Texas Medicaid and CHIP Managed Care Organizations' Special Investigative Units Review and Recommendations

As directed by
Rider 152, Article II, 85th Texas Legislature

Texas Health and Human Services
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Executive Summary

The Texas Medicaid and CHIP Managed Care Organizations' Special Investigative Units Review and Recommendations report is submitted in compliance with the 2018-2019 General Appropriations Act, 85th Legislature, Regular Session, 2017 (Article II, Health and Human Services Commission [HHSC], Rider 152).

HHSC Rider 152 required the Office of the Inspector General (OIG) to:

1. Conduct a review of Medicaid and Children's Health Insurance Program (CHIP) managed care organizations (MCOs) Special Investigative Units (SIUs); and

2. Develop recommendations in collaboration with Medicaid and CHIP MCOs for the composition and activities of SIUs.

The OIG conducted a review of the literature in this area in addition to distributing a 32-question SIU Composition and Activities Survey[1] to the 22[2] Texas Medicaid and CHIP MCOs and DMOs. In addition to the OIG SIU Composition and Activity Survey, the OIG reviewed findings from the OIG Cost Avoidance Waste Prevention Survey, the OIG's Audit report on MCOs' SIU performance, the MCOs' fraud, waste, and abuse (FWA) Compliance Plans, and managed care contracts from other states.

Currently, MCOs and DMOs (hereinafter collectively referred to as MCOs,) are required to:

1. Develop a FWA Compliance Plan that outlines the MCOs processes to prevent, detect, investigate, report and refer potential FWA to the OIG and Attorney General's Medicaid Fraud Control Unit (MFCU). The FWA Compliance Plan's critical elements can be carried out by many of the MCO's business areas, including SIUs, Claims Adjudication, Legal, and Provider Relations. MCO efforts to prevent FWA may also intersect with their cost avoidance activities. Cost avoidance refers to a deliberate intervention that reduces or eliminates a cost that would have otherwise occurred if not for that use of that intervention.[3]

2. Establish an SIU to prevent, detect, and investigate fraudulent claims and other types of program abuse by members and service providers. Establishing an SIU with the right staffing configuration, education and experience and necessary resources can lay the foundation for MCOs to develop effective FWA activities that produce cost avoidance savings, recoveries and referrals to the OIG. Effective SIUs are an essential part to ensuring state and federal funds are spent appropriately on the provision of health care services while protecting the health and safety of members.

3. Report annually to the OIG the dollar value of their recovered overpayments. Overpayments occur when a provider receives an improper payment from the MCO. MCOs are responsible for detecting and identifying improper payments. Overpayments may be identified through a SIUs' FWA investigations or from detection methods used by other MCO business areas.

To prevent, detect, and investigate FWA the MCOs implement their FWA Compliance Plans and establish an SIU. The MCOs' FWA Compliance Plans' activities may be carried out by other business areas. Given that a variety of MCO business areas may be involved, the amount of recoveries may not be solely dependent on an SIU's composition and activities. The total dollar value of MCOs' annual FWA recoveries do not provide a comprehensive view of the MCOs' efforts to prevent, detect, and investigate FWA. To have a comprehensive view, other variables should be considered including the MCOs' pre-payment efforts in addition to their post payment efforts.

Based on the OIG's research, collaboration with Medicaid CHIP Services department, and the MCOs and DMOs the OIG developed recommendations to improve the effectiveness of MCOs' SIUs and FWA activities. The Medicaid and CHIP MCOs and DMOs may consider adopting one or more of the following recommendations based on their assessment of their specific needs and whether they have already adopted these recommendations:

Recommendation 1: Employ an SIU manager whose time is 100 percent dedicated to direct oversight of their MCO's SIU and FWA activities, and is considered key personnel in Medicaid and

CHIP managed care contracts with HHSC.

Fourteen MCOs currently employ a SIU manager whose sole responsibility is direct oversight of the SIU and FWA activities, including referrals to the OIG. In SFY 2017, MCOs that had a dedicated SIU manager averaged $9,024 in annual recoveries per 10,000 enrolled members, while those MCOs SIUs without a dedicated SIU manager, averaged $4,365 in annual recoveries per 10,000 enrolled members.

Recommendation 2: Meet contract requirements that will be developed by the state for the method and frequency of member verification of services.

The 2017 Legislative Budget Board Government Effectiveness and Efficiency Report stated that according to the United States Department of Health and Human Services Office of Inspector General, verification of services is a primary program integrity concern of states, MCOs, and CMS.[4] In the instances where fraudulent schemes cannot be detected through data mining, post-payment reviews, and predictive modeling, targeted efforts for member verification of services can lead to increased detection of FWA.

Recommendation 3: Employ or subcontract SIU staffing that includes, at minimum, a full-time equivalent position who is either an accredited investigator or an investigator who's a certified fraud examiner.

Seventeen MCO SIUs reported they currently employ at least one investigator who is responsible for all their FWA investigations. Ten MCOs recommended the SIU should contain investigators.

Recommendation 4: Use standardized methodologies developed by the state, with stakeholders' input, to calculate and evaluate their cost avoidance savings related to FWA prevention activities.

Other states and the federal government have noted that establishing a standard methodology and definition would allow a baseline for measurement and comparison among MCOs SIUs and/or other business functions.[5] Moreover, in several of its recent state program integrity reviews, CMS recommended states collect supporting documentation from MCOs regarding their cost avoidance and prevention activities.[6] In order to be able to compare data across all MCOs

methodology should be standardized.

Recommendation 5: Require SIU staff, including those employed by a third party to conduct SIU activities, to attend national organizations' FWA focused trainings to learn and adopt innovative techniques for the prevention, detection and investigation of FWA.

There are national organizations that provide continuing education and professional development training on FWA trends, emerging fraudulent schemes, and notable practices to prevent, detect, investigate, and prosecute FWA. Thirteen MCOs require or allow investigators to attend national organizations' trainings related to anti-fraud efforts.

Recommendation 6: Ensure program integrity activities are integrated into each business area responsible for providing support to the SIU and/or executing FWA activities through documented and up to date policies and procedures that clearly define roles, responsibilities and performance expectations.

Effective communication and collaboration across the MCO's different business areas increases the opportunities to prevent and detect FWA. Sixteen MCOs noted information is shared across business areas; however, only one MCO reported having a formal and documented procedure in place. The remaining 15 MCOs reported they informally share information as needed through meetings and/or email.

Recommendation 7: Periodically review and revise algorithms for fraud, waste, and abuse detection focused data analytics.

Data analytics can establish a baseline that enhances the SIUs abilities and likeliness to recognize unusual trends, high volume or high cost outliers, provider and member utilization patterns, and provider referral patterns.[7] A higher rate of FWA detection could occur because of utilizing regularly updated algorithms to identify fraudulent schemes executed in other states and analyzing data from different perspectives. Since fraud schemes adapt to detection efforts, it is important to revisit criteria frequently.

Recommendation 8: Use non-traditional third-party resources to gather information to aid in FWA detection and investigation efforts.

Non-traditional resources may enhance detection efforts and supplement ongoing investigations by providing additional insight and supplemental information not found in traditional detection and investigation sources.

Seven MCOs reported using non-traditional third-party resources to further enhance their detection and investigation efforts.

Introduction

Medicaid and the Children's Health Insurance Program (CHIP) managed care and dental maintenance organizations (hereinafter collectively referred to as MCOs) are required to have a special investigative unit (SIU) to carry out detection and investigation efforts related to fraud, waste, and abuse (FWA). MCOs may fulfill this requirement using their own employees or subcontract with a third-party entity. MCOs are able to recover overpayments paid to their providers based on their SIUs' FWA investigations. SIUs investigations may also lead to FWA referrals to the Office of the Inspector General (OIG) and/or the Office of the Attorney General's Medicaid Fraud Control Unit (MFCU). MFCUs are federally required[8] and operate independently from the state Medicaid program, to investigate and prosecute Medicaid provider fraud, including fraud committed by providers under contract with Medicaid managed care plans.[9]

As the single state Medicaid agency, the Health and Human Services Commission (HHSC) contracts with 22[10] MCOs to deliver medical and dental services to members enrolled in Medicaid and CHIP. MCOs must balance the objectives of being cost effective while providing access to quality care and ensuring appropriate utilization of services. In state fiscal year (SFY) 2017, 18 of the 22 MCOs recovered $5.6 million (All Funds) and referred 208 cases to the OIG because of their SIUs' investigation and recovery efforts. This represents less than 0.1 percent of the capitation payments paid by HHSC.[11] In the same fiscal year, 4 of the 22 MCOs did not make recoveries and did not make referrals to the OIG. MCOs recover overpayments or chose an alternative approach (e.g., provider education, training or offsetting their overpayments against their future claims) to requiring providers to make a cash payment in full to settle the overpayment. These alternative approaches may mitigate the MCOs risk of not meeting their required provider network standards (i.e., prescribed member travel time and distance to providers) because of provider abrasion and losing providers.

The total dollar value of an MCO's annual FWA recoveries does not provide a complete picture of an MCO's efforts to prevent, detect, and investigate FWA.

What is fraud?

Fraud is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. This term does not include unintentional technical, clerical, or administrative errors.[17]

Examples of provider fraud are: when a provider bills for services that were not rendered, such as when a provider bills for individual therapy and only group therapy was performed; misrepresenting a diagnosis or falsifying documents such as certificates of medical necessity, plans of treatment and medical records to justify payment.

Members (i.e., Medicaid and CHIP clients enrolled in managed care) can also commit fraud. Member fraud may include doctor shopping to obtain multiple prescriptions for narcotics or other prescription drugs. Doctor shopping may also be indicative of an underlying scheme, such as stockpiling or reselling drugs on the black market/street. Another type of member fraud is theft of identification and services. Theft of identification is when one uses a member's Medicaid or CHIP card to receive medical care, supplies, pharmacy scripts, or equipment.

What is waste?

Waste includes any practice that a reasonably prudent person would deem careless or that would allow inefficient use of resources, items, or services.[18]

Examples of waste are: when a physician (unaware of the generic alternative) consistently prescribes a high-priced medication for his patients instead of the less expensive drug available in the formulary. Waste is not generally considered to be caused by criminally negligent actions, but the misuse of resources.

To have a comprehensive view, MCOs' cost avoidance activities should also be considered. Cost avoidance refers to a deliberate intervention that reduces or eliminates a cost that would have otherwise occurred if not for that use of that intervention.[12] Examples of these activities include an MCO's pre- and post-payment efforts that may be carried out by their SIU or other business areas. Pre-payment activities refers to processes an MCO has in place to prevent services being paid in the first place, such as prior-authorizations and system edits.[13] Post-payment activities refers to recovering payments after a provider is paid. The recovery process at a MCO involves coordination across multiple business areas, such as an MCO's claims department and/or legal team.[14] An active culture of program integrity compliance in each MCO at its highest levels of management, across its business areas including the SIUs, can drive total cost avoidance and recoveries due to fraud, waste and abuse.

State Medicaid programs must comply with federal Medicaid program integrity requirements[15] and are required to have MFCUs, as well as mechanisms to identify, investigate, and refer suspected fraud cases to appropriate state and federal law enforcement. Lastly, states must cooperate with all federal program integrity initiatives, including, but not limited to, the Medicaid Integrity Program and the Payment Error Rate Measurement program.[16]

MCOs conduct a variety of program integrity activities, including those required by federal rule, as a condition of contracting with the state, and initiated by the MCO itself to minimize improper provider payments. The Texas Administrative Code (TAC), Title 1, Sections 353.501 through 353.505 identifies requirements for Medicaid MCOs to prevent and detect possible acts of FWA.

State Requirements for Managed Care Organizations' Program Integrity Activities

Inherent to the managed care model, MCOs may implement certain operational policies to administer program benefits and to implement organizational structures to meet the requirements of the contract. The SIUs and the FWA Compliance Plans are just two methods the MCOs utilize to prevent, detect, and investigate FWA, that support their objective of improving cost effectiveness while ensuring access to

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What is abuse?

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to Medicaid, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes client practices that result in unnecessary cost to Medicaid.[19]

Examples of abuse are: charging in excess for services or supplies; providing medically unnecessary services; billing for items or services that should not be paid for by Medicaid or CHIP; providing services that fail to meet professionally recognized standards for health care.

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care, appropriate utilization of services, and improving quality of care. In adherence with federal program integrity requirements, the TAC establishes minimum requirements for the types of processes MCOs must have in place for FWA detection, investigations, and referrals to the OIG.[20] One of these requirements is for MCOs to establish and maintain a SIU to investigate allegations of FWA for all services. MCOs may implement certain operational policies and use various organizational structures for their SIU. For example, MCOs have the choice to locate their SIU in or outside of Texas or subcontract all or a portion of their SIU functions to a third party.[21] Figure 1 contains examples of how MCOs may adhere to these requirements.

Another requirement is for MCOs to develop a FWA Compliance Plan. FWA Compliance Plans tend to reflect the principles, values, and priorities of the MCO and focus on increasing health care fraud awareness, maintaining a process of fraud identity, educational programs, deterrents to fraud, and reporting suspected fraud to the OIG. MCOs may execute the FWA Compliance Plan in a way that best fits their business model and corporate and/or organizational structure. The FWA Compliance Plan elements can be carried out by multiple MCO business areas including the MCOs' Claims department, Legal, and/or Provider Relations. MCOs must submit their annual FWA Compliance Plans to the OIG for approval. The

Figure 1. SIU Composition Requirements and Examples of MCO Application

SIU Composition	Requirement	Examples of MCO Applications
SIU	• Establish SIU	• One SIU for all lines of business (e.g., commercial, Medicare, Medicaid, and CHIP) • SIU comprised of MCO personnel • Subcontract all or a portion of SIU function(s)
SIU Location	• None	• SIUs can be physically located in or outside of Texas
Key Personnel	• Contract does not designate SIU staff as key personnel	• Not applicable
Staffing	• Assign an officer or director responsible for reporting all investigations to OIG • Assign person responsible for carrying out FWA Compliance Plan • Employ adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases based on objective criteria considering, but not necessarily limited to, the MCOs' total member population, claims processes, risk exposure, current caseload, and other duties	• Assign a compliance officer, manager of government relations, or regulatory compliancy analyst to report investigations • Employ dedicated SIU manager whose accountable and sole responsibility is execution and monitoring of the FWA Compliance Plan • Subcontract all or a portion of SIU function(s) to another entity • Assign MCO staff to perform FWA activities in addition to other roles in the organization (e.g., registered nurses perform clinical reviews for the MCO's utilization management team and for the SIU's data analytics staff) • The number of staff performing FWA activities
Education and Experience	• None	• Require specific education and experience (e.g., certified fraud examiner or individual with government program experience)
Training	• Provide annual FWA training to all MCO and subcontractor staff	• May require staff obtain training from a national organization such as the National Health Care Fraud Anti-Fraud Association

Source: Texas Administrative Code 353.501-353.505, Uniform Managed Care Contract; as of March 2018.

OIG conducts a limited review to ensure that MCOs have touched on required elements as specified in the Texas Administrative Code.[22] A summary of the FWA Compliance Plan requirements are illustrated in Figure 2. This figure provides examples and is not inclusive of all FWA Compliance Plan requirements.

FWA Compliance Plans must also include the following: [23]

- Provider audits to monitor compliance and assist in detecting and identifying program violations and possible FWA;

- Monitoring of service patterns for providers, subcontractors, and members;

- Data matching, analysis, trending, and statistical activities;

- Random payment review of claims;

- Use of edits to prevent payment for fraudulent claims; and

- Verification that MCO members received the services that were billed by the provider.

Rider 152 Requirements and Methodology

The 2018-2019 General Appropriations Act, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 152) required the OIG to conduct a review and develop recommendations for Medicaid and CHIP MCOs' SIU composition and activities. For purposes of this report, SIU activities encapsulate detection, prevention, investigation, referrals, and reporting.

The OIG distributed to the MCOs a 32-question SIU Composition and Activities Survey. All MCOs responded by documenting their SIU composition and activities, how they use their resources to prevent, detect, and investigate fraud, waste, and abuse, and making recommendations to the OIG related to SIU composition and activities. This report details the aggregate findings from their survey responses. The OIG did not independently validate or audit the survey responses provided by the MCOs.

In addition to the collaboration between the OIG and the MCOs related to SIU composition, effective FWA activities, and cost avoidance and waste prevention strategies, the OIG researched and reviewed notable practices in other states, and other states' managed care contracts. OIG reviewed all of the MCOs FWA

Figure 2. Example of Fraud, Waste, and Abuse Compliance Plans' Requirements

Prevent Fraud, Waste, and Abuse

- MCOs must have edits or other evaluation techniques to prevent payment for fraudulent or abusive claims. MCO prevention efforts must also include FWA provider and member education.

Detect Provider and Member Fraud, Waste, and Abuse

- MCOs must have detection methods in place. Most MCOs perform audits and internal monitoring, including data matching, analysis, and statistical modeling.
- MCOs are required to have processes in place to analyze claims for certain patterns, such as members with high volumes of emergency room visits, or providers who frequently treat members assigned to different primary care providers.

Investigate Possible Provider and Member Fraud, Waste, and Abuse

- MCOs must conduct preliminary investigations that include reviewing providers' billing patterns and claim samples.

Educate MCO Staff, Providers, and Members on Fraud, Waste, and Abuse

- MCOs must have procedures on how they will educate on FWA prevention, detection, investigation, and reporting.

Refer Possible Fraud, Waste, and Abuse to the Special Investigative Units

- MCOs must have internal policies and procedures for their staff on when, how, and under what circumstances to refer possible acts of FWA internally to their SIUs.

Report Possible Acts of Fraud, Waste, and Abuse

- MCOs are required to report possible acts of FWA to the OIG and to MFCU. Additionally, the MCO must designate an officer who is responsible for reporting possible acts of FWA to the OIG and MFCU.

Source: Tile 1, Texas Administrative Code Part 15. Chapter 353. Section 353.502. As of March 2018.

Compliance Plans in an effort to gain an understanding of their current FWA activities. This report is also informed by the OIG Cost Avoidance Waste Prevention Survey and the "Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities Report,"[24] released on March 1, 2018, as required by the 2018-2019 GAA, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 151.)

Section 1: Special Investigative Unit Composition

The OIG found that SIU composition characteristics vary among MCOs. Regardless of the SIU composition, all MCOs need resources, staff, capital (e.g., data analytics software,) established and documented processes, and dedicated leadership to effectively deploy an SIU. According to the results of the OIG SIU Composition and Activities Survey, all MCOs have a single SIU for their Texas Medicaid and CHIP lines of business (e.g., STAR[25], STAR+PLUS[26], STAR Kids[27], STAR Health[28], and CHIP[29]). However, MCOs vary on the entities that carry out their various FWA activities. MCOs also vary on the physical location of their SIUs. Some SIUs are physically located in Texas and others are located outside of the state.[30] Some MCOs use their employees to administer their SIU function while others delegate, by contract, to a third party. This section highlights the different organizational structures used by MCOs to deploy their SIUs.

Located Within or Outside of Texas

According to the OIG SIU Composition and Activities Survey,[31] less than half (ten) of the state's MCOs have SIUs that are physically located within Texas. The HHSC Uniform Managed Care Contract does not prohibit the MCOs from physically locating their SIUs outside of Texas, but they must be adequately staffed to handle Texas' volume.[32] Like Texas, Tennessee,[33] Washington,[34] and South Carolina[35] do not require state-based SIU staff. Unlike these states, Florida requires their MCOs' Fraud Investigation Units to have "adequate Florida based staffing and resources to enable the compliance officer to investigate incidents of fraud and abuse."[36]

An MCO with contracts in multiple states may choose to centralize their FWA activities in one location because it is more cost effective than establishing separate offices in each of the states they do business. Four of Texas' MCOs are operational in 10 or more of the 39 states with Medicaid MCOs, and are also active in other markets.[37] Three of these MCOs have an SIU located outside of Texas. A centralized location may have advantages by increasing the MCOs' abilities and likeliness to compare FWA data across all of their states' contracts and prevent and/or detect fraudulent schemes executed in one or more of the states.[38] Evaluation of the OIG SIU Composition and Activities Survey results showed no correlation could be made between SIU location and MCO recoveries or referrals when comparing SIUs located within Texas and outside of Texas.

In-House SIUs vs. Subcontracted SIUs

MCOs have the discretion to establish their SIU within their organizational structure that is staffed with their employees or through a subcontract with a third party for all or a portion of the SIU activities.[39] Even though an MCO may subcontract with a third party, the MCO remains contractually responsible and accountable for the FWA Compliance Plan's activities, and must assign an officer or director responsible for making FWA referrals to the OIG.[40]

MCOs' SIU organizational structures fall into one of the four main categories:

1. In-house SIU that has responsibility for all lines of the MCO's businesses (e.g., commercial, Medicare, Medicaid and CHIP);

2. In-house SIU solely focused on Medicaid and CHIP;

3. Subcontract with a third party for a portion of the SIU activities with the remaining activities conducted by MCO employees (e.g., in-house); or

4. Subcontract with a third party for all SIU activities.

According to MCOs' responses to the OIG SIU Composition and Activities Survey: 18 MCOs have an in-house SIU and do not subcontract with a third party (See Figure 3 below)[41] and 11 of these have responsibility for all lines of the MCO's business; 7 MCOs have an in-house SIU solely dedicated to

Medicaid and CHIP; 3 MCOs subcontract with a third party for a portion of their SIU activities (e.g., data analytics, utilization reviews, etc.); and 1 MCO subcontracts with a third party for 100 percent of their SIU activities.[42]

Figure 3. Texas MCOs' SIU Organizational Structures
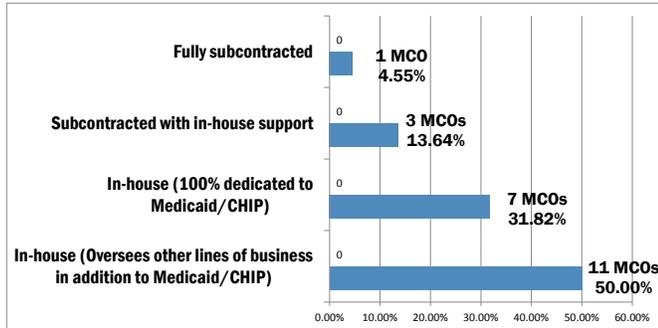
In SFY 2017, the seven MCOs with in-house SIUs that were 100 percent dedicated to their Medicaid and/or CHIP lines of business reported annual average recoveries of $190,000. Considering the varying number of enrolled members in each plan, these seven MCOs reported $5,598 in annual average recoveries per 10,000 enrolled members. The 11 MCOs with SIUs that oversee Medicaid and CHIP, in addition to other lines of business, averaged $383,000 recovered ($10,193 annually per 10,000 enrolled member). The three MCOs that subcontracted a portion of their SIU activities averaged $64,000 in annual recoveries ($2,396 per 10,000 enrolled members), while the one MCO that fully subcontracts its SIU functions reported $58,000 recovered (averaged $7,542 in annual recoveries per 10,000 members.). This variation in the annual average total dollars recovered (or dollars recovered per member) is an observation based on available data. It is possible that other factors (e.g., lack of recoupment activities) could explain their lower rates of recoveries.

SIU Oversight/Key Personnel

Health care organizations are complex and dynamic. In health care organizations, the scope and complexity of tasks that need to be carried out can be so complex that they cannot be tasked to individual staff working on their own. The role of a manager is needed to guide completion of organizational tasks in the best way and see that the appropriate resources are available. Effective management plays a role to ensure business requirements and performance expectations are met.

MCOs are required to designate key management and principal technical personnel who will be assigned to the MCO contract for specified functional areas (e.g., member services, claims processing, benefit administration, and utilization and care management.)[43] Within the Uniform Managed Care Contract, MCOs have specific requirements for "key personnel." Key personnel serve as a direct line to a particular business area when HHSC has questions or concerns about the function.[44] The individual responsible for the oversight of SIU and FWA activities is not considered "key personnel" in the current MCO contract, and as a result, HHSC has limited recourse if they are dissatisfied with an employee's performance related to the MCO's FWA efforts, including the rate of recoveries or referrals to the OIG.

By state rule, MCOs are required to designate an individual including an "…officer or director responsible for reporting all investigations resulting in a finding of possible acts of FWA to the OIG."[45] An officer could be, but is not limited to, a compliance officer, manager of government relations, or a regulatory compliance analyst.[46] Other states vary as to whether they require managers and/or compliance officers. Florida requires their MCO Fraud Investigation Units to employ persons to carry out the duties of a manager and compliance officer.[47] Other states such as Arizona,[48] New Mexico,[49] Missouri,[50] and Illinois[51] only require a compliance officer. In three of these states- Illinois, New Mexico, and Florida- the compliance officer is required to be a full-time equivalent (FTE) and dedicated to the state program.

MCOs also reported on who within their organization was responsible for SIU oversight. Eight MCOs reported that the individual responsible for the oversight of the SIU had other competing duties. Some MCOs reported that their SIU manager was also the compliance officer or manager of government relations. Compliance officers and managers of government relations may have a breath of responsibilities that could interfere with their ability to prioritize their oversight of the SIU.

Fourteen MCOs employ an SIU manager whose sole responsibility is direct oversight of the SIU and FWA activities, including referrals to the OIG. SIU managers' primary responsibility is to prevent, detect, and investigate FWA. Results from the OIG SIU

Composition and Activities Survey indicate that in SFY 2017, the 14 MCOs with an SIU Manager had a higher median rate of both total dollars recovered and referrals than those MCOs without an SIU manager. Median annual recoveries by SIUs with dedicated SIU managers were $125,000, while those without a manager had median annual recoveries of $18,900. Accounting for member population, MCOs that had a dedicated SIU manager averaged $9,024 in annual recoveries per 10,000 enrolled members, while MCO SIUs without a dedicated SIU manager averaged $4,365 in annual recoveries per member 10,000. However, it is possible that other factors (e.g., lack of recoupment) could explain their lower rates of recoveries.

SIU Investigative Function and Staffing Expertise

State rule requires FWA Compliance Plans to provide the MCO's procedures for investigating possible acts of FWA by providers.[52] The procedures must include a preliminary investigation that determines if the allegation is a repeat offense, and if applicable, review of all materials of previous investigation(s). The preliminary investigation also includes review of the provider's billing patterns, payment history, prior education received from the MCO, if any, and policies and procedures for the program type in question (e.g. STAR, STAR+PLUS, STAR Kids, STAR Health, CHIP or dental). If the preliminary investigation determines indicators of FWA, further sampling of the provider's claims related to the allegation must be selected for further review. Knowledge of common health care fraud schemes, investigative strategies, evaluation of cases for merit, detection of potential red flags in medical and billing record, and the ability to identify the appropriate resources to aid in fraud detection and investigation are all characteristics of investigators.[53] These characteristics may help investigators in carrying out the requirements of prevention and detection of FWA. The National Health Care Anti-Fraud Association (NHCAA) which MCOs listed as a source for staff trainings develops investigators skills and serves as a national resource for health care anti-fraud information and professional assistance. Through the OIG SIU Composition and Activities Survey responses, 17 MCOs reported their SIU composition includes an investigator.

Adequate MCO Staff and Resources

Given that MCO membership varies among all MCOs, so does the variation of the number of MCO staff dedicated to SIU and FWA activities. MCOs provided the number of SIU staff by position type, educational requirement, and percentage of time dedicated to Texas' Medicaid and CHIP lines of business in the OIG SIU Composition and Activities Survey. In the OIG SIU Composition and Activities Survey, MCOs also reported the percentage of time their reported staff members spent on Texas Medicaid and CHIP program integrity activities.

> MCOs are required to have "...adequate staff and resources apportioned at the levels and experience sufficient to effectively work Texas cases based on objective criteria considering, but not necessarily limited to, the MCOs' total member population, claims processes, risk exposure, current caseload, and other duties..." [54]

The OIG used the self-reported number of staff members and the percentage of time spent on Texas Medicaid and CHIP by SIU staff on program integrity to derive the number of FTEs each SIU had dedicated to Texas Medicaid and CHIP. The number of total SIU staff range from two to 16 for those who do not fully subcontract SIU functions. These totals do not reflect the amount of subcontracted staff who may carry out some SIU functions. The OIG found that the amount of time SIU staff spent on Texas Medicaid and CHIP could vary significantly. For instance, one MCO reported it has a total of 14 SIU staff and only 2.5 FTEs are dedicated to Texas Medicaid and CHIP. Twenty-one of the MCOs indicated they have at least one FTE dedicated to Texas Medicaid and CHIP, and 12 MCOs indicated they have more than five FTEs dedicated to their Texas Medicaid and CHIP lines of business. MCOs' SIU staff commonly include data analysts, clinicians, investigators, and other positions. In SFY 2017, the number of members enrolled in each MCO varied from fewer than 6,000 to more than 1.9 million.

On average, the ratio of total dedicated Medicaid

and CHIP SIU staff to members was one FTE per every 74,000 Medicaid and CHIP members. Eleven MCOs had ratios of less than one FTE per 25,000 members. The median ratio was one SIU FTE per 24,108 members. The smallest ratio was one FTE per 1,185 members, while the largest ratio was one FTE per 655,043 members. These ratios represent the number MCO employees to members and does not include contracted staff who may carry out SIU functions.

HHSC does not currently require MCOs to maintain a staffing ratio for their SIU activities. Some states have established ratios for general SIU staff, while others have requirements specifically for investigators. New Mexico, like Texas, does not have contract requirements that specify the composition of SIUs. New Mexico requires "adequate staffing and resources to investigate unusual incidents and develop and implement corrective action plans to assist in preventing and detecting potential fraud, waste and abuse."[55] In other states, the ratio requirement is based on enrolled members per SIU investigator. For example, Illinois requires MCOs to employ a minimum ratio of one investigator per every 100,000 enrollees, and Nebraska[56] requires one investigator for every 50,000 members.[57] New Jersey requires a minimum of one SIU investigator per every 60,000 enrollees.[58] In Texas, 17 MCOs reported they employ at least one investigator who is responsible for all their FWA investigations.[59]

Additionally, MCOs did not specify whether the staffing information provided included only information on the number of in-house SIU employees, or if MCOs included the number of subcontracted SIU employees. Furthermore, in some organizations SIU are responsible for identifying cost avoidance activities, so evaluating SIU performance solely on the dollar value of recoveries and may not be wholly representative of the work SIUs do. Additional analysis would need to be done to determine the effect of increasing the number of number of SIU FTEs per enrolled members in Texas and the impact to cost avoidance, FWA referrals and recoveries.

Staff Education and Expertise

SIU teams typically include a combination of management responsible for oversight; a medical and dental director; certified professional coders; data analysts; clinicians (e.g. nurses, behavioral health professionals, and pharmacists) and/or investigators. Investigators may hold certifications from the Association of Certified Fraud Examiners, be an Accredited Health Care Fraud Investigator, or have previous law enforcement experience.[60]

MCOs are required to employ SIU staff with experience to effectively work Texas cases.[61] However, "effectively" is not defined in state rule or in the MCO contract. Nor does the contract require the MCOs to employ SIU staff with a minimum education level, length and type of experience, and specific licenses, certifications or accreditations. MCOs establish their own staff education and length of experience requirements, and can use their discretion to determine the professional composition (e.g., certified medical coders, clinicians, data analysts, etc.) of their SIU staff.

Of all the MCOs, 12 reported their SIUs included certified medical coders, 12 reported their SIUs included certified fraud examiners, and seven reported their SIUs include both certified medical coders and certified fraud examiners.[62] Certified medical coders have the knowledge to translate complex billing rules and can determine when a provider has billed for one service incorrectly.[63] They may also be trained to identify improvements to the MCO's claims processing rules that may reduce the overall vulnerability to FWA. Certified medical coders may also develop coding and compliance education programs for MCO staff. Certified fraud examiners use their understanding of complex financial transactions and their familiarity with investigative techniques to identify potential fraud.[64] Certified fraud examiners also have expertise in fraud prevention, detection, and investigation.

MCOs are required to provide annual FWA training to all their staff and those of their subcontractors.[65] The training is required to be delivered within 90 days of hire and annually thereafter. The training is to be specific to areas of interest, including data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, and quality assurance and marketing.[66] Establishing an SIU with the right staffing configuration, education and experience and necessary resources can lay the foundation for MCOs to develop effective FWA activities that produce cost avoidance savings, recoveries and referrals to the OIG.

Role of Other Business Areas and Health Services Subcontractors in FWA Activities

MCOs may opt to maximize their overall staff resources by enlisting staff from other business areas to support SIU and FWA activities. In addition to coordination with other MCO business areas, coordination with health care subcontractors is also important. MCOs can choose to subcontract health care services such as vision and behavioral health. These subcontracted entities may be tasked with carrying out FWA activities which are then referred to the MCO's SIU.
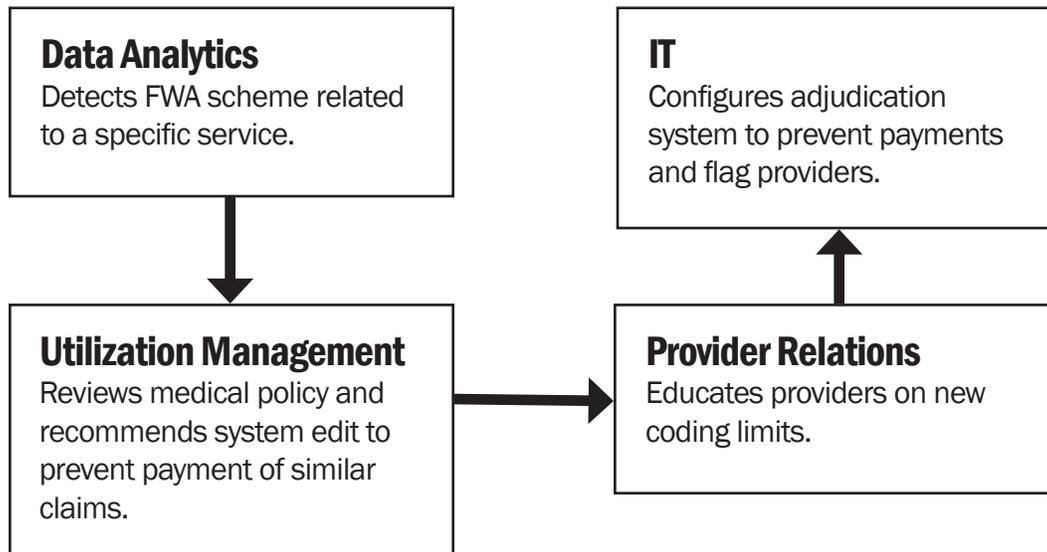
An MCO may have a business intelligence team that conducts data analytics including overutilization trends, or may rely on clinical staff to conduct additional utilization reviews for medical necessity to identify potential fraud, waste, or abuse activities. Enhanced communication and collaboration between different business areas can also be a form of prevention.

Figure 4 illustrates how different business areas within an MCO can collaborate for FWA detection and prevention efforts.

Given the varying SIU organizational structures (in-house vs. subcontracted) and collaboration with other staff to conduct FWA activities, MCOs may ensure policies and procedures are in place related to the method and frequency of communication. This may facilitate a better coordinated and more holistic effort to prevent, detect, and investigate FWA.

Figure 4. Interaction of MCO Business Areas for FWA Efforts

Data Analytics
Detects FWA scheme related to a specific service.

IT
Configures adjudication system to prevent payments and flag providers.

Utilization Management
Reviews medical policy and recommends system edit to prevent payment of similar claims.

Provider Relations
Educates providers on new coding limits.

Section 2: Special Investigative Unit Activities

Federal regulations require state Medicaid programs to have protections in place to combat FWA.[67] States with Medicaid managed care delivery models are required to establish contractual requirements for MCOs to implement and maintain arrangements or procedures designed to prevent and detect FWA.[68] At a minimum, MCOs are required to develop FWA Compliance Plans to guard against FWA.[69] The Centers for Medicare and Medicaid Services (CMS) does not explicitly require MCOs to establish SIUs, so in addition to federal FWA requirements, HHSC has exercised their authority to require SIU FWA activities that best meet the needs of the state. For purposes of this report, FWA activities include prevention, detection, investigation, referrals, and reporting. Because state statute includes the process for which MCOs must refer and report FWA allegations to the OIG, this report focuses on those activities that are not prescribed in rule or contract. The FWA activities where the MCOs have the most discretion are the prevention, detection, and investigation of FWA.

Prevention and Cost Avoidance

Prepayment cost avoidance and waste prevention activities can be more effective than post-payment, pay-and-chase recoupment efforts. Recovering payment for claims requires more investment in time and resources. Preventing the improper payment from occurring allows funds to be retained instead of recouping or settling for partial amounts of the overpayment or settlement.[70] As part of the MCOs' FWA Compliance Plan, they are required to develop and implement activities, such as prepayment review, provider credentialing, provider education, cross-business area collaboration, and cost avoidance to prevent FWA.

According to the OIG Cost Avoidance Waste Prevention Survey, prepayment activities was selected by 18 of the MCOs as one of the most effective cost avoidance and waste prevention strategies, that includes FWA activities such as front-end claim edits and prior authorization programs.[71] Front-end claim edits identify and deny claims that contain billing errors before the claims are accepted into the claims system and paid.[72] Prior authorization is a requirement for providers to obtain approval from the MCO prior to providing the service to the member as a condition of payment.

Prior authorization often requires a clinician to review supporting documentation submitted by the provider to determine if there is a medical need for the requested service. When a service requires a prior authorization, the claim will only be paid if the service was pre-approved by the MCO.

According to the OIG SIU Composition and Activities Survey, 18 MCOs reported performing audits and internal monitoring strategies. Once improper payments have been recovered because of audits or post-payment reviews, program integrity efforts do not end.[73] Nine MCOs indicated post-payment reviews and/or audits can be used to implement preventative measures. MCOs reported implementing new claim edits, prepayment reviews, and education efforts to increase prevention efforts.

Detection and Investigation

MCOs may engage in similar activities and use the same staff for FWA detection and investigations. Detection and investigative activities may include extensive data mining, post-payment reviews, utilization review, assessment of medical records, and predictive modeling. Predictive modeling represents statistical techniques that use historical data to predict future behaviors (e.g., identify potentially improper billings) and is an effective tool for detection of FWA.[74] For investigations, MCOs can reach out to members to verify receipt of services to compile evidence for an investigative case. This section focuses on various detection and investigation methods used by MCOs and other entities that lead to recoveries and/or process improvements to prevent FWA.

Data Mining

Data mining allows MCOs to evaluate trends over longer periods of time and can be less resource intensive than other types of reviews such as manual claims and medical documentation performed by clinical staff. Data mining can identify anomalies, changes in utilization, and schemes to maximize reimbursement through algorithms and other sophistical methods targeted to specific programs, populations, and provider types.[75]

MCOs establish criteria or algorithms to detect FWA such as data matching, trending, and statistical analysis based on peer-to-peer or member-to-member comparisons. Information can be reviewed to compare how one provider varies from another based on similar services in the same geographical area. Data analysis can establish a baseline to enable SIUs to recognize unusual trends, high volume or high cost services, provider and patient utilization patterns, and provider referral patterns. Two MCOs reported it is important to update data analysis technology quarterly to detect new industry trends and fraudulent schemes.[76] Frequent updates may detect new fraudulent schemes from other states or analyze data from different perspectives and greatly increase the amount of FWA detected. Twenty-one MCOs reported they use data mining as a post-payment review strategy. [77]

FWA detected through data mining includes: [78]

- Outliers (e.g., a member who has an extremely long hospital stay for a specific diagnosis);

- Upcoding (e.g., a provider bills with a higher procedure code than the service provided);

- Unusual billing patterns (e.g., a provider who routinely bills for a higher-level office visit at an abnormal rate);

- Doctor shopping (e.g., a member who goes to one or more providers seeking a desired diagnosis or therapy rather than required, in the opinion of the first provider);

- Data matching (e.g., MCO matches their claims data with other insurers to identify unreported third-party liability);

- Duplicate payments (e.g. e., MCO makes duplicate payments due to a lack of internal controls and/or administrative processing errors);

- Inappropriate code combinations (e.g., inappropriate diagnosis for a member's age); and

- Top controlled substance prescribers (e.g., providers who have a higher rate than normal of prescribing opioids.)

Post-payment efforts continue to be a central piece of program integrity even though pay-and-chase methods can be time consuming and labor intensive.[79] Post-payment reviews allow MCOs to observe billing

trends to identify potential acts of FWA by providers or members. MCOs may conduct post-payment reviews by looking at medical records and/or by analyzing their claims data. Seventeen of the MCOs identified post-payment review as one of the most effective strategies of cost avoidance and waste prevention in addition to prepayment review. This is comparable to the number that identified pre-payment review as one of the most effective strategies.[80]

Because providers and recipients can adapt fraudulent schemes if they become aware of detection efforts, it is important to revisit criteria frequently.[81] The need to update criteria frequently was expressed by one MCO who reported to maintain data analysis technology that is updated quarterly to detect industry trends.[82] The need to maintain technology is vital for detecting FWA. Detecting for new schemes found in other states or analyzing data from different perspectives can improve efforts to identify FWA.

Member Verification of Services

There are other types of fraudulent schemes that cannot be detected through data mining, post-payment reviews and predictive modeling. There are instances where the provider's claim submission and supporting documentation is adequate; however, the member never received the service. The 2017 Legislative Budget Board Government Effectiveness and Efficiency Report stated that according to the United States Department of Health and Human Services Office of Inspector General, verification of services is a primary program integrity concern of states, MCOs, and CMS.[83] As part of the FWA Compliance Plan, MCOs are required to develop policies and procedures to confirm that services billed by providers were delivered through member verifications.[84] Yet, there are no specific requirements in state statute or the MCO contracts on the methods or frequency of member verification of services. MCOs can verify services in a variety of ways, including issuing to their members an explanation of benefits (EOBs) or conducting member surveys. EOBs are sent to select members who are asked to verify they received the services billed to Medicaid. Seventeen MCOs reported their most common method for member verification of services is through phone calls, whereas ten MCOs reported they issue and mail EOBs to their members. One MCO that mails EOBs reported they issue EOBs to .004 percent of their member population.[85] Another

MCO reported they randomly select 50 members weekly to verify they received the service to support the provider's claim.[86]

During a program integrity review of Louisiana, CMS found that limited or no responses were received from beneficiaries surveyed to confirm receipt of services. As a result, Louisiana is considering sending out surveys that focus specifically on beneficiaries with known problematic procedural codes in an effort to increase the probability of returns.[87] Research on the sample size of member verification of services found that the District of Columbia contractually requires MCOs to verify benefits were received by sampling 7.5 percent of the previous months' paid claims.[88] Through member verification, MCOs may identify services that were not delivered and require investigation by their SIU.

Non-Traditional Third-Party Sources

The OIG provides guidance on the type of documentation MCOs should review and submit to the OIG along with their FWA referrals. The information includes: an investigative report identifying the allegation; federal or state statutes or regulations violated or considered; summary of the interviews conducted; related medical records; and other information as necessary.

Several MCOs noted in their FWA Compliance Plans, and in meetings with the OIG, that in addition to medical claims and documentation, they review non-traditional third-party sources to further investigate FWA allegations. Non-traditional third-party sources may include local newspaper announcements on provider retirements or deaths.[89] The MCOs can use the date the provider retired or passed to match claims with date of services on or after that date. If claims matching that criteria are identified the MCO has supporting documentation to support their investigation.

In Texas, for most providers, enrollment in Medicare is a prerequisite for enrollment in Medicaid. A recent presentation by the Florida Agency for Healthcare Administration at the National Association for Medicaid Program Integrity (NAMPI) meeting also cited ProPublica's Treatment Tracker, which provides information on Medicare payments to providers and offers peer comparisons on services and reimbursement, as a useful third-party source.[90]

Other non-traditional third-party sources are property appraiser and tax records to identify if more than one business is listed under a provider's address. There are other data aggregators with data compiled on existing cases and an individual's information such as property ownership and financial data. These tools may enhance an MCO's detection efforts and supplement ongoing investigations by providing additional insight and supplemental information not typically found in traditional detection and investigative sources.

Staff Training

Innovative detection and investigative techniques and sources are only useful if they are deployed by staff that have the knowledge, skills, abilities and leadership to effectively utilize them. Several MCOs noted their SIU staff have credentials through national organizations such as the NHCAA, the American Academy of Professional Coders or Association of Certified Fraud Examiners. Each of these provide continuing education units and professional training on FWA trends, emerging fraudulent schemes, and best practices to prevent, detect, investigate, and prosecute FWA. Three examples are:

- SIU leadership training with a session on "Developing an Investigating Team for the Future"[91];

- "National Health Care Fraud Trends"; and

- "Using Identity-Focused Approach to Understand the "Who" in Medicaid Fraud." [92]

Although the OIG offers annual FWA training to MCOs, additional training offered by these or other national organizations can provide professional development opportunities for staff to develop techniques to detect and investigate FWA.

Thirteen MCOs reported in response to the OIG SIU Composition and Activities Survey they either require or allow their investigators to attend trainings offered by national organizations such as NHCAA or NAMPI.

Provider Audits

TAC requires MCOs to perform audits using data matching, analysis trending, and/or statistical activities to monitor compliance and to assist in detecting and identifying violations and possible FWA overpayments.[93] MCOs' FWA Compliance Plans

include how these functions are executed as a method of FWA detection. Different from audits performed to identify overpayments, many MCOs perform provider compliance audits to monitor compliance with all aspects of Medicaid and CHIP. These provider compliance audits include the review of credentialing, licensure, and claims. Providers are categorized by risk for FWA and selected at random. Provider compliance audits may be performed by staff from the SIU or another MCO business area and their findings may require action from business areas other than the SIU. Therefore, it is important for the MCOs to have documented and current policies and procedures in place for how, when and what is to be shared among the different areas, and each area's role and responsibilities.

One MCO illustrated how information is not only shared, but used as a trigger to implement changes in other business areas to improve the prevention and detection of FWA.[94] This process calls for a documented referral process around the function of provider audits. The SIU performs audits to identify potential FWA, while the Quality Improvement department audits focus on medical record standards and standard quality of care. By way of their internal referral process, providers are frequently referred from the SIU to the Quality Improvement department and vice versa depending on the nature of issues found. The information is shared through a template that requires relevant information such as provider identifiers, issues/ concerns encountered, and supporting documentation. This is then forwarded to the appropriate department. Many SIU investigations determine areas of concern or improvement needed by the provider. These are addressed as provider education issues. The internal referral process is then used to send all identified issues to the provider relations department. The provider relations department then contacts the provider or facility and provides one-on-one education and/or additional training. Based on specifications drafted by the SIU, the information technology services (IT)

department builds profiling reports that are then used by the SIU analysis team for data mining, fraud profiling, and targeting providers for investigation. Information identified by the SIU during analysis and investigations is shared with the IT department so that new edits can be built into the claims processing system to prevent improper payments in the future. This process highlights the collaboration with other business areas to further prevent FWA. The OIG's review of the MCOs' FWA Compliance Plans and their responses to the OIG SIU Composition and Activities Survey identified this notable practice was not replicated by many of the Texas MCOs. While 16 MCOs noted that information is shared across business areas, only one MCO reported to have a formal documented procedure. The remaining 15 MCOs reported sharing information as needed informally through meetings or email.

The various detection and investigation methods discussed in this section, if used by MCOs, may lead to cost avoidance savings, recoveries, referrals and/or process improvements to prevent FWA. Data mining allows MCOs to evaluate trends over longer periods of time and can be less resource intensive than other types of reviews. In the event where the provider's claim submission and supporting documentation is adequate; verification of services may be needed to ensure the member did in fact receive services. Use of non-traditional third-party sources to gather information may enhance an MCO's detection efforts and supplement ongoing investigations by providing additional insight and supplemental information not typically found in traditional detection and investigative sources. MCO SIUs who receive training by national organizations are exposed to emerging trends and new tools to help prevent and detect FWA. Lastly, the findings of provider audits performed by the SIU or other business areas that are communicated and formally documented may lead to changes not otherwise identified and further prevent FWA.

Section 3: Recommendations

MCOs are at risk for the total cost of their members' health care and expected to conduct their businesses in an efficient and cost-effective manner. The state receives medical and administrative cost information from the MCOs through encounter data and financial reports. The state uses encounters for medical costs and MCO financial reports for administrative costs. Both medical and administrative costs are used to set capitation rates.[95] Capitation rates under full risk contracts are federally required[96] to be actuarially sound. The administrative rating component of the capitation is intended to be a reasonable amount to cover all administrative costs, and is reviewed annually.[97]

There are financial and non-financial costs associated with program integrity activities to prevent, detect and investigate FWA. Financial costs include SIU staffing as well as other supports, such as professional development (e.g., education and training,) sophisticated fraud detection software, and investigations. Non-financial costs may include provider abrasion due to FWA activities (e.g., audits, pre- and post-payment reviews) and the challenge of maintaining adequate provider networks. States want to ensure that MCOs make sufficient investments in program integrity and are good stewards of public taxpayer dollars; while at the same time, MCOs must manage program integrity expenses within their overall administrative allocation. Federal regulations target a Medical Loss Ratio of 85 percent. This ratio is the percentage of the capitation rate that represents medical and quality improvement costs. The remaining 15 percent represents administrative expense and profit.[98] Program integrity expenses are considered an administrative expense,[99] and as a result, may influence the MCO in determining the amount of resources to commit to FWA activities.[100] However, the cost benefits resulting from reduced FWA may serve to fund the additional cost of staffing the SIU function, if dollars saved through cost avoidance and recoveries are greater than the added expenses. Enough competent and well-trained SIU staff with the necessary resources and tools to prevent, detect and investigate FWA is critical to the program integrity of Medicaid and CHIP.

At the time of this report, there is limited guidance or information available from CMS; state statues, rules, or contracts; best practices from other states; or research for how states can effectively and equitably measure MCOs' SIU's effectiveness.
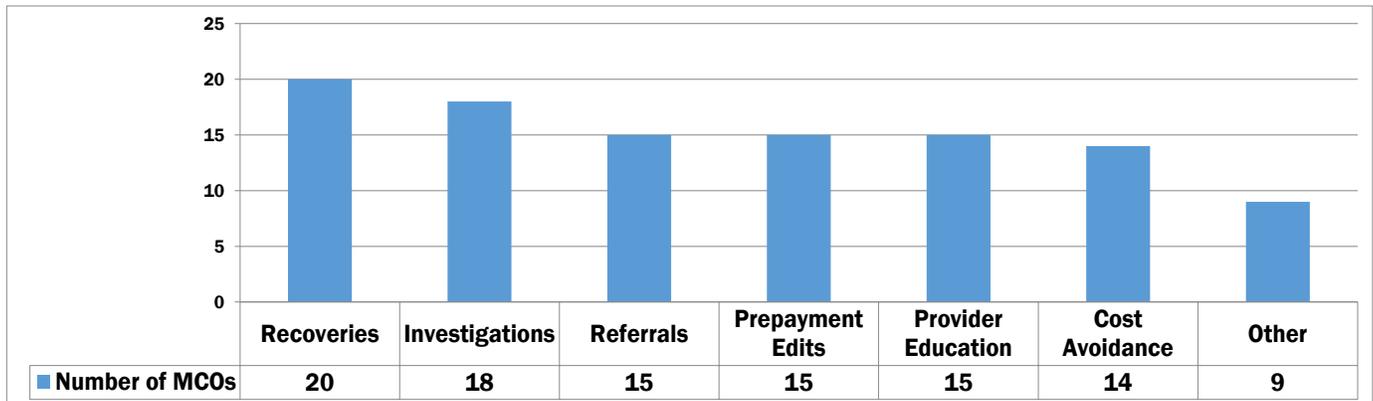
Currently, the TAC and contracts requirements set forth the state's expectations of SIUs; however, performance-based measures have not been established. One possible measure for assessing the SIUs' functions and activities is the amount of their recoveries. However, this only captures the MCOs' post-payment efforts to recover provider overpayments. If a MCO has a high rate of recoveries this may be an indication of ineffective pre-payment activities that prevent inappropriate services and payments (e.g., claim system edits and prior authorizations).[101] It is also possible that a low rate of recoveries may also be the result of ineffective post-payment activities (e.g., non-existent data analytics and investigations). Effective SIU activities performed by the right composition of staff is a balance an MCO must strike between pre-and post-payment activities (i.e., cost avoidance and recoveries.) The OIG evaluated MCOs' SIU efforts based on state statutes, rules, and contract requirements, and identified issues that impacted their cost avoidance and recoveries FWA efforts.

OIG Audit Findings on Select MCOs' SIU and FWA Compliance Plans

In February 2016, the OIG released an informational report with a high-level overview of MCO SIU functions and structure. The OIG compiled and analyzed non-audited information submitted by MCOs and noted that MCOs produce limited results in their SIU FWA detection, investigation, recovery, and referral efforts.[102] The summary report also noted that in SFY 2015, the MCOs received more than $17 billion in capitation payments, paid $12.5 billion to their health care providers, and reported a total of $2.5 million in recoveries. The total recoveries represent 0.02 percent of the total aggregate paid medical claims dollars. This was down from 0.03 percent in the previous year.

The OIG followed up this informational report with a series of performance audits to assess the MCOs' compliance of TAC and contract requirements, and measure their SIUs' performance in (a) preventing, detecting, and investigating FWA and (b) reporting to

Figure 5. MCO Reported Activities to Measure SIU Effectiveness

Number of MCOs	Recoveries	Investigations	Referrals	Prepayment Edits	Provider Education	Cost Avoidance	Other
	20	18	15	15	15	14	9

Source: Self-reported by MCO SIU staff from OIG SIU Composition and Activities Survey

HHSC reliable information on their activities, results, and recoveries.[103] The audits covered six MCO SIUs and one third party contractor that provided SIU services to six additional MCOs.[104] The audits included SFYs 2014 and 2015, which covered the period from September 2013 through August 2015.

The audits assessed how well MCOs performed according to the set requirements. The OIG evaluated MCO SIU efforts related to: prevention, detection, recoveries, investigations, disposition, reporting, and data and information technology analysis.

The OIG reported that MCO SIUs experienced systemic issues that impacted their FWA efforts. The areas identified for MCO improvement included:

- SIU staffing: SIUs should be staffed with sufficient numbers of qualified individuals to effectively carry out FWA detection, investigation, and reporting activities;

- Use of data analytics: Post-payment claims analysis enables more complex data analysis over longer periods of time than is available at a pre-payment level;

- Scope and number of investigations: Differing interpretations of state statutes have resulted in some MCOs limiting investigations that might otherwise have been expanded to include a larger sample of recipients or claims related to the original case of suspected fraud, waste, or abuse;

- MCO reporting: The OIG observed instances of incomplete and inaccurate information reported to the OIG which the OIG relies on to coordinate fraud prevention, detection, and investigation

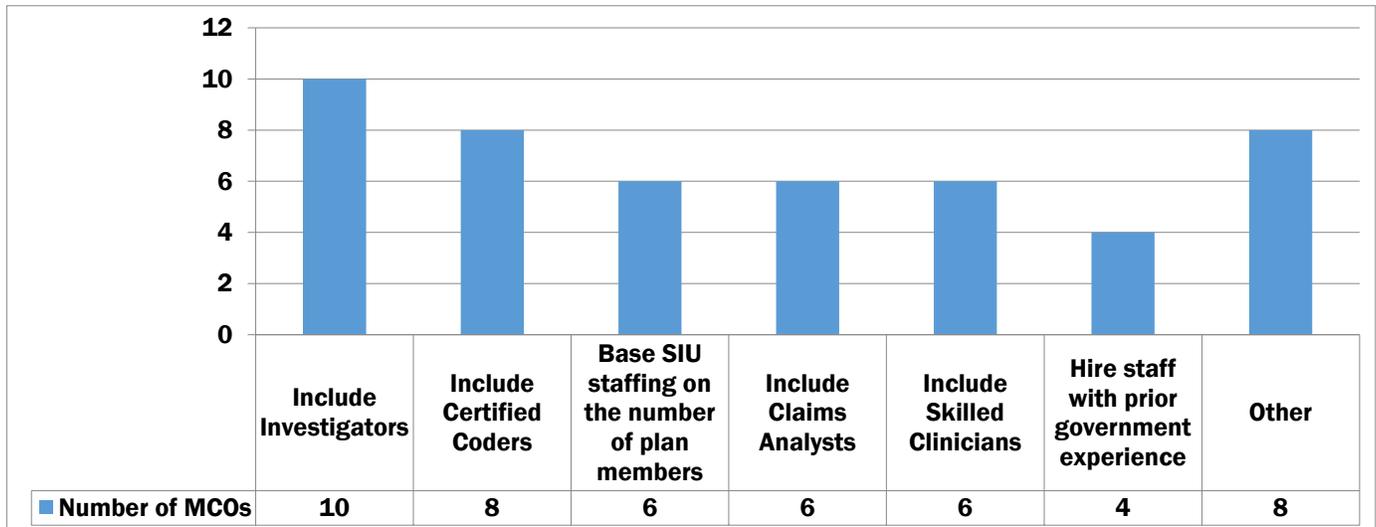efforts. Reported information that is accurate and complete will result in more positive outcomes; and

- FWA training: By consistently providing FWA training, MCO employees, providers, and subcontractors are expected to acquire the knowledge and awareness needed to prevent, detect, and report suspected FWA to the SIU and/or the OIG.

MCO Self-Evaluations and Recommendations for Other SIUs

The OIG SIU Composition and Activities Survey provided the MCOs an opportunity to provide recommendations to the OIG and were considered throughout the development of this report and the recommendations. The most common variable reported by 20 MCOs to evaluate their SIU's effectiveness was recoveries (see Figure 5.) The second most reported variable to evaluate SIU effectiveness was investigations (18 MCOs,) while 15 MCOs assessed their SIU's effectiveness through SIU's referrals, prepayment edits, and provider education.

The OIG SIU Composition and Activities Survey also asked MCOs for their input and recommendations related to SIU composition. (See Figure 6.) When asked for staffing recommendations, six MCOs recommended using the number of the MCOs covered lives as a basis for the number of required SIU staff. While not all the MCOs' SIUs include an investigator, 10 MCOs reported investigators are an essential role to have within a SIU. Other recommendations included staff focusing on areas that are classified as higher FWA risk areas and requiring dedicated SIU staff for their Medicaid and

Figure 6. MCO Recommendations for SIU Composition

Number of MCOs	Include Investigators	Include Certified Coders	Base SIU staffing on the number of plan members	Include Claims Analysts	Include Skilled Clinicians	Hire staff with prior government experience	Other
	10	8	6	6	6	4	8

Source: Self-reported by MCO SIU staff from OIG SIU Composition and Activities Survey

CHIP lines of business. Four MCOs recommended the number of SIU staff should be proportional to the level of FWA risk within their service delivery area. However, a methodology for how risk could be calculated was not provided as part of the recommendation.

While a cost-benefit analysis was not conducted as part of this report, the following recommendations could potentially increase the MCOs administrative costs. Absent a cost estimate, it is not known if increased administrative expenses would be offset by increased cost avoidance savings, recoveries and/or referrals to the OIG. Nor if they would be significant enough to justify an adjustment in the MCOs' capitation rates or the impact to their administrative cost cap.

OIG Recommendations for SIU Composition and FWA Activities

The recommendations below are based on the OIG's research; observations; review of MCOs' FWA Compliance Plans; the MCOs' responses to the OIG SIU Composition and Activities Survey,[105] the OIG Cost Avoidance Waste Prevention Survey;[106] the report titled, "Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities,"[107] and collaboration with the MCOs and HHSC's Medicaid and CHIP Services department. The recommendations in this report include FWA activities used by a subset of the MCOs, however the OIG found them to be notable practices and could be applicable to all MCOs.

Based on the OIG's research, collaboration with

Medicaid CHIP Services, and the MCOs and DMOs the OIG developed recommendations to improve the effectiveness of MCOs' SIUs and FWA activities. The Medicaid and CHIP MCOs and DMOs may consider adopting one or more of the following recommendations based on their assessment of their specific needs and whether they have already adopted these recommendations:

Recommendation 1: Employ an SIU manager whose time is 100 percent dedicated to direct oversight of their MCO's SIU and FWA activities, and is considered key personnel in their contract with HHSC.

Fourteen MCOs currently employ a SIU manager whose sole responsibility is direct oversight of the SIU and FWA activities, including referrals to the OIG. In SFY 2017, MCOs that had a dedicated SIU manager averaged $9,024 in annual recoveries per 10,000 enrolled members, while those MCOs SIUs without a dedicated SIU manager, averaged $4,365 in annual recoveries per 10,000 enrolled members.

Recommendation 2: Meet contract requirements that will be developed by the state for the method and frequency of member verification of services.

The 2017 Legislative Budget Board Government Effectiveness and Efficiency Report stated that according to the United States Department of Health and Human Services Office of Inspector General, verification of services is a primary program integrity

concern of states, MCOs, and CMS.[108] In the instances where fraudulent schemes cannot be detected through data mining, post-payment reviews, and predictive modeling, targeted efforts for member verification of services can lead to increased detection of FWA.

Recommendation 3: Employ or subcontract SIU staffing that includes, at minimum, a full-time equivalent position who is either an accredited investigator or an investigator who's a certified fraud examiner.

Seventeen MCO SIUs reported they currently employ at least one investigator who is responsible for all their FWA investigations. Ten MCOs recommended the SIU should contain investigators.

Recommendation 4: Use standardized methodologies developed by the state, with stakeholders' input, to calculate and evaluate their cost avoidance savings related to FWA prevention activities.

Other states and the federal government have noted that establishing a standard methodology and definition would allow a baseline for measurement and comparison among MCOs SIUs and/or other business functions.[109] Moreover, in several of its recent state program integrity reviews, CMS recommended states collect supporting documentation from MCOs regarding their cost avoidance and prevention activities.[110]

Recommendation 5: Require SIU staff, including those employed by a third party to conduct SIU activities, to attend national organizations' FWA focused trainings to learn and adopt innovative techniques for the prevention, detection and investigation of FWA.

There are national organizations that provide continuing education and professional development training on FWA trends, emerging fraudulent schemes, and notable practices to prevent, detect, investigate, and prosecute FWA. Thirteen MCOs require or allow investigators' to attend national organizations' trainings related to anti-fraud efforts.

Recommendation 6: Ensure program integrity activities are integrated into each business area responsible for providing support to the SIU and/or executing FWA activities through documented and up to date policies and procedures that clearly define roles, responsibilities and performance expectations.

Effective communication and collaboration across the MCO's different business areas increases the opportunities to prevent and detect FWA. Sixteen MCOs noted information is shared across business areas; however, only one MCO reported having a formal and documented procedure in place. The remaining 15 MCOs reported they informally share information as needed through meetings and/or email.

Recommendation 7: Periodically review and revise algorithms for fraud, waste, and abuse detection focused data analytics.

Data analytics can establish a baseline that enhances the SIUs abilities and likeliness to recognize unusual trends, high volume or high cost outliers, provider and member utilization patterns, and provider referral patterns.[111] A higher rate of FWA detection could occur because of utilizing regularly updated algorithms to identify fraudulent schemes executed in other states and analyzing data from different perspectives. Because providers and recipients will adapt fraudulent schemes if they become aware of detection efforts, it is important to revisit criteria frequently.

Recommendation 8: Use non-traditional third-party resources to gather information to aid in FWA detection and investigation efforts.

Non-traditional resources may enhance detection efforts and supplement ongoing investigations by providing additional insight and supplemental information not found in traditional detection and investigation sources. Seven MCOs reported using non-traditional third-party resources to further enhance their detection and investigation efforts.

Appendix A: SIU Composition and Activities Survey

Survey Questions

General Cost Avoidance and Waste Prevention Strategies:

1. Select your MCO or DMO (from pull-down menu)

2. Please identify whom at your organization the OIG may contact if we need to follow up with your organization about your survey responses.

Name and Title

Emil address

Phone number

3. Is your SIU located outside the state of Texas?

☐ Yes

☐ No

4. Select the option that best describes your SIU structure

☐ In-house (dedicated to just Medicaid/CHIP lines of business)

☐ In-house (corporate - dedicated to other lines of business in addition to Medicaid/CHIP)

☐ Subcontracted

☐ Subcontracted with in-house support

5. Describe the position (manager, director) that oversees SIU functions. (e.g., internal management overseeing internal SIU, internal management overseeing subcontracted SIU

6. What percentage of time is dedicated to SIU management by the position that oversees SIU functions, excluding work as an individual contributor?

☐ 1-25%

☐ 26-50%

☐ 51-75%

☐ 76-100%

7. If you do not have a manager within your SIU, please describe who oversees your SIU.

8. Do you have SIU staff dedicated solely to Texas

Medicaid/CHIP lines of business?

☐ Yes

☐ No

9. Describe the number of SIU staff by position type, educational requirements, and percent of time dedicated to Texas Medicaid/CHIP lines of business. Job areas:

Analysts

Data Analysts

Clinicians

Investigators

Management

10. Please select credentials your current SIU staff hold.

☐ Certified Public Accountant Certified Medical Coder

☐ Accredited Health Care Fraud Investigator Certified Fraud Examiner

☐ Certified Law Enforcement

☐ Master of Business Administration

☐ Certified Professional Medical Auditor Certified Risk Adjustment Coder Certified Outpatient Coder

☐ Other (please specify)

11. . Describe required and optional training that is specific to SIU staff as well as frequency.

Required:

Optional:

12. List all business areas that receive fraud, waste and abuse training. (e.g., claims adjudication, utilization management, provider relations)

13. Does your MCO measure the effectiveness of its SIU unit?

☐ Yes

☐ No

14. If so, how does your MCO measure SIU effectiveness? Select all applicable measures:

☐ Recoveries

☐ Referrals

☐ Pre-Payment Edits

☐ Cost Avoidance

☐ Investigations

☐ Provider Education

☐ Other (please specify)

15. Please provide definition of measures selected in previous question.

16. Please provide any additional information your MCO would like to share on SIU performance. (e.g., targets)

17. If your MCO subcontracts health services (vision, behavioral health, pharmacy benefit managers), select who performs SIU activities related to those services:

Detections/Data Analytics

Investigations

Referrals

Recoveries

18. Describe how your MCO coordinates SIU activities for health service subcontractors. (e.g., schemes, over utilization).

19. Describe your MCO's recommendations pertaining to SIU composition. (e.g., number of FTEs, expertise).

20. Describe your MCO's recommendations for SIU activities. (e.g., detection, referrals).

21. Provide the following information on the individual responsible for carrying out the MCO's FWA compliance plan:

Name and Title

Credentials (education and background)

22. Is this person dedicated solely to compliance for Texas Medicaid/CHIP lines of business?

☐ Yes

☐ No

23. If not, what percent of time is dedicated to Texas Medicaid/CHIP FWA compliance?

☐ 1-25%

☐ 26-50%

☐ 51-75%

☐ 76-100%

24. Who does this individual report to?

25. For the following list of FWA related activities, please select if they are performed, and who they are performed by; choices are MCO SIU; MCO Utilization Management; MCO Claims Adjudication; MCO Compliance Team; SIU Subcontractor; Other. Activities are:

MCO staff training

Provider and member education

Member validation of services

Data analytics

System edits

Pre and post payment reviews

Medical record reviews

Provider audits

Member and provider investigations

Investigations of potential MCO waste

Recoveries

Other

26. If the activities listed above are performed by multiple groups within your MCO, describe how information is shared across groups, including the frequency and mediums for sharing information. (If not applicable, respond with N/A)

27. Select all that you currently use for triggers in monitoring FWA service patters:

☐ Demonstrate a pattern of submitting falsified encounter data or service reports

☐ Demonstrate a pattern of overstated reports or up-coded levels of service

☐ Alter, falsify or destroy clinical record documentation

☐ Make false statements relating to credentials

☐ Misrepresent medical information to justify Enrollee referrals

☐ Fail to render medically necessary covered services they are obligated to provide according to their provider contracts

☐ Charge Enrollees for covered services

☐ Bill for services not rendered

☐ Other (please specify):

28. What criteria does your MCO use to perform targeted payment review of claims? (e.g., high cost service, frequent utilization of service)

29. Separate from changes included in TMHP bulletins and TMPPM, how does your MCO select, implement and apply other techniques to prevent payment for FWA claims?

30. Separate from investigations, does your MCO use any of the following techniques to verify if a member has received the services billed?

Biometric technology

Electronic verification

Explanation of benefits sent to beneficiaries

Telephone calls

Mail questionnaire

31. Describe how your MCO uses the techniques indicated above.

32. Please identify any additional information your MCO would like to share on SIU composition or activities or FWA Compliance Plans.

Appendix B: Acronyms used in this report

CHIP Children's Health Insurance Program

CMS Centers for Medicare and Medicaid Services

DMO Dental Maintenance Organization

EOBs Explanation of Benefits

FTE Full-time equivalent

FWA Fraud, Waste, and Abuse

GR General revenue

HHSC Health and Human Services Commission

IT Information Technology

MCO Managed Care Organization

MFCU Medicaid Fraud Control Unit

NAMPI National Association for Medicaid Program Integrity

NHCAA National Health Care Anti-Fraud Association

OAG Office of the Attorney General

OIG Office of the Inspector General

SFY State fiscal year

SIU Special Investigative Unit

TAC Texas Administrative Code

TMPPM Texas Medicaid Provider Procedures Manual

US United States

Appendix C: Endnotes

1 HHSC-OIG, "OIG SIU Composition and Activities Survey," HHSC-OIG, 2017.

2 At the time of this publication 20 MCOs are contracted with HHSC.

3 "Identify, Predict, Prevent, Recover: A Handbook for Medicaid Program Integrity," The Governing Institute and OPTUMTM, 2015. https://stg-www.optum.com/resources/library/medicaid-program-integrity.html Page 8.

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6 CMS, "State Program Integrity Review Reports List," CMS, Accessed January 2018. https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/State-Program-Integrity-Review-Reports-List.html OIG Staff reviewed all reports released from January 2016 until January 2018. The 19 program integrity reviews that discussed MCO cost avoidance activities were: MD, MI, MO, NC, NE, NH, NJ, NY, NV, OH, PA, Puerto Rico, RI, SC, TX, VA, VT, WI and WV.

7 "Identify, Predict, Prevent, Recover: A Handbook for Medicaid Program Integrity," The Governing Institute and OPTUMTM, 2015.

8 42 CFR 5.1007.

9 Title 1, Texas Administrative Code Part 15. Chapter 353. Section 353.502.

10 At the time of this publication, HHSC contracts with 19 MCOs and 2 DMOs to deliver medical and dental services to members enrolled in Medicaid and CHIP.

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13 HHSC-OIG, "Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities Report," HHSC-OIG, March 2018.

14 HHSC-OIG, "OIG Cost Avoidance Waste Prevention Survey," HHSC-OIG, December 2017.

15 42 CFR 4.455.

16 42 CFR 4.455. Medicaid and CHIP Payment and Access Commission, "Managed Care Program Integrity," Medicaid and CHIP Payment and Access Commission, 2017.

17 Title 1, Texas Administrative Code Part 15. Chapter 371. Section 371.1.

18 Title 1, Texas Administrative Code Part 15. Chapter 371. Section 371.1.

19 Title 1, Texas Administrative Code Part 15. Chapter 371. Section 371.1.

20 Title 1, Texas Administrative Code Part 15. Chapter 353. Section 353.505.

21 UMCC Attachment A. Section 8.1.9 Fraud, Waste, and Abuse. Page 8-119. Version 2.24.

22 Title 1, Texas Administrative Code Part 15. Chapter 353. Section 353.501.

23 Title 1, Texas Administrative Code Part 15. Chapter 353. Section 353.502.

24 HHSC-OIG, "Review of Managed Care Organizations' Cost Avoidance and Waste Prevention Activities Report," HHSC-OIG, March 2018.

25 STAR provides primary, acute care, and pharmacy services for low-income families, children, pregnant women, and some former foster care youth.

26 STAR+PLUS integrates the delivery of basic, acute care Medicaid services and long-term services and supports for individuals who have a disability or who are age 65 and older.

27 STAR Kids integrates the delivery of acute care, behavioral health, and LTSS benefits for children and young adults 20 and younger with disabilities.

28 STAR Health provides medical, dental, vision, and behavioral health benefits, including unlimited prescriptions, for children and youth in conservatorship of the Department of Family and Protective Services (DFPS).

29 CHIP provides medical and dental services for children who do not qualify for Medicaid.

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[32] HHSC, "Attachment B-1. Medicaid and CHIP Managed Care Services RFP, Section 8, 8.1.19.1 Special Investigative Units, Version 2.24," HHSC, 2017. Page 8-120.

[33] Tennessee Division of TennCare. Statewide TennCare Managed Care Services Contract. Page. 39

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[35] South Carolina Department of Health and Human Services. Contract Between South Carolina Department of Health and Human Services and Contractor for the Purchase and Provision of Medical Services Under the South Carolina Medicaid Managed Care Program.

[36] Florida Agency for Health Care Administration. "Attachment II Core Contract Provisions Effective June 1, 2017". Florida Agency for Health Care Administration. Page 164.

[37] Henry J. Kaiser Family Foundation. "Key Findings on Medicaid Managed Care: Highlights from the Medicaid Managed Care Market Tracker." Figure 7. Five Firms have a Wider Geographic Reach in Medicaid and Figure 10. The six larger firms are also active in other insurance markets.

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[39] Title 1, Texas Administrative Code Part 15. Chapter 531. Section 531.113.

[40] Title 1, Texas Administrative Code Part 15. Chapter 353. Section 353.502.

[41] HHSC-OIG, "OIG SIU Composition and Activities Survey," HHSC-OIG, December 2017.

[42] HHSC-OIG, "OIG SIU Composition and Activities Survey," HHSC-OIG, December 2017.

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[46] Title 1, Texas Administrative Code Part 15. Chapter 353. Section 353.502.

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[48] Arizona Health Care Cost Containment System Administration. "AHCCCS Complete Care Program Contract for Contractors, Solicitation Number YH19-0001". Arizona Health Care Cost Containment System Administration. Page 93.

[49] State of New Mexico Human Services Department. "Medicaid Managed Care Services Agreement. Human Services Department". Page 33.

[50] State of Missouri Office of Administration Division of Purchasing. "MO HealthNet Managed Care - Central, Eastern, Western, and Southwestern Regions". State of Missouri Office of Administration Division of Purchasing. Page 21.

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