Quarterly Report

Quarter 4

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 fourth quarterly report for fiscal year 2019, summarizing the excellent work this office has performed during this quarter as well as the fiscal year, to Governor Greg Abbott, Executive Commissioner Dr. Courtney Phillips, the Texas Legislature, and the citizens of Texas.

During this quarter, the OIG recovered nearly $84 million. For fiscal year 2019, our recoveries totaled $421.2 million, a record year for this office. In addition, $170.7 million was identified for potential future recoveries, and another $164.1 million was achieved in cost avoidance by deterring potentially questionable spending before it could occur.

As we enter a new fiscal year, the OIG continues to refine its work to thrive in a managed care environment. We have reorganized to align functions more smartly, which increases our operational efficiency and will lead to better outcomes. This office is also continuing to refine and mature its data analytics work; we are committed to producing strong investigative results, as well as audit and inspections reports, that are backed by a wealth of data to support our findings. Among our priorities are a continued focus on prevention to reduce the need to recover money improperly spent; strengthening our oversight of non-Medicaid contracts; and continuing to improve in everything we do.

The OIG team goes into fiscal year 2020 with a firm commitment to the taxpayers of Texas: guided by our core values of Integrity, Accountability, Collaboration and Excellence, we will ensure the integrity of the state's health and human services, ensuring that funds are properly spent to help those who need those services. I am honored to work with these dedicated public servants.

Respectfully,
Sylvia Hernandez Kauffman

Fiscal year 2019 results

Dollars recovered

Audit	
Collections	$6,040,915
Inspections	
WIC collections	$94,140
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$30,153,402
Voluntary repayments by beneficiaries	$323,224
Total	**$30,476,626**
Medicaid Program Integrity	
Provider collections	$16,412,148
Acute care provider collections	$9,494,436
Hospital collections	$19,332,961
Nursing facility collections	$818,084
Total	**$46,057,629**
Third Party Recoveries	
TPR recoveries	$295,744,177
RAC recoveries	$42,563,050
Total	**$338,307,227**
Peace Officers	
EBT Trafficking team collections	$242,529
Total dollars recovered	**$421,219,066**

Dollars identified for recovery

Audit	
Provider overpayments	$27,539,188
Inspections	
WIC vendor monitoring	$7,673,259
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$43,920,894
Medicaid Program Integrity	
*MCO identified overpayments	$22,941,671
Acute care providers	$5,384,625
Hospitals	$18,666,222
Nursing facility overpayments	$1,621,771
Total	**$48,614,289**
Third Party Recoveries	
RAC audits	$37,388,285
Peace Officers	
EBT trafficking	$5,616,082
Total dollars identified for recovery	**$170,751,997**

*Numbers reported in previous quarters have been adjusted to reflect updated amounts.

Cost avoidance

Inspections	
Vendor disqualifications	$6,131,901
Benefits Program Integrity	
Client disqualifications	$5,884,534
Medicaid Program Integrity	
Medicaid provider exclusions	$18,556,015
Pharmacy Lock-In	$5,652,758
Total	**$24,208,773**
Third Party Recoveries	
TPR	$127,069,742
Peace Officers	
Disability determination services	$850,663
Total cost avoidance	**$164,145,613**

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.

All instances of identified overpayments and/or recoveries refer to potential, preliminary dollar amounts as part of ongoing inspections and investigations.

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	$242,529
Dollars identified for recovery	$5,616,082
Cost avoidance	$850,663
Completed cases involving OIG peace officers	1,013

Fiscal year 2019 overview

Preventing fraud, waste and abuse

One of the OIG's top priorities for fiscal year 2019 was to focus on prevention. Rather than paying and chasing dollars, what can we do up-front to ensure those dollars are spent properly?

The OIG developed a fraud, waste and abuse (FWA) prevention strategy that focused on raising awareness of FWA and educating three specific audiences: Medicaid providers, Medicaid clients, and HHS staff. Individuals in each of these three categories play a unique role in FWA prevention in the provision and delivery of health and human services in Texas. Two provider types were identified to initiate the prevention strategy: dental and attendant care providers.

Dental solicitation

The OIG engaged Medicaid dental providers through a multifaceted approach. The OIG wrote an article for TDA Today, published by the Texas Dental Association, about preventing illegal Medicaid dental solicitation. The Communications Team created a fraud and abuse prevention advisory for the OIG website, and social media channels warned patients to be wary of marketers who offer cash, gifts or other items to influence their health care decisions.

Staff from the OIG and HHS Medicaid and CHIP Services (MCS) formed a workgroup to develop recommendations to address select FWA issues in the Children's Medicaid Dental Services program.

The workgroup reviewed Medicaid dental data and identified two major areas of concern: excessive or medically unnecessary restorations and improper dental solicitation.

The OIG hosted a stakeholder meeting with attendees from MCS, two dental maintenance organizations (DMOs) and three dental associations. The concerns and ideas shared in the discussions led the workgroup to make several recommendations, including:

- Adding dental associations to Texas Fraud Prevention Partnership meetings
- Presenting OIG dental solicitation data analysis to MCS and DMOs
- Recommending MCS limit restorations in certain circumstances on the same tooth within a 12-month period
- Analyzing three years of data to identify policy issues and data patterns to communicate with MCS
- Providing MSC with dental billing codes identified as recurring risks for fraud, waste, and abuse

OIG's recommendations were based on documented issues and supported with available data. They were implemented throughout fiscal year 2019.

Fiscal year 2019 data

Audit reports issued	38
Inspections reports issued	9
Investigations completed (BPI, IA, Peace Officer)	16,339
Medicaid provider investigations completed	
Preliminary	2,039
Full-scale	260
MPI cases transferred to full-scale investigation	279
MPI cases referred to Medicaid Fraud Control Unit	382
Hospital claims reviewed	18,098
Nursing facility reviews conducted	368
Medicaid and CHIP provider enrollment screenings performed	112,241
Medicaid providers excluded	300
Fraud hotline calls answered	27,283

Personal care attendants

Medicaid Program Integrity (MPI) identified a number of personal care attendant cases in fiscal year 2019 that included billing for services not rendered. This trend provided an opportunity for prevention through education that included an email to providers with an advisory and letters in English and Spanish for attendants and clients highlighting fraudulent behavior. OIG staff engaged and educated providers via a booth at the annual Texas Association for Home Care & Hospice (TAHCH) conference.

OIG staff collaborated with HHS Regulatory and MCS Services to address select fraud, waste and abuse issues.

Social media campaign

OIG prevention efforts also included outreach on the eligibility side. The OIG Benefits Program Integrity division (BPI) coordinated with HHS Access and Eligibility Services on an anti-fraud social media campaign. The posters and

social media messages remind Medicaid providers and recipients to be aware of program fraud and the role the OIG plays in investigating FWA.

Other key accomplishments of the FWA Prevention Strategy in fiscal year 2019 include increasing the OIG's presence on social media, increasing and categorizing content on the OIG Resources web page, adding OIG contact and social media information on a variety of OIG communication collaterals, and authoring eight articles submitted to and published by provider associations.

Strengthening managed care oversight

As part of OIG's fiscal year 2019 managed care transition plan, the OIG has improved its approach, infrastructure, expertise and collaboration in the agency's work in managed care. The managed care transition plan included details about:

- **Recoveries:** The plan mapped existing OIG processes in all areas related to recoveries and provided recommendations to improve OIG recovery efforts including better system-wide approaches, maximizing organizational efficiencies and improving reporting on recoveries.
- **Transition of Utilization Reviews:** The OIG quantified the impact of Nursing Facility Utilization Review's work in managed care by reporting the amount of dollars MCOs adjusted in encounters since the OIG initiated the reviews.
- **Managed Care Professional Development:** The OIG provided opportunities for staff to learn more about managed care, including collaborating with Medicaid and CHIP Services for five presentations dedicated to managed care topics, and OIG staff visiting three regional offices (San Antonio, Pharr and Houston) to provide specialized managed care training.

As part of continuing efforts to improve the rigor of our operations, the OIG contracted with an actuary through fiscal year 2019 to advise the OIG on the impact of overpayment recovery options in Medicaid managed care and provide guidance for moving forward. The actuary scope of work included addressing how to measure the impact of OIG work on the calculation of capitation rates, discussing methods of recovering provider overpayments, and analyzing the actuarial soundness of recommendations in a draft audit conducted by the OIG.

The actuary concluded that the OIG, in most circumstances, may collect provider overpayments from either the provider or the MCO without negatively impacting the rates paid to MCOs by the state.

The actuary also suggested a new metric to calculate the impact of OIG recovery efforts on the rates paid to MCOs.

Reinforcing relationships with stakeholders

Outreach continued throughout the year with numerous presentations, conference visits, and stakeholder meetings. During the 86th Texas Legislature, IG Kaufman and staff met with 19 representatives and eight senators:

- 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
- Rep. Donna Howard
- Rep. Giovanni Capriglione
- Dr. John Zerwas
- Rep. Bobby Guerra
- Rep. Ina Minjarez
- Rep. Candy Noble
- Rep. Richard Raymond
- Rep. James Frank
- Sen. Dawn Buckingham
- Sen. Kel Seliger
- Sen. Carol Alvarado
- Sen. Bob Hall
- Sen. Jane Nelson
- Sen. Charles Perry
- Sen. Royce West
- Sen. Chuy Hinojosa

The team conveyed budget priorities and program updates to the legislators. IG Kauffman testified in front of the House Appropriations Committee; the House Appropriations, Subcommittee on Art. II; the Senate Finance Committee; the House Health and Human Services Committee; and the Senate Nominations Committee. Government Relations also attended a town hall on managed care.

Throughout fiscal year 2019, OIG staff met with district attorneys across the state to discuss how to better collaborate on client fraud cases. Staff held stakeholder meetings related to nursing facility and hospital utilization reviews, Medicaid dental services, and attendant care.

The OIG continued to expand its inclusive, multi-agency approach to fraud prevention in Texas Medicaid. The Texas Fraud Prevention Partnership (TFPP) now includes managed care organizations, dental maintenance organizations, HHS Medicaid and CHIP Services, the Office of Attorney General Medicaid Fraud Control Unit, and health care provider associations. TFPP meetings in 2019 focused on current prevention initiatives across the agencies and organizations; Government Relations presented a wrap-up of the 86th Texas Legislative Session at one of the quarterly meetings.

IG Kauffman gave presentations to health care associations, organizations, and universities on the role of the OIG in Medicaid and fraud prevention; a small sample of her outreach includes the Texas Association for Home Care & Hospice, the American Association of Medical Audit Specialists and UT Health-San Antonio. Stakeholder engagement also included one-on-one meetings with several MCOs throughout the year, which provided opportunities to identify the latest trends in FWA.

Integrating data analytics

In an effort to become a more data-driven organization, the OIG continued to integrate data analytics into agency operations during fiscal year 2019. A targeted use of algorithms developed by the OIG's Data and Technology (DAT) unit allowed investigators to focus their work on areas with higher risk for Medicaid fraud. Using data as a starting point helps investigators be more efficient in their work and realize a higher success rate in fraud detection.

OIG developed a data review of Medicaid dental billing to identify high-risk providers exhibiting patterns of possible patient solicitation activity. After having received numerous complaints, the OIG put together a workgroup consisting of program, clinical and data experts to devise a methodology to study the issue. Several billing indicators were developed and measured in the data. Results were weighted and scored to determine which providers were statistically different from the peer group. The OIG used these data findings to prioritize provider investigations and presented the information to both the Medicaid and dental managed care organizations to coordinate on any additional efforts to address this issue. You can read more about data-driven dental investigations in the Program Integrity Spotlight on page 24.

Data analysis is at the heart of the Fraud Detection Operation, helping to discover and assess anomalies in provider billing patterns. Quarterly FDOs conducted by MPI this year included examinations of chemical dependency, behavioral health, and dental providers. With each FDO, DAT provided MPI with analysis to help select providers identified as outliers from their peers. MPI investigators collected records from the providers, interviewed staff and contacted clients where Medicaid had paid for services. OIG FDOs resulted in multiple cases opened for identified program violations.

Cases initiated by data-driven FDOs have realized a higher success rate than traditionally initiated cases, such as MCO referrals or calls to the Fraud Hotline. An OIG analysis of all FDOs to date compared outcomes with non-FDO cases. The analysis revealed that FDO data-driven allegations were four times more likely to result in full-scale investigations. As a result of that success, MPI will continue to expand data-driven initiatives among provider types.

OIG expertise guides evaluations

The OIG Centralized Risk Review (OCCR) was developed to identify key areas of risk for fraud, waste and abuse in the programs, systems and services delivered by providers and contractors.

Through the OCCR process, skilled policy and data analysis staff conduct a preliminary examination of a topic. This process considers known and emerging risks on each topic based a number of factors, including other state and federal agency reports, initial data reviews, and interviews with HHS and Department of Family and Protective Services staff to estimate the potential impact of a topic. The process yields various potential areas of focus for the topic and data strategies the OIG may consider for future audits, inspections and investigations.

Key areas of the OIG further refine approved topics

according to their respective business processes.

New workload management leads to increased BPI recoveries

The San Antonio BPI team implemented a new regional workload management process in October 2018. The process prioritizes different types of investigations based on case management criteria, including the type of potential benefit fraud and level of evidence that is needed early in the investigation. Since the new process implementation, the unit has identified $6,967,787 in new recoveries in the fiscal year to date. This is a $2 million increase over the total at this time last year. With this new workload management and prioritization strategy, this BPI team is currently tracking a 150 percent productivity increase over last fiscal year. This new strategy will be implemented with various BPI units across Texas.

Third Party Recoveries moves to OIG

The Third Party Recoveries (TPR) division officially transitioned from Medicaid/CHIP Services to the OIG in September 2018. TPR worked closely with vendors to increase third party liability (TPL) activities in several areas in an effort to increase overall recoveries for the state. Activities include implementing electronic billing processes with insurance payers and matching casualty claims against a national data warehouse to identify third parties responsible for payment reimbursement to the state.

As a result, TPR recoveries have continued to increase in fiscal year 2019.

Motor vehicle and casualty claims pilot. OIG implemented a new data match process in fall 2018 to increase recoveries related to tort cases by contracting with a vendor that electronically matches with a national data warehouse, Insurance Services Organization, where multi-state casualty claims are recorded. If a match is made, the system notifies the responsible casualty insurance carrier of the state's lien and attempts to intercept payments before they are made to the claimant. Cost recoveries from this initiative were realized beginning in February 2019 with $334 and have significantly increased by an average of 20 percent each month, ending with a total of $321,000 in recoveries for fiscal year 2019.

Third Party Recoveries activity

Cost recoveries	$338,307,227
Cost avoidance	$127,069,742

Audit division dispenses range of services

The Audit Division conducts risk-based performance, provider, contractor, and information technology audits related to services delivered through medical providers and contractors, and to programs, functions, processes, and systems within the HHS System and DFPS.

Audits were also conducted to assess the timeliness, coordination and management of services delivered to some of Texas' most vulnerable residents, including a series of audits evaluating the coordination of services delivered to STAR+PLUS members with the greatest level of medical need, and audits evaluating the services delivered to medically fragile children and young adults with significant and complex medical needs enrolled in STAR Health and STAR Kids.

HB 2379 implemented

Over the past year, the OIG has implemented a process to begin recouping Medicaid overpayments in relation to HB 2379 which passed in 2017. HB 2379 mandates that one-half of provider fraud and abuse recoveries made by MCOs for MCO cases referred to the OIG on or after September 1, 2017, be shared with the OIG.

In March, OIG began sending notification letters to MCOs requesting payments or case updates in cases they previously referred to the OIG that are related to HB 2379 recovery sharing. In total this year, there were 18 different MCOs that received letters on 214 previously referred cases. At the end of fiscal year 2019, OIG has processed $141,962 in shared recoveries from seven different MCOs.

OIG recommendations implemented for Electronic Visit Verification System

HHS and MCOs are implementing most of the recommendations from the Electronic Visit Verification (EVV) System inspection report published in May 2018. The EVV system was designed to deter fraud, waste and abuse in personal care attendant services in Texas Medicaid. Those services, performed by attendants who are not required to be licensed or certified, are provided in client homes to help vulnerable, medically fragile clients continue to live in the community. The purpose of the inspection was to verify EVV data.

As a result of the inspection, much of the EVV system was revised, and new policies and procedures were created.

Some of the new policies involve additional training, as well as billing and coding fixes that will help ensure clients receive services for which the state is billed and claims are paid.

Introduced more rigor, professionalism and accountability

Staff across the OIG remain dedicated to professional development to be better prepared to work in the changing healthcare landscape. Internal and external trainings are highlighted throughout this report. An additional example is the enhanced training completed by Internal Affairs in August. All investigators from around the state, including support staff and forensic examiners converged in Austin for four days of training. Sessions focused on investigative techniques, leadership concepts, and cultural awareness; each day culminated with a case study putting concepts into action.

Benefits Program Integrity (BPI) supported administrative team members with three days of training in July. Presentations and exercises focused on effective communication and collaboration.

OIG University provides additional instructions and tools to help staff meet professional challenges and maintain accountability. In fiscal year 2019, OIG University offered 170 trainings on topics ranging from case management skills for Internal Affairs to interviewing skills for MPI to leadership development. OIG University also offered 15 Explore OIG presentations specific to better understanding HHS programs. Topics included Electronic Benefit Transfer overview, Managed Care Compliance and Operations, Provider Integrity Enrollment Screening, and Procurement and Contracting Law, Rule and Policy.

Quarter 4 results

Dollars recovered

Audit	
Collections	$504,967
Inspections	
WIC collections	$3,012
Benefits Program Integrity	
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$4,492,974
Voluntary repayments by beneficiaries	$86,209
Total	**$4,579,183**
Medicaid Program Integrity	
Provider collections	$716,976
Acute care provider collections	$3,029,430
Hospital collections	$4,746,167
Nursing facility collections	$762,652
Total	**$9,255,225**
Third Party Recoveries	
TPR recoveries	$61,848,238
RAC recoveries	$7,619,701
Total	**$69,467,939**
Peace Officers	
EBT Trafficking team collections	$64,222
Total dollars recovered	**$83,874,548**

Dollars identified for recovery

Audit	
Provider overpayments	$773,587
Inspections	
Out-of-state clients	$4,657,919
WIC vendor monitoring	$45
Total	**$4,657,964**
Benefits Program Integrity	
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$12,494,355
Medicaid Program Integrity	
MCO identified overpayments	$6,190,764
Acute care providers	$3,046,572
Hospitals	$1,619,944
Nursing facility overpayments	$501,336
Total	**$11,358,616**
Third Party Recoveries	
RAC audits	$10,997,721
Peace Officers	
EBT trafficking	$342,412
Total dollars identified for recovery	**$40,624,655**

Cost avoidance

Inspections	
Vendor disqualifications	$0
Benefits Program Integrity	
Client disqualifications	$1,393,903
Medicaid Program Integrity	
Medicaid provider exclusions	$10,624,615
Pharmacy Lock-In	$1,595,854
Total	**$12,220,469**
Third Party Recoveries	
TPR	$28,429,023
Peace Officers	
Disability determination services	$0
Total cost avoidance	**$42,043,395**

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.

All instances of identified overpayments and/or recoveries refer to potential, preliminary dollar amounts as part of ongoing inspections and investigations.

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	$64,222
Dollars identified for recovery	$342,412
Cost avoidance	$0
Completed cases involving OIG peace officers	233

Trends

Medicaid Program Integrity

The Medicaid Program Integrity (MPI) Division opened seven cases based on a Clinical Laboratory Improvement Amendments (CLIA) initiative. The CLIA initiative is designed to identify independent laboratories that received payment for specific types of testing without holding the appropriate CLIA certification to perform such testing. CLIA regulations set standards that are designed to improve quality in all laboratory testing and include specifications for quality control, quality assurance, patient test management, personnel and proficiency testing.

MPI opened nine cases based on the identification of multiple providers inappropriately billing for certain electroencephalographic (EEG) services. Neurologists and other clinicians are billing for an EGG service which requires 24-hour monitoring by a clinician who can intervene in the monitoring and/or patient care as needed. The OIG initiative identified providers who are equipping patients with mobile EEG units and sending them home for overnight monitoring without 24-hour monitoring by a clinician. As a result, the providers inappropriately received a higher reimbursement amount.

Cases worked by MPI this quarter include:

- **Private duty nursing bills for impossible hours.** An MPI investigation found that a single registered nurse in Pflugerville was billing for continuous 24 hour shifts for weeks at a time. The Texas Medicaid Provider Procedures Manual indicates that a registered nurse cannot be reimbursed more than 16 hours of private duty nursing services in one day. Private duty nursing includes observation, assessment, intervention, evaluation, rehabilitation, care and counsel, or health teachings of a recipient who has a disability or chronic health condition or who is experiencing a change in normal health processes. The provider has completed a self-report, which identified a total overpayment amount of $93,945.

A sample of case results for MPI settled by Litigation for this quarter include:

- **Durable medical equipment settlement.** The OIG reached a settlement with a durable medical equipment (DME) provider in El Paso for $1,210,376. An OIG audit of the DME company found the provider violated Medicaid policy by using expired or incomplete Title XIX forms (a physician order), billing for supplies without the proper authorization forms and inadequate or missing delivery documentation. Under the terms of the agreement executed in June, the DME provider will pay the overpayment amount in addition to interest.
- **Personal care attendant settlements.** The OIG reached two settlements in June in attendant care cases. One investigation identified an attendant from San Antonio who billed for services that were not performed. The second investigation identified an attendant from Houston who was billing for services while the client was incarcerated and not available to receive services. Although they generally involve

Types of complaints received by MPI

Attendants	51%
Physician (individual, clinic, or group practice)	10%
Home health agency	10%
Medical transportation program	7%
Dental	6%
Pharmacy	3%
Nursing facility	3%
Therapy/counseling	2%
Hospital	2%
Managed care organization	2%
Other	4%

Types of MPI field provider investigations

Attendants	18%
Physician (individual/group/clinic)	16%
Pharmacy	14%
Lab/radiology/X-ray	10%
Durable medical equipment	10%
Home health agency	8%
Hospital	8%
Therapy/counseling	6%
Dental	4%
Case management	2%
Rehabilitation center	2%
Other	2%

relatively lower dollar amounts than other cases, attendant care complaints made up more than half of the complaints received by MPI. In addition to pursuing settlements, the OIG often pursues exclusion of the attendant for causing false claims to be filed with Medicaid. In the fourth quarter, Litigation issued 11 procedural notices and excluded eight individuals.

Benefits Program Integrity

The Benefits Program Integrity (BPI) division opened 2,610 investigations involving some form of benefit recipient overpayment or fraud. Eighty percent involved unreported income (33 percent) or an issue with the reported household composition (47 percent). Household composition cases usually involve an unreported household member who has income or could also include a household member who does not actually live in the same residence. Both instances cause the household to receive more benefits than it is entitled to receive. Other types of opened investigations (20 percent) include prison matches, felony drug convictions, felony fugitive matches or dual participation of benefits in other states.

BPI completed 286 investigations where fraud was found. BPI referred 41 investigations for prosecution and 245 for an administrative disqualification hearing. Ninety-six percent of fraud investigations completed involved either unreported income (17 percent) or an issue with the reported household composition (79 percent).

A sample of cases worked by BPI this quarter include:

- **Restitution ordered.** BPI resolved a case where, on four separate occasions, a client failed to report her husband as a household member, which excluded his income in the calculation for benefit eligibility and resulted in an overpayment. The investigation was completed and submitted to the Haskell County District Attorney's office. The client was charged with Medicaid fraud. In June, a judge ordered the client to pay restitution in the amount of $20,457, and the client was also placed on 10 years of deferred adjudication probation.
- **Fraudulently obtained benefits.** BPI resolved a case in July with the Hidalgo County District Attorney involving a client who fraudulently obtained SNAP and Medicaid benefits. The client submitted falsified applications by failing to include her husband as part of her household composition and his income from November 2015 to November 2017. The client was charged with theft, ordered to pay $25,097, disqualified from receiving SNAP benefits, and placed on probation for five years.
- **Public complaint leads to conviction.** BPI received a public complaint alleging a client who did not reside in Texas was receiving benefits. During this investigation, BPI obtained evidence verifying that the client and her children resided in Juarez, Mexico and not in El Paso. The case was submitted to the El Paso District Attorney's office for prosecution. The overpayment included SNAP, TANF and Medicaid benefits totaling $94,960. The individual was found guilty, sentenced to serve 10 years of community supervision and ordered to pay full restitution.

EBT Trafficking Unit

This quarter, the Electronic Benefits Transfer (EBT) unit completed 52 investigations and presented another 21 investigations for either administrative disqualification hearings (18) or prosecution (3).

Trends identified by the unit include:

- **Excessive SNAP card replacement.** The EBT Trafficking Unit utilized data analytics to confirm a pattern of SNAP recipients receiving an excessive number of replacement cards in a 12-month period. This variable, a possible indicator of fraudulent activity, was discovered through a Food and Nutrition Service audit. OIG staff initiated investigations and a process to communicate results of the research and investigations with HHS Access and Eligibility Services.
- **Selling SNAP benefits**. In addition, the unit identified and continues to monitor trends regarding the selling of SNAP benefits for illegal activities. One of the trends EBT identified involves non-recipient business owners fraudulently obtaining benefits by illegally purchasing SNAP cards for 50 cents on the dollar and using SNAP to purchase supplies and products for their own business. Another illegal activity involves SNAP recipients trading their benefits for cash to pay for illegal gaming, such as casino-style, eight-liner slot machines.

A sample of cases worked by EBT this quarter include:

- **SNAP fraud.** An EBT Trafficking Unit investigation led to the arrest of a business owner in Beaumont and 61 SNAP recipients who were charged with fraud. The investigation discovered more than 300 purchases from 92 EBT cards from more than 61 SNAP recipients, totaling approximately $71,000 in unauthorized SNAP benefits. The illegally purchased items were used by the owner of a restaurant to stock his business. Investigators executed a search warrant based on information obtained during the investigation conducted by EBT trafficking investigators. Additional arrests and charges are pending.
- **Undercover operation.** EBT Trafficking Unit investigators received information from an investigative agency regarding SNAP fraud at a Travis County food truck. EBT investigators determined a restaurant owner — and non-participant in the SNAP program — used more than 100 EBT cards to obtain approximately $42,000 in unauthorized SNAP benefits. SNAP recipients involved in the case told investigators the owner purchased SNAP benefits at fifty cents on the dollar and used the benefits to stock his food truck. Undercover investigators sold SNAP benefits to the owner on multiple occasions. This case is being referred to the Travis County District Attorney.
- **Selling SNAP benefits.** A tip from an investigative agency led to the discovery of SNAP fraud at a Dallas County grocery. EBT Trafficking Unit investigators received information regarding the use of more than 200 EBT cards to make purchases on the account of a convenience store that has a restaurant. Investigators determined the store and the owners did not participate in the SNAP program as a retailer or client, and therefore were unauthorized to use SNAP benefits. The investigation determined that more than 100 recipients were involved in selling benefits to the store owner, which resulted in more than $47,000 in fraudulently used benefits. This case is being referred to the Dallas County District Attorney.

Internal Affairs

The Internal Affairs (IA) Division had 94 active cases in the fourth quarter involving fraud, waste and abuse in the delivery of health and human services, employee benefits fraud, and other issues; 64 cases were closed at quarter's end. IA processed 97 referrals this quarter and investigated 34 of those referrals, with the remaining forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers, DFPS Office of Consumer Relations and HHS Complaint and Incident Intake.

Type of cases closed by IA this quarter

Perjury	11
Benefits fraud	8
Falsifying information/documents	3
Unauthorized release of information	3
Unprofessional conduct	3
Vital statistics fraud	3
Youth camp compliance	2
Contract fraud	1
Misapplication of fiduciary property	1
Tampering with a government record	1
Theft	1
Workplace threats	1

Trends identified by the unit include:

- **Privacy-related cases.** IA saw a decrease in privacy-related cases from nine cases in the third quarter to three in the fourth quarter. IA provides investigative support to the HHS Privacy Office when an employee is alleged to have accessed, collected or distributed protected health information, personally identifiable information or information protected under the Health Insurance Portability and Accountability Act (HIPAA).
- **CPS perjury cases.** The number of perjury allegations involving testimony or affidavits by Child Protective Services caseworkers seen in the third quarter dropped slightly in the fourth quarter. IA closed 19 cases in third quarter, while 15 cases were closed this quarter.

A sample of a case conducted by IA this quarter:

- **HHS employee fraud scheme.** A case IA worked in 2014 involving a former HHS employee-driven fraud scheme resolved this quarter in Hidalgo County. The employee, a former Texas Works Advisor, was accused of conspiring with two other HHS

employees to fraudulently certify benefits recipients. The judge ordered the former Texas Works Advisor to pay restitution to HHS in the amount of $71,085.

State Centers Investigations Team

The OIG's State Center Investigations Team (SCIT) opened 205 investigations and completed 181 investigations in the fourth quarter, with an average completion time of 23.7 days. This compares to 166 opened investigations and 169 completed investigations in the third quarter of fiscal year 2019. In the fourth quarter of 2018, SCIT opened 202 investigations and completed 238 investigations, with an average completion time of 29.7 days.

During the fourth quarter, several suspects were sentenced in SCIT cases. At the San Antonio State Supported Living Center, a suspect was accused of assaulting a client. Subsequent interviews and review of video evidence confirmed the allegation. The suspect was sentenced in June to two years deferred adjudication, with the court imposing court costs and fines. In another case, a suspect was found guilty in Washington County for unlawfully restraining a client at the Brenham State Supported Living Center. Video and documentation confirmed the allegation. In July, the suspect was sentenced to two years deferred adjudication and 100 hours of community service along with paying court costs and fines.

Rule proposals

Closing investigations amendment

Proposed amendments to 1 TAC §§371.1305, 371.1307 and proposed new rule 1 TAC §371.1312, related to closing investigations, were adopted on July 1, 2019 and published in the July 19, 2019 issue of the Texas Register. The adopted rules outline the criteria for opening, prioritizing and closing preliminary, full-scale and recipient investigations. The adopted rules provide greater transparency into the office's investigative processes. These rules became effective on July 23, 2019.

HB 2379 implemented: MCO referrals and recoveries

Proposed amendments to 1 TAC §353.502, §353.505, and §371.1311 related to HB 2379 were adopted on June 27, 2019 and published in the July 12, 2019 issue of the Texas Register. The adopted rules align with HB 2379 (85th Legislative Session) and update changes to MCO referral procedures. These rules became effective on July 18, 2019.

Administrative enforcement

Draft amendments to 1 TAC §371.1603 and §371.1715 related to Administrative Enforcement were posted to the HHS Rules Coordination Office for informal comment from June 19, 2019 through July 3, 2019. The amendments clarify the factors that the agency applies when determining the seriousness, prevalence of error, harm or potential harm of a violation, as required by statute. The amendments add examples of mitigating factors and clarify that a person potentially subject to an enforcement action may introduce such mitigating factors in any contested case, as well as during the agency's informal resolution process. The rule amendments also clarify that the agency assesses penalties in accordance with relevant law, particularly Texas Human Resource Code Section 32.039. OIG received comments from seven stakeholders during the informal comment period and has made revisions to the rules in response to those comments. OIG plans to present the proposed rules at the Medical Care Advisory Committee and HHSC Executive Council meetings in November 2019.

MCO audit coordination

Draft amendments to 1 TAC §371.37 related to MCO Audit Coordination were posted to the HHS Rules Coordination Office for informal comment from August 21, 2019 through September 4, 2019 along with the HHS companion rule 1 TAC §353.6. The rule amendments clarify OIG and HHS Medicaid and CHIP Services Department roles and jurisdiction related to audits of MCOs, providing greater transparency to existing processes. The amendment to 1 TAC §371.37 adds new detail that describes the coordination - in planning and performance - between OIG and HHS when OIG plans and conducts MCO audits. When the informal comment period closed, the OIG began reviewing stakeholder comments and developing proposed rules for presentation at the Medical Care Advisory Committee and HHS Executive Council meetings in 2020.

Policy recommendations

Revise therapy sessions in nursing facilities

The OIG completed an audit of the statewide financial impact of therapy practices at long-term care nursing facilities in state fiscal year 2017. Audit results indicated that the practice of clustering therapy sessions resulted in nursing facilities billing MCOs an estimated $39.2 million more for resident daily care in 2017 than what would have been billed if the practice were prohibited by Texas Medicaid policy. Additionally, nursing facilities sometimes performed Minimum Data Set (MDS) assessments just before the resident's therapy order expired, which resulted in the facilities receiving daily care payments from MCOs based on the Resource Utilization Group level established during the assessments for as many as 92 days without delivering any therapy to the resident. Just as with clustering, this practice was not prohibited by Medicaid policy.

The OIG recommended that HHS make policy and associated procedure changes designed to limit the number of therapy sessions used to conduct an MDS assessment to the frequency and duration per week prescribed for the resident. Prohibiting the practice of clustering could result in future savings to the state of approximately $39.2 million annually. As a result of the recommendation, MCS is drafting a proposed TAC rule amendment to address clustering of therapy.

Strengthen pharmacy benefit functions

The OIG completed an audit of Molina Healthcare of Texas, Inc. (Molina) and CaremarkPCS Health, L.L.C. (Caremark), Molina's pharmacy benefit manager (PBM). Molina subcontracts with Caremark to process and pay prescription claims, process updates to the Medicaid and CHIP formularies and the Medicaid preferred drug list (PDL), develop and manage maximum allowable cost (MAC) lists, and contracting with network pharmacies. Audit results indicated that Caremark's management of Molina's Medicaid and CHIP formularies, Medicaid PDL and MAC lists did not fully comply with applicable requirements. Investigators also identified additional issues related to MAC lists, prior authorization, pharmacy network management and reporting, pharmacy reporting and drug identification.

The OIG recommended to MCS to require Molina to achieve full compliance and strengthen its pharmacy benefit functions related to the Medicaid and CHIP formularies, the Medicaid PDL, MAC lists, prior authorization, pharmacy network management and reporting, pharmacy reporting and drug identification.

Ensure compliance with service coordination requirements and clarify requirements for face-to-face service coordination visits

The OIG completed audits of service coordination for Level 1 STAR+PLUS members at UnitedHealthcare Community Plan (United), Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company (Amerigroup), and HealthSpring Life and Health Insurance Co., Inc., doing business as Cigna-HealthSpring (Cigna). Level 1 members are generally enrolled in the Home and Community-Based Services (HCBS) program or are residents in nursing facilities. Audit results indicated that for 24 of 113 sampled members at United, 44 of 113 sampled members at Amerigroup, and 43 of the 113 sampled members at Cigna, the MCOs did not provide one or more of the required service coordination activities, which include conducting face-to-face visits, following up on member receipt of approved services, and performing an assessment of members entering nursing facilities.

The OIG recommended to MCS that MCOs should comply with their contractual requirements related to face-to-face visits for HCBS and nursing facility members, HCBS members' receipt of approved services, and nursing facility member assessments. In addition, the OIG offered a recommendation to MCS which, if implemented, will clarify requirements for the interval between the two required face-to-face service coordination visits each year for HCBS members.

Strengthen DFPS controls over child-specific contract payments

The OIG completed an audit of Texas Department of Family and Protective Services (DFPS) child-specific contracts for individuals in state conservatorship who received inpatient services from a psychiatric hospital. STAR Health, which is a Texas Medicaid managed care program administered by Superior HealthPlan (Superior), coordinates health services to children and young adults in state care. When medical necessity for the individual ends, the STAR Health program covers up to 15 additional inpatient hospital

days, called placement days. A child-specific contract is a contract between DFPS and the hospital under which the hospital, once the 15 placement days are exhausted, continues to provide routine 24-hour care for the child until placement can be found. Audit results indicated that from September 1, 2016, through May 31, 2018, there were 966 days of service paid by both DFPS and Superior for foster children inpatient psychiatric hospital stays. This resulted in duplicate payments to psychiatric hospitals of $587,488.

The OIG offered recommendations to DFPS which, if implemented, will result in recovery of the duplicate payments and the strengthening of DFPS's controls over child-specific contract payments.

Strengthen security controls for confidential HHS System information

The OIG completed an audit of the design and effectiveness of selected security controls over confidential HHS System information stored and processed by Texas Children's Health Plan (TCHP), and the design and effectiveness of business continuity and disaster recovery plans for operations relating to the processing and storage of confidential HHS System information by TCHP. Audit results indicated that TCHP complied with HHS Information Security Standards and Guidelines (ISSG) requirements related to workforce training, information security oversight, configuration management, and information systems monitoring, and that TCHP also complied with ISSG requirements related to business continuity and disaster recovery planning. However, results indicated that improvements are needed in TCHP's user account management and risk management control areas to adequately protect confidential HHS system information.

Auditors offered recommendations to MCS which, if implemented, will result in TCHP performing required reviews of and adjusting users' access, roles, and privileges; automatically disabling inactive user accounts; immediately disabling terminated user accounts; strengthening account lockout policy and configurations; and conducting required vulnerability scans of its IT system and timely remediating identified vulnerabilities.

Correct reporting of unallowable, unsupported, or overstated expenses to HHS

The OIG completed an audit of MCNA Insurance Company (MCNA), A Texas Medicaid and CHIP Dental Maintenance Organization. The audit reviewed Texas policies, practices, and activities related to claims processing, and financial and performance reporting for the period of September 2016 through February 2018, and other relevant activities through April 2019. Audit results indicated that MCNA adjudicated paid dental claims selected for review in accordance with requirements, and reasonably processed and resolved selected provider complaints. However, MCNA's SFY 2017 Administrative Expenses financial statistical report (FSR) included unallowable, unsupported, or overstated consulting and non-executive bonus expenses. In addition, MCNA did not request prior written approval from MCS for a July 2012 administrative fee increase, or for an unaffiliate sales exception or fair market value exception implemented for its affiliate third-party administrator, as required by the UMCM (MCNA later requested and obtained retroactive approval from MCS).

Auditors recommended to MCS, through its contract oversight responsibility, to require MCNA to address and correct its reporting of unallowable, unsupported, or overstated expenses to HHS. In addition, MCS should strengthen oversight of employee bonus plans. Furthermore, MCS should strengthen contract oversight and financial monitoring to ensure MCNA fees paid to affiliates comply with contractual requirements and affiliate profits are appropriately reported to MCS, and reassess affiliate reporting exceptions based on 2013 information.

The OIG completed an audit of MCNA Insurance Company (MCNA), A Texas Medicaid and CHIP Dental Maintenance Organization. The audit reviewed Texas policies, practices, and activities related to claims processing, and financial and performance reporting for the period of September 2016 through February 2018, and other relevant activities through April 2019. Audit results indicated that MCNA adjudicated paid dental claims selected for review in accordance with requirements, and reasonably processed and resolved selected provider complaints. However, MCNA's 2017 Administrative Expenses financial statistical report (FSR) included $777,660 in unallowable, unsupported, or overstated consulting and non-executive bonus expenses, which reduced the experience rebate amount owed to HHS. In addition, MCNA did not request prior written approval from HHS for a July 2012 administrative fee increase, or for an unaffiliate sales exception or fair market value exception implemented for its affiliate third-party administrator, as required by the Uniform Managed Care Manual (MCNA later requested

and obtained retroactive approval from MCS).

Auditors recommended that MCS, through its contract oversight responsibility, should require MCNA to address and correct its reporting of unallowable, unsupported, or overstated expenses to HHS. In addition, MCS should strengthen oversight of employee bonus plans. Furthermore, MCS should strengthen contract oversight and financial monitoring to ensure MCNA fees paid to affiliates comply with contractual requirements and affiliate profits are appropriately reported to HHS, and should also reassess affiliate reporting exceptions that were based on 2013 information.

Implement consistent policies and procedures to monitor and enforce contract requirements

The OIG completed an audit of MCS's processes to monitor and enforce contract requirements related to the STAR Kids and STAR Health programs. The audit focused on monitoring and enforcement of selected deliverables related to service coordination, service planning, and utilization of services. The audit objective was to determine whether MCS, through monitoring selected contract deliverables, effectively managed the STAR Kids and STAR Health programs for the Medically Dependent Children Program (MDCP).

MCS is engaged in monitoring activities including operational reviews of MCO administrative functions, targeted reviews of processes that support medical necessity determinations, reviews of utilization of services for specific members, and overseeing the receipt and review of deliverables.

Auditors recommended that MCS should implement consistent policies and procedures that include activities to proactively enforce timely submittal, determine completeness and accuracy, analyze provided information, and store contract deliverables; work with the MCOs to improve technical guidance and data sources chosen for contract deliverable inclusion; update contract deliverable requirements of the STAR Kids and STAR Health contracts, UMCM report deliverable instructions, and the UMCM Consolidated Deliverable Matrix, as appropriate; and use information obtained from contract deliverables to measure performance, enforce compliance and identify opportunities for improvement.

Agency highlights

Medicaid support services provider pays $4.6 million settlement

The OIG reached a settlement in August with a Medicaid support services provider for $4,665,716. OIG's past audit work examining three HHS-provider contracts and the provider's subsequent cost reconciliations revealed that the provider's costs were substantially overstated. The agreed settlement amount has been paid in full.

Settlement agreement reached with dental provider

The OIG entered into settlement agreement in June with a dental provider in Irving for $98,094. The investigation found that the provider submitted claims with a pattern of inappropriate coding or billing that resulted in excessive costs to the Medicaid. The investigation found numerous program violations, including billing for services or merchandise that were not provided to the client, failing to maintain required records and other documentation of services and providing medically unnecessary health care services. Investigators also found evidence that some of the dental care failed to meet professionally recognized standards of health care.

Provider self-report leads to settlement agreement

The OIG entered into a settlement agreement in June with a dental provider in Tyler for $89,265. The provider self-reported that dental hygienists were billing codes which require the dentist to be present in the office, when the dentist was out of the office. Provider also self-reported that when the dentist was out of the office, some of the dentists who covered the office were not enrolled to see Medicaid patients.

Results from July 2019 dental FDO

MPI is analyzing results from a July dental fraud detection operation (FDO). An FDO is a data-driven investigation designed to review providers that appear as statistical outliers

among their peers and assess whether this outlier status is due to program violations, fraud, waste, or abuse. It's an advanced data analytics method of assessing issues that may or may not lead to a full-scale investigation. Preliminary findings indicate two of the four dental providers were engaging in illegal dental solicitation. Dental providers are prohibited from offering cash, gifts or other items to people who have Medicaid in order to influence their health care decisions. Initial clinical exams identified providers received reimbursement for restorations when either sealants or no restorations were performed. These cases will move to full-scale investigations.

BPI intake unit helps increase identified recoveries

In effort to streamline and make investigative processes more efficient, BPI has a designated intake unit to screen, prioritize and validate referrals. The intake unit includes teams of specialized investigators who process referrals created from external sources and data matches. Data matches are a type of referral produced from automated comparisons of client data sets. This quarter, BPI processed 15,544 referrals and 6,136 matches. In the past, every BPI investigator was required to screen referrals to verify if sufficient and appropriate evidence existed to begin an official investigation. As a result of the preliminary validation performed by the intake unit, identified recoveries have increased by $7,158,787 from last fiscal year.

Deconfliction dashboard launched

Data and Technology created the deconfliction dashboard to provide better coordination across divisions. The dashboard pings a central repository which DAT built to consolidate several different case tracking systems (PI Case Tracker, OIG Audit, OIG Inspections, Medicaid Fraud Control Units, Civil Medicaid and more). The dashboard allows staff to search for any known open activity on a provider on demand. The tool was designed in response to concerns across divisions that case activity information is not in one central place. This was seen as a risk for areas engaging with the same provider without prior coordination. Before the dashboard, deconfliction was conducted through manual search processes in multiple systems and via individual emails across divisions. The dashboard was developed in consultation with key members of MPI, Audit, Inspections and Chief Council.

Quarter 4 data

Audit reports issued	18
Audits in progress	11
Inspections reports issued	3
Inspections in progress	8
Investigations completed (BPI, IA, Peace Officer)	4,394
Investigations opened	3,680
Medicaid provider investigations completed	
Preliminary	507
Full-scale	67
MPI cases transferred to full-scale investigation	49
MPI cases referred to Medicaid Fraud Control Unit	94
Hospital claims reviewed	3,388
Nursing facility reviews conducted	71
Medicaid and CHIP provider enrollment screenings performed	23,390
Medicaid providers excluded	81
Fraud hotline calls answered	7,279

Medical Services implements new coordination process for MCOs

New instructions were implemented for MCO deconfliction — the process of avoiding duplicate payment recovery efforts on the same OIG case of fraud, waste or abuse. The new case coordination process also includes stand-down instructions, which is the process of halting any recovery efforts already in progress by MCOs when a deconfliction is confirmed. Training for MCOs on the new instructions started in July during the Texas Fraud Prevention Partnership/Special Investigative Unit meeting; monthly calls provide MCOs the opportunity to give and received feedback on the new process.

Hospital managed care reviews underway

Medical Services Hospital Utilization Review (HUR) is continuing managed care claim reviews that began in February 2019. The goal of these reviews is to validate inpatient admissions for medical necessity, correct DRG (billing code) assignment, billing errors or quality of care issues. Notification to providers of approved managed care claims began July 2019. HUR conducted a teleconference

with the MCOs in August to provide updates, exchange information, answer questions and initiate steps to gather supporting information for managed care claims with potential for being denied. MCOs now have access to SharePoint to send and receive documentation.

OIG review of MCO cost avoidance and waste prevention activities

As required by HHS Rider 114 from the 86th Legislative Session, the OIG is continuing its review of MCO cost avoidance and waste prevention activities. Currently, MCOs report recoveries, but this reporting doesn't capture MCOs' actions to avoid costs in the provision of health services covered by Medicaid. The OIG is collaborating with HHS Medicaid and CHIP Services and MCOs to develop criteria, guidelines and options for methodologies to calculate the dollar value of cost avoidance and waste prevention activities utilized by MCOs. The OIG will include its findings and recommendations from the review in the report to be issued to the Legislative Budget Board and the Governor's Office on March 1, 2020.

TQ and SUR teams begin new processes for providers

Medical Services implemented a new process to request payment for identified billing errors after all rights for appeal have been exhausted from the provider when reimbursed by either traditional Medicaid or through MCOs. This process includes new provider notification letters that offer education, identify potential billing errors, and explain the appeals process. These business processes started in June.

WIC VMU compliance buys

The WIC Vendor Monitoring Unit (VMU) team conducted 304 compliance buys, 177 on-site store reviews, and 56 invoice audits across the state in 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 WIC VMU field and operational activities resulted in increased metrics across the priorities identified by their work plan. The increased metrics include eliminating the carry-over of open investigations from federal fiscal year 2017; mitigation of timely investigative processing; the development of a quality assurance/quality control process; completion of WIC travel analysis; completion of Data and Technology/On-site Store Review analysis; and redefining the investigative scope of compliance buys.

Nursing facility redesign project

The Centers for Medicare & Medicaid Services (CMS) is changing its skilled nursing facility reimbursement methodology from a Resource Utilization Group (RUG)-III based method to the Patient Driven Payment Model (PDPM). This will impact the Texas Medicaid nursing facility reimbursement as CMS currently calculates the RUG via the Minimum Data Set (MDS).

HHS staff have been diligently researching the impact and timeframes by reviewing information posted by CMS about the change to PDPM. Staff concluded that Texas' current use of the MDS and RUG-IIIs will not be impacted until October 1, 2020. The OIG is a member of this Nursing Facility Redesign Project. The workgroup was initiated by HHS's Rate Analysis Department, Medicaid and CHIP Services Department, and Long-Term Care Regulatory. The internal workgroup is developing an interim plan to maintain RUG-III-based NF payments past CMS's October 2020 deadline and a long-term plan for more significant changes to address stakeholders' concerns.

Completed reports

Audit

Audit of United Way of Metropolitan Dallas. The OIG completed an audit of the United Way of Metropolitan Dallas (United Way). The audit objectives were to determine whether contract funds were used as intended, and contractor billing and performance were in accordance with federal or state rules, guidelines, and applicable contractual requirements.

The audit scope was the period from September 1, 2017, through February 28, 2019, and included a review of expenditures under the Healthy Outcomes through Prevention and Early Support (HOPES) and Maternal Infant Early Childhood Home Visiting (MIECHV) programs reimbursed by DFPS to United Way, as well as United Way's monitoring of its subcontractors under the two programs' contracts. No significant reportable issues were identified during the audit.

Financial Impact of Clustering Therapy Services of Long-Term Care Nursing Facilities. The OIG completed an audit of the statewide financial impact of therapy practices at long-term care nursing facilities in fiscal year 2017. The audit was conducted after previous OIG audits of two nursing facilities identified a practice of clustering therapy

sessions during the Minimum Data Set (MDS) assessment look-back period. The practice of clustering therapy sessions at the two nursing facilities increased the Resource Utilization Group (RUG) level assigned to associated residents and resulted in MCOs paying higher daily RUG reimbursements to the nursing facilities.

Audit results indicated that the practice of clustering therapy sessions allowed nursing facilities to bill MCOs an estimated $39.2 million more for resident daily care in 2017 than what would have been billed if the practice were prohibited by Texas Medicaid policy. Additionally, nursing facilities sometimes performed MDS assessments just before a resident's therapy order expired, which resulted in the facilities receiving daily care payments from MCOs for as many as 92 days without delivering any therapy to the resident. Just as with clustering, this practice was not prohibited by Medicaid policy.

Auditors offered recommendations to HHS which, if implemented, will result in policy changes and associated procedures designed to limit the number of therapy sessions used to conduct an MDS assessment to the frequency and duration per week prescribed for the resident. This would result in cost savings to the Texas Medicaid program by lowering the MCO costs.

American Medical Response, Inc.: A Texas Medicaid Medical Transportation Organization. The OIG completed an audit of American Medical Response, Inc. (AMR), a Texas Medicaid medical transportation organization. The audit objective was to determine whether AMR's performance in selected areas was in accordance with contract requirements.

Audit results indicated that AMR's transportation encounter data was accurate and supported by information in its transportation management system, and the data used to form audit conclusions was reliable. Weekly spreadsheets used by AMR to monitor provider accidents and incidents contained complete and accurate information. AMR generally complied with the other contract provisions tested related to Demand Response driver logs, Individual Transportation Provider (ITP) mileage reimbursement forms, and AMR's management of complaints. Information AMR relied on to pay Demand Response and ITP claims did not always include required information or use required forms.

Auditors offered recommendations to AMR which, if implemented, will improve compliance with transportation claim form requirements and documentation and processing of complaint information. For instances of noncompliance identified in the audit, MCS will consider tailored contractual remedies to compel AMR to meet contractual requirements related to transportation claims and complaints.

STAR+PLUS Service Coordination: UnitedHealthcare Community Plan. The OIG completed an audit of service coordination for selected STAR+PLUS members at UnitedHealthcare Community Plan (United), a Medicaid and CHIP MCO. The audit objective was to evaluate whether United complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members. Level 1 members generally are enrolled in the Home and Community-Based Services program or are residents in nursing facilities.

Audit results indicated that for 24 of 113 sampled members, United did not provide one or more of the required service coordination activities, which include conducting face-to-face visits, following up on member receipt of approved services, and performing an assessment of members entering nursing facilities.

Auditors offered recommendations to MCS which, if implemented, will result in United meeting contractual requirements for service coordination. In its management responses, MCS indicated it will require United to submit a corrective action plan to correct the issues noted, and that its Results Management unit will review MCO compliance with the contractual issues identified in this audit during its biennial onsite operational reviews.

Best Med, Inc.: A Texas Vendor Drug Program Provider. The OIG completed an audit of Best Med, Inc. (Best Med), a Texas Vendor Drug Program (VDP) Provider. The audit objectives were to determine whether Best Med properly billed the VDP for Medicaid claims submitted, and whether Best Med complied with contractual and Texas Administrative Code (TAC) requirements.

As permitted by TAC rule 371.35(a), auditors used sampling and extrapolation as part of the audit. Audit results indicated there were exceptions related to claims validity, NDC usage, and quantity. Best Med did not bill the VDP properly or comply with other contractual or TAC requirements for 18 of the 120 claims tested. The 18 exceptions resulted in overpayments of $15,674 subject to extrapolation and recoupment. The total amount due to the State of Texas is $96,892. There were also 91 claims that may be subject to penalty. Based on the results of the IT

general controls testing, data was sufficiently reliable for the purposes of this audit.

Auditors offered recommendations to Best Med which, if implemented, will correct deficiencies in compliance with contractual and TAC requirements. The OIG issued a notice letter to Best Med to refund the overpayment of $96,892 to the State of Texas.

STAR+PLUS Service Coordination: Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company Plan. The OIG completed an audit of service coordination for selected STAR+PLUS members at Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company (Amerigroup), a Medicaid and CHIP MCO. The audit objective was to evaluate whether Amerigroup complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members.

Audit results indicated that for 44 of 113 sampled members, Amerigroup did not provide one or more of the required service coordination activities, which include conducting face-to-face visits, following up on member receipt of approved services, and performing an assessment of members entering nursing facilities.

Auditors offered recommendations to MCS which, if implemented, will result in Amerigroup meeting contractual requirements for service coordination. In its management responses, MCS indicated it will require Amerigroup to submit a corrective action plan to correct the issues noted, and that its Results Management unit will review MCO compliance with the contractual issues identified in this audit during its biennial onsite operational reviews.

Child Specific Contracts: Texas Department of Family and Protective Services. The OIG completed an audit of Texas Department of Family and Protective Services (DFPS) child-specific contracts for individuals in state conservatorship who received inpatient services from a psychiatric hospital. Hospital costs are covered by STAR Health, which is the Texas Medicaid managed care program administered by Superior HealthPlan (Superior) that coordinates health services to children and young adults in state care. The objective of the audit was to determine whether DFPS child-specific contract payments were made to psychiatric hospitals only for services not covered by STAR Health.

When medical necessity for the individual ends, the STAR Health program covers up to 15 additional inpatient hospital days, called placement days. A child-specific contract is a contract between DFPS and the hospital under which the hospital, once the 15 placement days are exhausted, continues to provide routine 24-hour care for the child until placement can be found. From September 1, 2016, through May 31, 2018, there were 966 days of service paid by both DFPS and Superior for foster children inpatient psychiatric hospital stays. This resulted in duplicate payments to psychiatric hospitals of $587,489.

Auditors presented audit results, findings, and recommendations to DFPS, and recommended that DFPS should recover duplicate payments of $189,375 it made to psychiatric hospitals for days of service covered by STAR Health, and strengthen its child-specific contract payment process. Auditors also recommended that DFPS should notify Superior that it may recover duplicate payments of $398,114 it made to psychiatric hospitals for days of service that were not covered by STAR Health and were paid by DFPS through child-specific contracts. DFPS agreed with the audit findings, and indicated it has implemented processes to prevent future errors and plans to recover overpayment amounts.

Medical Transportation Management, Inc.: A Texas Medicaid Medical Transportation Organization. The OIG completed an audit of Medical Transportation Management, Inc. (MTM), a Texas Medicaid Medical Transportation Organization. The objective of the audit was to determine whether MTM's performance in selected areas was in accordance with contract requirements.

Audit results indicated that MTM's transportation encounter data was accurate and supported by information in its transportation management system, and the data used to form audit conclusions was reliable. MTM generally complied with the other contract provisions tested related to Demand Response driver logs, Individual Transportation Provider (ITP) mileage reimbursement forms, and MTM's management of complaints, accidents and incidents. Information MTM relied on to pay Demand Response and ITP claims did not always include required information or use required forms, and some of the reported encounters included incorrect amounts. In addition, MTM did not always comply with all requirements for managing complaints, accidents and incidents.

Auditors offered recommendations to MTM which, if implemented, will improve compliance with transportation claim form requirements and documentation and processing of complaint, accident and incident information. For instances of noncompliance identified in the audit, MCS

will consider tailored contractual remedies to compel MTM to meet contractual requirements related to transportation claims, encounters and complaints.

Texas Medicaid and CHIP Pharmacy Benefit Services Delivered by Molina and Its PBM, Caremark. The OIG completed an audit of Molina Healthcare of Texas, Inc. (Molina) and Caremark PCS Health, L.L.C. (Caremark), Molina's subcontracted pharmacy benefit manager (PBM). The audit objective was to determine whether the delivery of selected pharmacy benefits by Molina and Caremark was effective and in compliance with criteria contained in the Uniform Managed Care Contract, the Uniform Managed Care Manual and applicable state rules and statutes. HHS paid a combined total of $530 million in capitation to Molina for pharmacy benefit services in fiscal years 2016 and 2017.

Audit results indicated that Molina's Medicaid and CHIP formularies did not match the HHS Vendor Drug Program (VDP) Medicaid and CHIP formularies, resulting in members being delayed or denied access to needed prescription drugs or supplies, as well as potential losses to the state in the form of missed federal rebates that would have been received if the items were properly listed. Also, an average of 8.3 percent of drugs on selected Molina Medicaid preferred drug lists (PDLs) did not match the drugs on VDP Medicaid PDLs for the periods tested, resulting in prior authorization being required for preferred drugs incorrectly classified as non-preferred drugs. As a result of the inappropriate classifications, members experienced a delay in access to, or denial of, valid and appropriate drugs and supplies. In addition, Molina's maximum allowable cost (MAC) lists improperly included 65 drugs that both appeared on VDP Medicaid PDLs and were brand name drugs, which inappropriately reduced reimbursement amounts to network pharmacies. Finally, the audit identified additional issues related to MAC lists, prior authorization, pharmacy network management and reporting, pharmacy reporting and drug identification.

Auditors offered recommendations to MCS which, if implemented, would help ensure Molina achieves full compliance and strengthen its pharmacy benefit functions related to the Medicaid and CHIP formularies, the Medicaid PDL, MAC lists, prior authorization, pharmacy network management and reporting, pharmacy reporting and drug identification.

Project Amistad: A Texas Medicaid Medical Transportation Organization. The OIG completed an audit of Project Amistad, a Texas Medicaid medical transportation organization. The objective of the audit was to determine whether Project Amistad's performance in selected areas was in accordance with contract requirements.

Audit results indicated that Project Amistad's transportation encounter data was accurate and supported by information in its transportation management system, and the data used to form audit conclusions was reliable. Project Amistad generally complied with the other contract provisions tested related to Demand Response driver logs, Individual Transportation Provider (ITP) mileage reimbursement forms, and its management of complaints, accidents and incidents. Information Project Amistad relied on to pay Demand Response and ITP claims did not always include required information or the correct version of the driver log.

Auditors offered recommendations to Project Amistad which, if implemented, will improve compliance with transportation claim form requirements. For instances of noncompliance identified in the audit, MCS will consider tailored contractual remedies to compel Amistad to meet contractual requirements related to transportation claims.

Security Controls over Confidential HHS System Information and Business Continuity and Disaster Recovery Plans: Texas Children's Medical Center. The OIG completed an audit of the Texas Children's Health Plan (TCHP). The objectives of the audit were to assess the design and effectiveness of selected security controls over confidential HHS System information stored and processed by TCHP, as well as business continuity and disaster recovery plans for operations relating to the processing and storage of confidential HHS System information by TCHP.

Audit results indicated that TCHP complied with HHS Information Security Standards and Guidelines (ISSG) requirements related to workforce training, information security oversight, configuration management, and information systems monitoring. TCHP also complied with ISSG requirements related to business continuity and disaster recovery planning. However, improvements are needed in TCHP's user account management and risk management control areas to adequately protect confidential HHS System information.

Auditors offered recommendations to MCS which, if implemented, will result in TCHP strengthening its user account management and risk management control areas. MCS concurred with the audit recommendations and will

coordinate with HHS IT and require TCHP to address the audit issues.

LogistiCare Solutions: A Texas Medicaid Medical Transportation Organization. The OIG completed an audit of LogistiCare Solutions (LogistiCare), a Texas Medicaid medical transportation organization. The objective of the audit was to determine whether LogistiCare's performance in selected areas was in accordance with contract requirements.

Audit results indicated that LogistiCare's transportation encounter data was accurate and supported by information in its transportation management system, and the data used to form audit conclusions was reliable. There were exceptions related to Demand Response driver logs, Individual Transportation Provider (ITP) mileage reimbursement forms, and LogistiCare's management of complaints, accidents and incidents. In addition, LogistiCare did not comply with all contract requirements for managing complaints, accidents and incidents.

Auditors offered recommendations to LogistiCare which, if implemented, will correct deficiencies in compliance with contract requirements. For instances of noncompliance identified in the audit, MCS will consider tailored contractual remedies to compel LogistiCare to meet contractual requirements related to transportation claims, complaints, and accidents and incidents.

STAR+PLUS Service Coordination: HealthSpring Life and Health Insurance Co., Inc. The OIG completed an audit of service coordination for selected STAR+PLUS members at HealthSpring Life and Health Insurance Co., Inc., doing business as Cigna-HealthSpring (Cigna), a Medicaid and CHIP MCO. The audit objective was to evaluate whether Cigna complied with contractual requirements for performing service coordination in support of STAR+PLUS Level 1 members.

Audit results indicated that for 43 of 113 sampled members, Cigna did not provide one or more of the required service coordination activities, which include conducting face-to-face visits, following up on member receipt of approved services, and performing an assessment of members entering nursing facilities.

Auditors offered recommendations to MCS which, if implemented, will result in Cigna meeting contractual requirements for service coordination. In its management responses, MCS indicated it will require Cigna to submit a corrective action plan to correct the issues noted, and its Results Management unit will review MCO compliance with the contractual issues identified in this audit during its biennial onsite operational reviews.

Medicine Man Pharmacy: A Texas Vendor Drug Program Provider. The OIG completed an audit of Medicine Man Pharmacy (Medicine Man), a Texas Vendor Drug Program (VDP) Provider. The audit objectives were to determine whether Medicine Man properly billed the VDP for Medicaid claims submitted, and whether Medicine Man complied with contractual and Texas Administrative Code (TAC) requirements.

As permitted by TAC rule 371.35(a), auditors used sampling and extrapolation as part of the audit. Audit results indicated there were exceptions related to claims validity, NDC usage, and quantity. Medicine Man did not bill the VDP properly or comply with other contractual or TAC requirements for 32 of the 187 claims tested. The 18 exceptions resulted in overpayments of $3,953 subject to extrapolation and recoupment. The total amount due to the State of Texas is $88,120. Based on the results of the IT general controls testing, data was sufficiently reliable for the purposes of this audit.

Auditors offered recommendations to Medicine Man which, if implemented, will correct deficiencies in compliance with contractual and TAC requirements. The OIG issued a notice letter to Medicine Man to refund the overpayment of $88,120 to the State of Texas.

Managed Care of North America Insurance Company – A Texas Medicaid and CHIP Dental Maintenance Organization. The OIG completed an audit of MCNA Insurance Company (MCNA), a Texas Medicaid and CHIP Dental Maintenance Organization. The audit objective was to evaluate the effectiveness of MCNA's performance in complying with selected contract requirements, achieving related contract outcomes, and reporting financial and performance results to HHSC.

Audit results indicated that MCNA's 2017 Administrative Expenses financial statistical report (FSR) included unsupported, overstated, or unallowable expenses. In addition, MCNA did not request prior written approval from HHSC for the July 2012 administrative services fee increase and affiliate reporting exception, as required by the Uniform Managed Care Manual. MCNA adjudicated paid dental claims selected for review in accordance with requirements, and reasonably processed and resolved selected provider complaints.

Auditors offered recommendations to MCS which, if implemented, will address unallowable, unsupported, or overstated expenses reported on MCNA's Administrative Expenses FSR for 2017, and strengthen oversight and compliance related to MCNA affiliate subcontracts.

Selected Services to STAR Kids Members in the Medically Dependent Children Program – Cook Children's Health Plan. The OIG completed an audit of selected services delivered by Cook Children's Health Plan (Cook Children's) to STAR Kids members in the Medically Dependent Children Program (MDCP) who received private duty nursing. These members are medically fragile children and young adults with significant and complex medical needs, and the OIG identified STAR Kids members in MDCP as a high risk group.

Audit results indicated that, when viewed in aggregate as part of the cycle that includes conducting assessments, developing service plans, carrying out service management, determining medical necessity, performing prior authorizations, and facilitating the delivery of services, Cook Children's did not always effectively administer the provision of STAR Kids and MDCP covered services.

Auditors offered recommendations to Cook Children's which, if implemented, will improve service management and program administration by reducing the number of STAR Kids - Screening and Assessment Instruments (SK-SAIs) that are incomplete or inaccurate; aligning the Individual Service Plan Narrative and the Individual Service Plan Tracking Tool with each other, to the SK-SAI, and with the medical status of the member in order to provide a comprehensive health picture of the member and to better identify necessary medical services; increasing consistent service coordinator contacts with members that help identify health concerns sooner and allow for timely service changes; reducing late authorizations and interruptions in service; and increasing the number of members receiving all necessary and planned services.

Selected Services to STAR Health Members in the Medically Dependent Children Program – Superior Health Plan. The OIG completed an audit of selected services delivered by Superior Health Plan (Superior) to STAR Health members in MDCP who received private duty nursing. These members are medically fragile children and young adults with significant and complex medical needs, and the OIG identified STAR Health members in MDCP as a high risk group.

The OIG reviewed selected data, systems, processes and controls at Superior related to service coordination elements. Audit results indicated that, when viewed in aggregate as part of the cycle that includes conducting assessments, developing service plans, carrying out service management, determining medical necessity, performing prior authorizations and facilitating the delivery of services, Superior did not always effectively administer the provision of STAR Health and MDCP covered services.

Auditors offered recommendations to Superior which, if implemented, will improve service management and program administration by reducing the number of Screening and Assessment Instruments (SAIs) that are incomplete or inaccurate; aligning the Healthcare Service Plan and Individual Service Plan Tracking Tool with each other, to the medical records, and to the SAI in order to provide a comprehensive health picture of the member and to better identify necessary medical services; increasing consistent service manager contacts with members that help identify health concerns sooner and allow for timely service changes; reducing late authorizations and interruptions in service; and increasing the number of members receiving all necessary and planned services.

Management of the STAR Kids and STAR Health Programs through Monitoring Contract Activities. The OIG completed an audit of MCS's management of the STAR Kids and STAR Health programs through its monitoring of contract activities. The audit objective was to determine whether MCS, through monitoring selected contract deliverables, effectively managed the STAR Kids and STAR Health programs for the Medically Dependent Children Program (MDCP).

Audit results indicate MCS did not develop consistent policies and procedures for the receipt, review, and use of the tested contract deliverables. Also, by not verifying completeness or accuracy of required deliverables, providing consistent guidance on report deliverable requirements, and using the information submitted for contract enforcement or program improvement, MCS did not effectively use the contract deliverables related to service coordination, service planning, and utilization of services for the STAR Kids and STAR Health programs.

Auditors offered recommendations to MCS which, if implemented, will improve contract monitoring and program management by providing consistent contract monitoring guidance for all units; providing technical

guidance to improve contract deliverables submitted by MCOs; obtaining consistent, critical information to measure performance and identify opportunities for program improvement; ensuring MCOs are aware of required contract deliverables; and using deliverable report data to analyze trends, identify outliers, establish performance standards and enforce contract compliance.

Inspections

Data Integrity of Online Provider Directories: Inspection on Accuracy of Provider Information. The OIG conducted this inspection to determine the accuracy of data contained in the managed care organizations' online provider directories. The OIG found that the three MCOs have policies and procedures for updating online provider directories. However, there are inconsistencies in the regulations governing MCOs and Medicaid providers, and there is no monitoring function to ensure reconciliation of provider contact information occurs.

The OIG recommended MCS establish consistent requirements for MCOs and Medicaid providers on the number of days required to update provider contact information with HHS or HHS's designee, and MCS should initiate activities to monitor and ensure provider information is accurate and complete. MCS agreed with the recommendations and has implemented a workgroup to review the monitoring of MCOs in respect to reviewing and updating network directories.

Eligibility Determinations for Out-of-State Clients: Inspection of Eligibility Actions Performed for Out-of-State Clients by Access and Eligibility Services. The OIG conducted this inspection to determine whether Texas Medicaid ensures that only eligible out-of-state Texas residents receive benefits. The inspection focused on determining if actions performed by HHS Access and Eligibility Services (AES) ensure proper eligibility determinations are made for clients. The inspection found the actions performed by AES ensure proper eligibility determinations are made for clients. However, a vulnerability exists in the information the Texas Integrated Eligibility Redesign System (TIERS) receives from the Social Security Administration (SSA).

During the inspection, HHS Social Services Applications identified a transaction code issue with records received from SSA. A data query identified 361 clients in TIERS with an out-of-state address and a transaction code issue. The OIG recommended HHS Social Services Applications, with assistance from AES, should work with SSA to resolve the transaction code issue to ensure TIERS receives accurate information; after the transaction code issue is resolved with SSA, AES should research the 361 clients and correct the eligibility for those found with errors. HHS Social Services Applications and AES agreed with the recommendations.

Member Complaints Received by Texas Medicaid Managed Care Organizations - Series II: Inspection of Resolution of Member Complaints. The OIG conducted this inspection to determine if the complaint intake and resolution processes of MCOs are consistent with the Uniform Managed Care Manual (UMCM) and Uniform Managed Care Contract (UMCC) requirements. The inspection focused on determining the effectiveness of the MCOs complaint resolution process.

The OIG found the complaint resolution processes of MCOs are generally consistent with UMCC and UMCM requirements. However, UMCC complaint resolution criteria is limited to MCOs providing members a resolution letter, but not requiring any specific action to resolve complaints. Also, based on inspection testing, MCOs did not always complete the UMCC complaint report form with accurate complaint information.

The OIG made the following observations:

- The UMCC MCO Internal Member Compliant Process contract provisions contain limited investigation documentation and resolution reporting requirements.
- The MCOs did not always accurately complete information in the complaint report form.

This inspection is the second in a series of three. Series I focused on how complaints and inquiries are discerned, logged, and reported to HHSC, and Series III focuses on reviewing MCO complaint appeal processes.

Stakeholder outreach

Engaging with Texas Pharmacy Business Council

At the request of the Texas Pharmacy Business Council, the Government Relations team hosted in August a briefing on the OIG audit process specific to pharmacies. The Audit division presented an overview of the audit process and how pharmacies are selected for an audit. Pharmacies enrolled in the Texas Vendor Drug Program (VDP) are subject to audit, and the VDP requests OIG perform pharmacy audits continuously. By the end of fiscal year 2019, the OIG completed five audits of VDP providers

and had an additional two pharmacy audits in progress. The Data and Technology Division (DAT) presented on the office's sampling and extrapolation process, using a hypothetical scenario involving a pharmacy audit.

Educating dental providers about data analytics

Jonathan O'Reilly, Director of Fraud Analytics in DAT, delivered a presentation of a data review to two dental associations in June. It focused on Medicaid dental billing that may demonstrate illegal patient solicitation activity. The presentation offered a deep dive into what the problem is and what data analysis revealed about the scope of the problem across the state. The OIG conducted a statewide examination of Medicaid dental claims between September 1, 2017 and August 31, 2018. Nearly 5,400 non-specialist billing providers were included, along with 2.3 million patients who had received a general dental service. The OIG used these data findings to prioritize provider investigations. The presentation help foster discussions among the OIG, DMOs, Medicaid/CHIP, and dental associations on how to collectively address the issue that illegal dental solicitation poses to the integrity of the Medicaid program.

Texas Fraud Prevention Partnership meeting

Texas Fraud Prevention Partnership (TFPP) meetings encourage all Texas Medicaid MCOs and DMOs to collaborate with OIG, HHS and the Attorney General's Medicaid Fraud Control Unit to strengthen the Medicaid program in Texas. In August 2019, OIG held a TFPP MCO leadership meeting with MCO CEOs. These meetings offer the opportunity to discuss current initiatives, as well as to focus on FWA prevention in Texas Medicaid. The agenda for this meeting included discussion of OIG priorities, including pre-payment review; cost avoidance and waste prevention; and FWA trends as well as updates on ongoing and upcoming OIG audits, inspections and reviews.

Collaboration with MCO Special Investigative Unit

The OIG held an MCO Special Investigative Unit meeting in July. The OIG shared information on recent FDOs and provided a legislative session update. Representatives from the affordable housing and homeless outreach organization Community First presented on their investigation on critical care visits in the emergency room. The Attorney General's Medicaid Fraud Control Unit discussed their collaboration with OIG and the MCOs and provided information on the types of investigations they conduct.

OIG engages durable medical equipment stakeholders

Members of the Audit Division met with a DME group in July. The stakeholder group requested background information on how the OIG selects its audits, as well as a general overview of the policies and criteria applicable to DME audits. The group was given an overview of the OIG's audit process, its risk-based selection of audit criteria using hierarchy of authorities and HHS program area policy experts, and examples of policies and rules used as criteria in prior OIG audits of DME providers.

Conferences and presentations

- IG Kauffman gave a presentation in August to anesthesiology residents and faculty at UT Health McGovern Medical School at Houston. The purpose of the presentation was to inform current and future providers about how the OIG ensures the integrity of the state's health and human services and how they can prevent fraud, waste and abuse.
- Several members of the OIG presented at this year's National Association for Medicaid Program Integrity (NAMPI) conference in August in Atlanta, Georgia. IG Kauffman, Chief of Strategy and Audit Olga Rodriguez, and Director of Fraud Analytics Jonathan O'Reilly presented on the OIG's use of fraud analytics to identify patterns of possible solicitation of Medicaid recipients by dentists. MPI Interim Chief Steve Johnson and MPI Interim Assistant Deputy Inspector General Anne Dvorak gave an overview of MPI's structure and work to combat fraud, waste and abuse. OIG Audit Director Steve Sizemore delivered a presentation about the OIG's audits of therapy clustering at long-term care nursing facilities, as well as the statewide financial impact of the therapy practices on nursing facility payments.
- OIG Senior Dental Analyst Sherry Jenkins gave a presentation in August on dental ethics to UT Health San Antonio dental hygiene students. The purpose of the presentation was to inform future hygienists about the prevention of fraud, waste and abuse and the importance of good record keeping practices.
- OIG staff presented in August at the Southwest Region Supplemental Nutrition Assistance Program (SNAP) Directors Meeting in San Antonio. Chief of Staff Susan Biles presented on how the OIG

utilizes communication tools to engage stakeholders. Electronic Benefit Transfer (EBT) Trafficking Unit Manager Adrian Abrams gave an overview of the types of investigations conducted by the unit and their successful outcomes.

Trainings

OIG staff participated in senior management training

OIG staff members completed the Governor's Center for Management Development, Senior Management Program held in June and July. This program is designed for managers who hold positions in the upper levels of agency organizations and have major program, project, and/or people-management responsibilities. A total of 13 staff members attended the training in San Antonio. They built skills and strategies in communication, teamwork, integrity, organizational culture and change management.

Inspections staff attend training

Inspections staff attended a variety of trainings in August. This included the Medicaid Integrity Institute (MII) Program Integrity Fundamentals Seminar in Columbia, South Carolina, which focused on program integrity functions within state Medicaid units. The course explored emerging health care fraud schemes and evidence-gathering techniques. The National Association for Medicaid Program Integrity (NAMPI) conference gave another Inspections staff member an opportunity to absorb the knowledge and resources of other states' approaches to detecting and preventing fraud, waste and abuse in Medicaid delivery. Four members from the Inspections and Investigations Division attended the United Council on Welfare Fraud Annual Training Conference in Chattanooga, Tennessee. The conference includes training workshops focused exclusively on public assistance fraud issues ranging from front-line fraud investigations to effective program administration and fraud recovery and collection techniques.

Program Integrity Spotlight

Data Drives Fight Against Medicaid Fraud in Dental Services

The OIG has taken an increasingly data-driven approach to fighting fraud, waste and abuse in Medicaid delivery. Experienced staff at the OIG have developed algorithms and data analysis processes to pinpoint areas where fraud may be occurring. After focusing attention on a particular provider or geographic region, the OIG then can deploy investigators and experts to corroborate findings from the data. The OIG used a data-driven approach in a recent OIG Fraud Detection Operation and an analysis of statewide Medicaid dental claims to find providers who were at high risk of illegally soliciting clients.

Fraud detection operation: Dental providers

One approach to fighting fraud is through a fraud detection operation (FDO). An FDO is a data-driven investigation that reviews providers who appear as statistical outliers among their peers and assesses whether this outlier status is due to program violations, fraud, waste or abuse. The advanced analysis of issues in an FDO may or may not lead to a full-scale investigation; identification of outlier status is not an automatic indicator of wrongdoing. The FDO simply flags providers who may warrant a closer look.

The OIG's Medicaid Program Integrity (MPI) division is currently analyzing results from a July FDO. After providers were flagged through data analysis, the OIG's chief dental officer and dental team conducted onsite clinical examinations of patients from four Dallas-Fort Worth area providers. The OIG team set up a mobile clinic to conduct the examinations, which were intended to verify that what was billed to Medicaid was indeed done. The team also checked the quality of procedures to ensure that the clients received the best care. Investigators also interviewed parents and dental staff to gain further insight.

Initial clinical exams identified providers who received reimbursement for restorations when either sealants or no restorations were performed. Preliminary findings also indicated two of the four dental providers were engaging in illegal dental solicitation. Dental providers are prohibited from offering cash, gifts or other items to people who have Medicaid in order to influence their health care decisions. These cases will move to full-scale investigations.

This scatterplot chart shows dental providers who are considered low risk (green), medium risk (yellow) and high risk (red).

Illegal dental solicitation

Data analytics played a significant role in the OIG's exploration of illegal dental solicitation. Medicaid providers are prohibited from offering clients inducements to influence their health care decisions. The OIG conducted a statewide examination of Medicaid dental claims between September 1, 2017 and August 31, 2018. Nearly 5,400 non-specialist billing providers were included, along with 2.3 million patients who received a general dental service.

Switching providers is often a natural occurrence in the course of care, but it also highlights conditions where solicitation can exist. OIG analysis revealed that client movement from one provider to another involves a minority of patients but a majority of providers. Eleven percent (257,790) of the patients in the data review received their services from two or more providers. Although a relatively small portion of the client population, that 11 percent was billed by 86 percent (4,662) of the non-specialist billing provider population.

Because client movement itself does not equate to solicitation, several data points were used to flag suspicious characteristics of provider activity that, in high volumes, can suggest patterns associated with solicitation. Red flags in the data include an unusually large number of new clients in a short period of time, clients receiving services on the same tooth from multiple providers or excessive services performed following a switch in providers.

The data analysis integrated such factors and ranked the providers as low, medium or high risk of illegally soliciting patients. One percent of the providers analyzed were considered high risk. Eighteen percent fell in the medium risk range, and the majority — 81 percent — were considered low risk. The providers flagged by the data as high risk may be subject to closer scrutiny from the OIG via an audit, inspection or investigation.

The OIG presented this data to dental maintenance organizations, dental associations and other stakeholders in June to inform them about the scope of the problem across the state. The presentation helped foster productive conversations among the stakeholders on how the issue of illegal dental solicitation affects the integrity of state health and human service programs.

Going forward

Traditionally encounter or claims data has formed the cornerstone of potential fraud, waste and abuse investigations. Going forward, the OIG is adopting a more sophisticated approach to analysis that, at times, combines new technology and traditional clinical examinations.

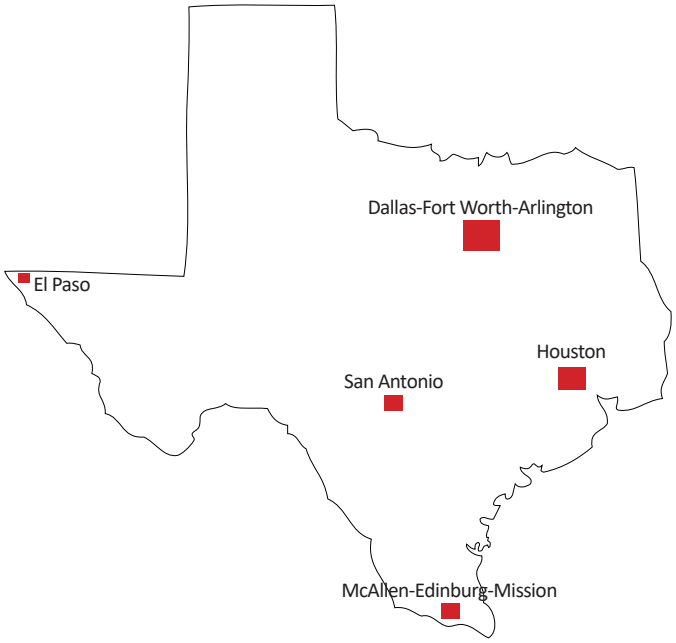
The OIG utilizes data analysis to not only launch audits, inspections and investigations of specific providers, it is also a method to proactively educate providers about how to prevent fraud, waste and abuse from happening in the first place. Increasing the breadth and depth of analysis to inform decisions leads to greater protection of patients and the entire integrity of Medicaid service delivery.

What does the data indicate?

One percent of provider population had a higher risk score.

- 85% are large group providers.
- 15% are individual providers.
- 60% are located in the Dallas-Fort Worth area.
- 15% are located in the Houston area.

Location of high-risk dental providers by Metropolitan Statistical Area



Division performance

Inspections and Investigations

Inspections conducts inspections of HHS programs, systems and functions. Inspections also oversees the state's Women, Infants and Children (WIC) Vendor Monitoring Unit. This unit conducts in-store evaluations, compliance buys, and invoice audits to monitor vendors participating in the WIC program.

Investigations includes commissioned peace officers and non-commissioned personnel. It has three units:

- State Centers Investigations Team conducts criminal investigations of allegations of abuse, neglect and exploitation at state supported living centers and state hospitals.
- Cooperative Disability Investigations investigates statements and activities that raise suspicion of disability fraud.
- Electronic Benefit Transfer Trafficking conducts criminal investigations related to trafficking of Supplemental Nutrition Assistance Program (SNAP) benefits.

Benefits Program Integrity 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.

EBT Trafficking Unit performance

Overpayments recovered	$64,222
Cases opened	22
Cases completed	52

State Centers Team performance

Overpayments recovered	$0
Cases opened	205
Cases completed	181

Peace Officers performance

Cost avoidance	$0

Inspections reports issued

- Member Complaints Received by Texas Medicaid Managed Care Organizations - Series II
- Data Integrity of Online Provider Directories: Inspection on Accuracy of Provider Information
- Eligibility Determinations for Out-of-State Clients: Inspection of Eligibility Actions Performed for Out-of-State Clients by Access and Eligibility Services

Inspections in progress

- Member Complaints Received by Texas Medicaid Managed Care Organizations - Series III
- Unclaimed Funds: Inspection of the Process to Recover HHSC Funds from the Texas Comptroller's Unclaimed Property Program
- OIG Review of Value-Based Payments
- Value-Based Payments Series II: Molina Quality Living Program
- Child and Adolescent Needs and Strengths Assessment in Community Based Care
- HHSC Quality Management of Local Mental Health Authorities
- Overlapping Long Term and Support Claims During Hospital Stays
- Mental Health Targeted Case Management and Rehabilitative Services in Managed Care

Inspections performance

Overpayments recovered	$3,012
Overpayments identified	$4,657,964

Benefits Program Integrity performance

Overpayments recovered	$4,492,974
Cases completed	4,099
Cases opened	3,413
Cases referred for prosecution	66
Cases referred for Administrative Disqualification Hearings	231

Strategy and Audit

The Strategy and Audit Division includes the Data and Technology (DAT), Audit and Policy units.

- DAT implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of fraud, waste and abuse. DAT assesses trends and patterns regarding behavior of providers, clients and retailers participating in Texas Health and Human Services (HHS) programs. DAT consists of four units 1) Fraud Analytics, 2) Data Research & Analysis, 3) Statistical Analysis, and 4) Data Operations.
- Audit conducts risk-based audits related to the accuracy of medical provider payments; the performance of HHS agency contractors; and programs, functions, processes and systems within the HHS system. Protocols of provider audits are periodically published on the Resources page on the OIG's website. Audit also coordinates all federal government audits of the HHS System.
- The Policy Advancement Unit serves as the health care policy subject matter expert and liaison across the OIG. The unit conducts analysis of program policies and coordinates and ensures timely and effective communication with a variety of stakeholders.

Audits in progress

- STAR+PLUS enrollment
- Durable Medical Equipment claims
- Pharmacy providers
- Managed care pharmacy benefit managers' compliance
- IT security and business continuity and disaster recovery planning assessments
- Dental maintenance organization performance
- MCO STAR+PLUS waiver program
- MCO special investigative units (SIU)
- MCO clean claims for nursing facility providers
- Selected DFPS contract areas
- Selected Local Intellectual and Developmental Disability Authority (LIDDA) contractors

Audit performance

Overpayments recovered	$504,967
Overpayments identified	$773,587
Audit reports issued	18

Audit reports issued

- Audit of United Way of Metropolitan Dallas
- Financial Impact of Clustering Therapy Services During MDS Look-Back Periods for Texas Medicaid Residents of Long-Term Care Nursing Facilities
- American Medical Response, Inc. - A Texas Medicaid Medical Transportation Organization
- STAR+PLUS Service Coordination: UnitedHealthcare Community Plan
- Best Med, Inc.: A Texas Vendor Drug Program Provider
- STAR+PLUS Service Coordination: Amerigroup Texas, Inc. and Amerigroup Texas Insurance Company Plan
- Child Specific Contracts – Texas Department of Family and Protective Services
- Medical Transportation Management, Inc. - A Texas Medicaid Medical Transportation Organization
- Texas Medicaid and CHIP Pharmacy Benefit Services Delivered by Molina and Its PBM, Caremark
- Project Amistad - A Texas Medicaid Medical Transportation Organization
- Security Controls over Confidential HHS System Information and Business Continuity and Disaster Recovery Plans: Texas Children's Medical Center
- STAR+PLUS Service Coordination – HealthSpring Life and Health Insurance Co., Inc.
- LogistiCare Solutions – A Texas Medicaid Medical Transportation Organization
- Medicine Man Pharmacy – A Texas Vendor Drug Program Provider
- Managed Care of North America Insurance Company – A Texas Medicaid and CHIP Dental Maintenence Organization
- Selected Services to STAR Kids Members in the Medically Dependent Children's Program – Cook Children's Health Plan
- Selected Services to STAR Health Members in the Medically Dependent Children's Program – Superior Health Plan
- Management of the STAR Kids and STAR Health Programs through Monitoring Contract Activities

Data and Technology performance

Data requests received	256
Data requests completed	225
Algorithms executed	27
New algorithms developed	0

Medicaid Program Integrity

Medicaid Program Integrity Division includes four units:

- The Provider Investigations unit investigates and reviews allegations of fraud, waste and abuse committed 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. Some referrals come through the OIG Fraud Hotline or complaints from the OIG's online Waste, Abuse and Fraud Electronic Referral System. Referrals are also received from managed care organizations throughout the state. When criminal Medicaid fraud is detected, MPI refers the matter to the Attorney General's Medicaid Fraud Control Unit. The two work together on joint investigations by sharing resources and information that will lead to successful administrative disposition or criminal prosecution.
- The Medical Services unit conducts claims and medical record reviews on a variety of health and human services, including acute care utilization, hospital utilization, nursing facility utilization, research and detection, and pharmacy lock-in. Medical Services also provides clinical consultation to the Benefits Program Integrity and Audit units, and the Inspections and Investigations Division on dental, medical, nursing and pharmacy services.
- The Program Integrity Development and Support (PIDS) unit provides support and process improvements to other MPI units. Responsibilities include developing projects to improve MPI investigative outcomes, reporting MPI statistics, acting as the Managed Care Organization Special Investigative Unit liaison, planning and conducting Investigative Initiatives and Fraud Detection Operations, and acting as the lead on open records requests.
- The Provider Enrollment Integrity Screenings (PEIS) unit is responsible for conducting certain federal- and state-required screening activities for providers seeking to enroll in Medicaid, CHIP and other state health care programs. The screenings and reviews conducted by PEIS promote compliance with federal provider enrollment program integrity requirements; increase accountability for the appropriate use of taxpayer resources by helping to prevent fraud, waste and abuse; and protect the health and safety of Texans.

Medicaid Program Integrity performance

Preliminary investigations opened	557
Preliminary investigations completed	507
Full-scale investigations completed	67
Cases transferred to full-scale investigation	49
Cases referred to AG's Medicaid Fraud Control Unit	94
Open/active full-scale cases at end of quarter	143

Medical Services performance

Acute Care provider recoveries	$3,029,430
ACS identified MCO overpayments	$3,046,572
Hospital and nursing home UR recoveries	$5,508,819
Hospital UR claims reviewed	3,388
Nursing facility reviews conducted	71

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	8,411
Individual screenings processed	23,390

External Relations

The External Relations Division focuses on engaging and ensuring a timely response to OIG critical stakeholders:

- Communications manages press relations, maintains the OIG website and social media platforms, publishes the agency's external facing reports and work products, and facilitates communication between the Inspector General and various stakeholders.
- Government Relations serves as the primary point of contact for the executive and legislative branches of government and state policy makers. Government Relations also analyzes legislation to understand the impact to OIG operations.
- Strategic Initiatives leads OIG-wide initiatives and special projects.

Operations

The Operations Division is comprised of five core functions:

- Operations Support includes OIG purchasing, contract management and the OIG Fraud Hotline. The Fraud Hotline receives allegations of fraud, waste and abuse and refers them for further investigation or action as appropriate.
- Finance and Budget oversees the OIG budget, tracks recoveries, reports Legislative Budget Board performance measures and works closely with HHSC Central Budget on the agency's LAR/Exceptional Items.
- Strategic Operations and Professional Development promotes OIG training services and internal policy development.

Operations performance

Fraud hotline calls answered	7,279

Third Party Recoveries performance

Dollars recovered	$69,467,939
Cost avoidance	$28,429,023

- Third Party Recoveries (TPR) works to ensure that Medicaid is the payor of last resort, oversees the Recovery Audit Contract and operates the Medicaid Estate Recovery Program.
- The Ombudsman provides an independent and neutral process for OIG employees to address concerns and work towards resolution.

Chief Counsel

The Office of Chief Counsel Division provides legal counsel and is comprised of the following:

- General Law provides legal support for audits, investigations, inspections and reviews. Furthermore, General Law supports OIG operations, including researching termination/exclusion issues, reviewing federal share obligations, analyzing extrapolation processes, contracting and assisting with rule and statute changes affecting the agency.
- Litigation handles the appeal of investigations and audits that determined providers received Medicaid funds to which they were not entitled.
- Internal Affairs investigates employee misconduct in the provision of health and human services, including contract fraud within the HHS system.

Internal Affairs performance

Investigations completed	62
Cases with sustained allegations	13

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