendants provided services. 2.) The Texas Health and Safety Code does not require home health providers to complete additional criminal history checks after the initial check. 3.) Fifteen percent of attendant records were either missing the required Nurse Aide Registry/Employee Misconduct Registry, the OIG exclusion background checks, or both.

Stakeholder outreach

Legislative session

Inspector General Sylvia Hernandez Kauffman presented the OIG budget request before the Senate Finance Committee in February. IG Kauffman also testified twice before the House Appropriations Article II subcommittee on the proposed OIG budget. Regarding the first time, IG Kauffman testified on the OIG budget requests. The second testimony included a discussion of current IT projects and technology related budget requests.

IG Kauffman also appeared in front of the Senate Nominations Committee in February as part of her confirmation process.

IG Kauffman met with other legislators and their staff to discuss the OIG's managed care focus and program integrity issues:

- Rep. Terry Meza
- Rep. Sarah Davis
- Rep. John Turner
- Rep. Matt Schaefer
- Rep. Mayes Middleton
- Rep. Cole Hefner
- Dr. Tom Oliverson
- Dr. J.D. Sheffield
- Rep. Diego Bernal
- Rep. Dan Huberty
- Rep. Rick Miller
- Sen. Dawn Buckingham
- Sen. Kel Seliger
- Sen. Carol Alvarado
- Sen. Bob Hall

OIG staff meets with dental and attendant care stakeholders

OIG staff held stakeholder meetings in February, hosting a Medicaid Dental Services Workgroup and Attendant Care

Services Workgroup. The OIG had established a workgroup with Medicaid and CHIP Services and HHSC Regulatory to address select fraud, waste, and abuse issues in these areas. The OIG presented preliminary recommendations, which were discussed with stakeholders at the meetings to obtain input and feedback. The OIG and HHSC were grateful for the contributions from stakeholders.

The Medicaid Dental Services Workgroup recommendations can be found in this report's Program Integrity Spotlight on page 11.

Texas Fraud Prevention Partnership meetings resume

The OIG began holding Texas Fraud Prevention Partnership (TFPP) MCO Leadership meetings in February. The February meeting included representatives from every Medicaid MCO and DMO in Texas and offered the opportunity to discuss current initiatives, as well as to focus on fraud, waste, and abuse prevention in Texas Medicaid.

Expanding the TFPP to include all health and dental plans was a long-term goal of the partnership from its inception in 2017. The renewed and expanded focus helps to identify ways to reach these goals:

- Reduce waste in the healthcare delivery model.
- Prevent and detect fraud, waste, and abuse in Texas Medicaid.
- Continue OIG collaboration with MCOs to strengthen the Medicaid program in Texas.

OIG hosts booth at home health conference in Austin

The OIG staffed a booth at the annual Texas Association for Home Care & Hospice conference in Austin in February. Staff provided attendees information on how to prevent fraud, waste, and abuse in home health care, including letters for providers, attendants, and clients, which can be found on the Resources page of the OIG website (https://oig.hhsc.texas.gov/resources). OIG staff had met with Texas Association for Home Care & Hospice representatives in December to discuss the monitoring services for the electronic visit verification and community attendant services programs funded by HHS.

OIG staff meets with groups to discuss audits

OIG staff met with Texas Health Care Association representatives in January to gain a better understanding of the issues and concerns of skilled nursing facility providers in the STAR+PLUS program. The OIG recently initiated an audit to determine whether selected STAR+PLUS MCOs accurately and timely adjudicated qualified nursing facility claims according to applicable criteria, and will consider the concerns discussed during the meeting as the OIG completes its audit.

OIG staff met with Alliance of Independent Pharmacists representatives in February to discuss the issues and concerns of independent pharmacies specific to pharmacy benefit services delivered through the current pharmacy benefit manager (PBM) model. OIG staff also updated them on the status of the in-progress audit on PBMs.

Nursing Facility Utilization Review Stakeholders meeting

OIG staff met with representatives of the HHS Medical and Social Services Division's Medicaid and CHIP Services, Texas Health Care Association, Leading Age, Texas Medicaid Coalition, and nursing facility providers at its quarterly Nursing Facility Utilization Review (NFUR) Stakeholders meeting in December. They discussed an audit of long-term care nursing facility therapy practices and their financial impact, the state resident assessment instrument coordinator's update on residential long-term care, an NFUR proposed rule change, and a provider survey on improving telephone exit processes for nursing facilities.

Hospital Utilization Review stakeholders meeting

OIG staff met with representatives of the HHS Medical and Social Services Division's Medicaid and CHIP Services, hospital associations, and health plan associations at its quarterly Hospital Utilization Review Stakeholders meeting in January. They discussed a managed care review update, the appeals process, submission of records, and survey results.

OIG educational articles published by health associations

Texas Pharmacy Magazine featured a story on the OIG's Lock-in Program in its winter 2019 edition, highlighting the increase in the number of clients and updated criteria for the program. An article on the OIG's dental fraud detection operations appeared in the January 2019 issue of the Texas Dental Association's newsletter.

Program Integrity Spotlight

Addressing Select Fraud, Waste, and Abuse Schemes in Children's Medicaid Dental Services

The OIG and Health and Human Services Commission (HHSC) Medicaid and CHIP Services (MCS) issued joint recommendations to address the issues raised by stakeholders about the provision of, and the fraud, waste, and abuse (FWA) in, the Children's Medicaid Dental Services program.

Background

Most children's Medicaid dental services are provided through one of two dental maintenance organizations (DMOs) to persons under 21 years of age, with limited exceptions. According to the HHSC state fiscal year 2018 operating budget, more than $1.5 billion in all funds is spent annually on Children's Medicaid Dental Services, with more than 3 million Texas children currently eligible for Medicaid dental services.

Given the number of allegations the OIG has received about FWA in dental services and the feedback received from dental stakeholders (allegations of dental provider FWA are among the top three most frequent categories of allegations received by the OIG), staff from the OIG and MCS formed a workgroup to develop recommendations to address select FWA issues in the Children's Medicaid Dental Services program. The workgroup met in fall 2018 and reviewed Medicaid dental data, assessed the type and breadth of program integrity issues, and identified recommendations for addressing the issues reviewed.

Based on data analysis and prioritization, the workgroup recommended that action be taken by the OIG and MCS in two areas of concern:

1. Medically unnecessary restorations (restorations on any single tooth, primary or permanent within a 12-month period), and excessive restorations (more than 10 restorations in one day), and
2. Improper dental solicitation.

Stakeholder discussion

To better understand how these issues might be addressed, the OIG hosted a stakeholder meeting in February with attendees from MCS; DentaQuest and MCNA (the two DMOs); and representatives of the Texas Dental Association (TDA), Texas Academy of Pediatric Dentistry (TAPD), and Texas Academy of General Dentistry (TAGD). During the discussion with stakeholders, several themes emerged:

- Participants wanted to address concerns about multiple restorations on one tooth within a 12-month period if exceptions are allowed to ensure that medically necessary care is not delayed.
- Participants needed further discussion on the issue of more than 10 restorations occurring for one child in one day. Participants were concerned that this could be a legitimate service provided to children for whom poor nutrition and oral health care may necessitate this action.
- Participants noted the Texas Medicaid Provider Procedures Manual (TMPPM) was written for sole proprietors or small group dental practices when managed care was not in place and has not been updated recently. Providers are mirroring policies from the TMPPM, but DMO policies differ from the TMPPM.
- Participants suggested that a dental billing code analysis could address FWA concerns in dental services and would help guide HHSC analysis of the appropriateness of dental claims. The suggestion was for this workgroup to include HHSC, DMOs, dental associations, academicians, and providers, with a different workgroup formed for each billing code group.
- Participants noted concerns about the service delivery and billing practices of large dental service provider groups (i.e., name changes and multiple locations) and suggested that the OIG focus FWA activities on those.
- Participants were very concerned about dental solicitation.

Recommendations

As a result of stakeholder input, the workgroup made these recommendations:

1. Address the concerns raised in the stakeholder meetings in Texas Fraud Prevention Partnership (TFPP) DMO meetings.
2. Add the dental associations to TFPP meetings (TDA, TAPD, and TAGD).
3. Set a time and date for presenting HHSC OIG dental

solicitation data analysis to MCS and then DMOs.

4. Submit formal, data driven recommendations to MCS to limit restorations in certain circumstances on the same tooth within a 12-month period. OIG's recommendations will be based on documented issues and supported with available data.
5. Analyze dental investigations from the last two to three years and identify policy issues and data patterns to communicate with MCS.
6. Submit a formal package to MCS identifying dental billing codes that been identified by the OIG as recurring risks for fraud, waste, and abuse for their use in any dental policy modernization efforts related to dental billing codes.
7. Support any MCS dental policy modernization efforts by having OIG staff serve as subject matter experts as questions arise during such a process.

The OIG will be implementing these recommendations during the balance of fiscal year 2019 .

Division performance

Inspections and Investigations

The OIG Inspections and Investigations divisions were combined in 2018 to form the Inspections and Investigations Division.

Inspections inspects HHS programs, systems, and functions for fraud, waste, abuse, and systemic issues in order to improve the HHS System and help assess risk in the system. Inspections oversees the state's WIC Vendor Monitoring Unit. This unit conducts in-store evaluations, compliance buys, and invoice audits to monitor vendors participating in the WIC program.

Investigations is comprised of the State Centers Investigative Team and the Electronic Benefit Transfer Trafficking Unit. The division protects the integrity of HHS programs through investigations of employee misconduct involving abuse, neglect and exploitation in state supported living centers and state hospitals as well as vendor and recipient EBT trafficking.

Cases are referred for administrative disqualification hearings and prosecution to appropriate state or federal regulatory and law enforcement authorities. Commissioned peace officers in the division conduct criminal investigations of allegations of abuse, neglect, and exploitation in state supported living centers and state hospitals, and EBT trafficking.

EBT Trafficking Unit performance

Overpayments recovered	$43,213
Cases opened	14
Cases completed	31

State Centers Team performance

Overpayments identified	$1,280
Cases opened	183
Cases completed	194

Peace Officers performance

Cost avoidance	$656,731

Inspections reports issued

- Automated Monthly SSN Verification
- Durable Medical Equipment
- Pharmacy Benefit Managers
- Personal Care Services

Inspections in progress

- Value-Based Purchasing
- Data Integrity of Online Provider Directories
- MCO Complaints Series I: Inspection of Intake of Member Complaints
- MCO Complaints Series II: Inspection of Resolution of Member Complaints
- MCO Complaints Series III: Inspection of Appeals Process of Member Complaints
- Eligibility Determinations for Out-of-State Clients
- Recovery of Unclaimed Funds

Inspections performance

Overpayments recovered	$8,720
Overpayments identified	$307,162

Audit

The Audit Division conducts risk-based audits that examine the performance of contractors, providers, and HHS programs to reduce fraud, waste, and abuse throughout the HHS System, and provide independent assessments of HHS programs and operations.

Audit coordinates federal government audits and is the single point of contact with the Centers for Medicare & Medicaid Services for Unified Program Integrity Contractors (UPIC) audits and Payment Error Rate Measurement (PERM) activities.

Audit performance

Overpayments recovered	$2,565,306
Overpayments identified	$20,174
Audit reports issued	6

Audit reports issued

- Epic Pediatric Therapy: A Texas Medicaid Speech Therapy Provider
- Cook Children's Teddy Bear Transport: A Texas Medicaid Air Ambulance Provider
- UnitedHealthcare Encounter Data
- Metscript Pharmacy No. 2: A Texas Vendor Drug Program Provider
- Bethesda Lutheran Homes and Services: A Texas Medicaid Home and Community-Based Services Program Provider
- Texas Medicaid and Healthcare Partnership - Third Party Recovery: Review of Accenture's Evaluation of health Management Systems, Inc.

Audits in progress

The Audit Division had 25 audits in progress this quarter on the topics listed below. A list of audits in progress and audit topics the OIG plans to initiate can be found in the two-year rolling audit plan located on the OIG's website.

- STAR+PLUS enrollment
- Durable Medical Equipment (DME) claims
- Pharmacy providers
- Managed care pharmacy benefit managers' compliance
- IT security and business continuity and disaster recovery planning assessments
- Medical transportation program vendor performance
- MCO STAR Kids and STAR Health programs
- Dental maintenance organization performance
- MCO STAR+PLUS waiver program
- MCO service coordination
- Statewide nursing facility therapy service analysis
- DFPS child-specific contract payments
- MCO clean claims for nursing facility providers
- Selected DFPS contract areas
- Selected Local Intellectual and Developmental Disability Authority (LIDDA) contractors

Benefits Program Integrity

The Benefits Program Integrity Division investigates allegations of overpayments to health and human services program clients enrolled in the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF) program; Medicaid; Children's Health Insurance Program (CHIP); and the Women, Infants, and Children (WIC) program. Clients can be disqualified from a program, denied benefits, and/or ordered to repay all benefits fraudulently received.

Benefits Program Integrity performance

Overpayments recovered	$3,570,111
Cases completed	3,490
Cases opened	3,541
Cases referred for prosecution	40
Cases referred for Administrative Disqualification Hearings	187

Medicaid Program Integrity

The Medicaid Program Integrity Division (MPI) investigates and reviews allegations of fraud, waste, and/or abuse by Medicaid providers, who may be subject to a range of administrative enforcement actions including education, prepayment review of claims, penalties, required repayment of Medicaid overpayments, and/or exclusion from the Medicaid program. Referrals are made to the Office of Attorney General's Medicaid Fraud Control Unit when there are indications of criminal Medicaid fraud.

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

Medical Services includes the Clinical Subject Matter Expert team (a physician, dentist, dental hygienist, and pharmacist) who provide clinical expertise to all OIG areas; the Acute Care Surveillance team, which identifies patterns of aberrant billing, performs Surveillance Utilization Reviews required by the federal Centers for Medicare & Medicaid Services, develops and runs targeted data queries to identify acute care billing outliers, and collects Medicaid overpayments; and the Quality Review team, which conducts retrospective utilization reviews of hospitals and nursing facilities, and administers the pharmacy Lock-in Program.

Medicaid Program Integrity performance

Preliminary investigations opened	533
Preliminary investigations completed	453
Full-scale investigations completed	63
Cases transferred to full-scale investigation	76
Cases referred to AG's Medicaid Fraud Control Unit	82
Open/active full-scale cases at end of quarter	158

Medical Services performance

Acute Care provider recoveries	$4,020,258
ACS identified MCO overpayments	$323,434
Hospital and nursing home UR recoveries	$3,587,522
Hospital UR claims reviewed	5,512
Nursing facility reviews conducted	105

Third Party Recoveries

The Third Party Recoveries (TPR) Division includes the Third Party Liability (TPL) unit and the Medicaid Estate Recovery Program (MERP). TPL works to reduce Medicaid expenditures by shifting claims expenses to third-party payers. TPL ensures Medicaid is the payer of last resort through cost avoidance and recovery efforts and other cost containment initiatives. Approximately 7 percent of people with Medicaid have other health insurance, which allows Medicaid to shift costs to the other insurance carrier. The Texas Medicaid & Healthcare Partnership (TMHP) operates the TPL program on behalf of HHSC, but TPL staff oversees those operations and provides program and policy guidance to TMHP, other HHSC areas, MCOs, and stakeholders.

The Omnibus Budget Reconciliation Act of 1993 requires all states to attempt to recover the costs paid by Medicaid for long-term care benefits received by Medicaid clients, 55 years and older, who applied for certain long-term care services. Texas implemented MERP in 2005, and it is only applicable to the estates of these Medicaid clients upon their death. Texas outsources the majority of the daily operations of MERP to a contractor, but MERP staff oversees those operations and provides program and policy guidance to the vendor, other HHSC areas, and stakeholders.

Third Party Recoveries performance

Dollars recovered	$81,117,471
Cost avoidance	$29,289,265

Chief Counsel

The Chief Counsel Division provides legal counsel to the IG and all OIG divisions so that each division is best able to accomplish the OIG mission. The Chief Counsel Division includes:

Litigation: The Litigation section receives referrals from Investigations staff to determine the amount of any overpayments that may have been made to Medicaid providers and recommend whether any further sanctions should be pursued in a case.

Litigation handles the appeals of investigations and audits that have determined that providers received Medicaid funds to which they were not entitled. These investigation cases are settled by agreement or resolved by hearing before a State Office of Administrative Hearings judge. Audit files are settled by agreement or resolved by hearing before an HHSC appeals judge.

Litigation terminates and excludes Medicaid provider enrollment for certain program violations and also works with providers who want to self-report a potential Medicaid violation.

General Law: The General Law section provides legal advice and support to all aspects of the OIG's operations, including researching termination/exclusion issues, drafting policies and procedures related to the OIG mission, determining federal share obligations, and proposing rule and statute changes. General Law is responsible for taking initial actions to terminate or exclude providers when a provider has been terminated or excluded from Medicare or another state Medicaid program.

Internal Affairs: The Internal Affairs section investigates employee misconduct as it relates to the delivery of health and human services.

Office of Strategic Initiatives: The Office of Strategic Initiatives (OSI) develops and implements OIG-wide related initiatives and special projects, and coordinates and performs complex research concerning program integrity activities related to Texas HHS programs. OSI also provides expert assistance and advice on coordinating and implementing OIG cross-functional projects and strategic initiatives.

Internal Affairs performance

Investigations completed	63
Cases with sustained allegations	18

Operations

The Operations Division includes the Fraud Hotline, which receives allegations of fraud, waste, and abuse and refers them for appropriate further investigation or action; the Program Integrity Research team, which completes the required state and federal disclosure and screening activities for high-risk providers seeking to enroll or re-enroll in Medicaid and other HHS programs; Business Operations and Operations Support, which is responsible for oversight of OIG purchasing and contract management, acting as a liaison for facility support and handling OIG administrative services; Strategic Operations and Professional Development, which promotes training services, internal policy development, and organizational support for all OIG divisions; and Finance, which is responsible for overseeing the OIG's budget and reporting Legislative Budget Board performance measures.

Operations performance

Provider enrollment inventory (applications and informal desk reviews) processed	8,289
Individual screenings processed	28,896
Fraud hotline calls answered	6,571

Chief Strategy Office

The Chief Strategy Office includes the Government Relations, Public Affairs and Publications, Policy, and Data and Technology (DAT) units. The office sets strategy for the OIG. The division coordinates and ensures timely and effective external communication with a variety of stakeholders. It provides outreach and communication with legislators, consumers, family members, MCOs, other agencies within the HHS System, and the media, and is the primary division for managing government relations for the OIG. The division analyzes legislation, conducts analysis of program policies, and handles all legislative and media inquiries.

DAT implements tools and innovative data analytic techniques that streamline OIG operations and increases the identification of fraud, waste, and abuse in HHS programs. DAT uses data research and data analytics to identify, monitor, and assess trends and patterns of behavior of providers, clients, and retailers participating in HHS programs.

Data and Technology performance

Data requests received	219
Data requests completed	192
Algorithms executed	54
New algorithms developed	20

Policy and Publications reports issued

- Issue Brief: Encounter Data
- Fraud and Abuse Prevention: Dental Services
- Fraud and Abuse Prevention: Home Health Aides

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