

OFFICE OF INSPECTOR GENERAL

TEXAS HEALTH AND HUMAN SERVICES COMMISSION

AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

Health Management Systems, Inc.:
Third Party SIU Contractor



August 29, 2016
IG Report No. IG-16-015



HHSC IG

TEXAS HEALTH AND HUMAN
SERVICES COMMISSION

INSPECTOR GENERAL

WHY THE IG CONDUCTED THIS AUDIT

HMS is a public company providing a variety of special investigative unit (SIU) services to Texas managed care organizations (MCO). MCOs are required to establish an SIU to investigate fraud, waste, and abuse.

Approximately 84 percent of Medicaid and CHIP enrollees are members of an MCO. At nearly \$27 billion a year, the Medicaid and CHIP programs constitute over 27 percent of the total Texas budget.

This audit reviewed SIU services provided by HMS to six Texas MCOs delivering Medicaid and CHIP health care services in Texas. Effective SIUs are essential to support MCO cost containment efforts and ensure state and federal funds spent on managed care are used appropriately.

The Texas Health and Human Services Commission is responsible for oversight of MCO contracts. The IG is responsible for approving SIU annual plans, and evaluating and sometimes investigating SIU referrals.

This is one of a series of performance audits to determine how effective selected MCO SIUs are at (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries.

WHAT THE IG RECOMMENDS

HHSC should implement corrective actions to strengthen MCO SIU fraud, waste, and abuse detection, investigation, and reporting activities.

View [IG-16-015](#)

For more information, contact:
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AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS

*Health Management Systems, Inc.
Third Party SIU Contractor*

WHAT THE IG FOUND

SIU services provided by HMS are designed to meet Texas regulatory requirements. While the six MCOs contracted with HMS maintained annual fraud, waste, and abuse plans, HMS SIU services were not fully utilized by all MCOs to implement their plans. Four of the six MCOs need to improve their SIU functions in order to comply with their plans, and to detect and investigate fraud, waste, and abuse effectively.

The six MCOs contracted with HMS received approximately \$2.4 billion in Medicaid and CHIP capitation and delivery supplemental payments in 2014, and \$3.3 billion in 2015. They paid approximately \$4.9 billion in medical claims dollars over those two years. During this two-year period, three MCOs reported no recoveries utilizing HMS services, while three MCOs collectively recovered just \$286,152, or approximately 0.006 percent of the total \$4.9 billion medical claims dollars paid by the six MCOs.

Year	Capitation Payments	Medical Claims \$	Recoveries
2014	\$ 2,448,088,034	\$ 2,062,359,405	\$ 185,233
2015	\$ 3,293,358,564	\$ 2,855,946,009	\$ 100,919
Total	\$ 5,741,446,598	\$ 4,918,305,414	\$ 286,152

Data analytics were a significant source of identified overpayments. HMS provides data analytics services through its Fraud, Waste, and Abuse Portal, which was largely underutilized by MCOs, and two MCOs never utilized this resource.

Overpayments identified by SIUs were sometimes overstated and not always recovered. Overstated recoveries resulted from MCO reporting that included non-SIU related claims department recoupments. Additionally, one MCO did not recover any of its \$1.1 million in overpayments identified using HMS services. Recovery of overpayments is necessary to deter fraud, waste, and abuse, and needed to allow for adjustment of capitation rates to reflect accurate medical expenses.

Two MCOs contracted with HMS were in compliance with Texas SIU regulations. Until the remaining four MCOs improve their SIU detection, investigation, and reporting activities, HHSC does not have assurance that these MCOs are maintaining effective SIUs that successfully recover losses due to fraud, waste, and abuse.

The HHSC Medicaid/CHIP Division concurred with the IG Audit Division recommendations outlined in this report, and will facilitate MCO development of corrective action plans designed to improve SIU functions.

The IG Audit Division will continue to publish reports during its ongoing audit of Medicaid and CHIP SIUs as it completes audit testing and validation for selected MCOs.

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INTRODUCTION

The Texas Health and Human Services Commission (HHSC) Inspector General (IG) Audit Division is conducting an audit of Medicaid and Children’s Health Insurance Program (CHIP) special investigative units (SIUs). The objective of the audit is to evaluate effectiveness of managed care organization (MCO) SIU performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC. The audit includes state fiscal years 2014 and 2015, which covers the period from September 2013 through August 2015, and includes a review of relevant SIU activities through the end of fieldwork in June 2016.

This audit report is one of a series of reports on MCO SIUs. The first report was an informational report that provided background, context, and a compilation of information provided by the 22 Texas Medicaid and CHIP MCOs.¹ This audit report is focused on SIU activities at Health Management Systems, Inc. (HMS).

Background

By contract and state law, MCOs are required to establish and maintain SIUs to investigate potential fraud, waste, and abuse by members² and health care service providers.³ An MCO may contract with an outside organization to perform all or part of the activities associated with the SIU. Based out of Irving, Texas, HMS is a public company providing a variety of SIU services to Texas MCOs, including analysis of claims information for detection, investigation, and resolution of potential cases⁴ of fraud, waste, and abuse.

¹ An MCO is an organization that delivers and manages health care services under a risk-based arrangement. The MCO receives a monthly premium or capitation payment for each managed care member enrolled, based on a projection of what health care for the typical individual would cost. If members’ health care costs more, the MCO may suffer losses. If members’ health care costs less, the MCO may profit. This gives the MCO an incentive to control costs. In this report, health plans, dental maintenance organizations, and behavioral health organizations are collectively referred to as MCOs.

² MCOs refer to enrollees as “members.” An “enrollee” is an individual who is eligible for Medicaid or CHIP services and is enrolled in an MCO either as a subscriber or a dependent.

³ Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015); Texas Government Code, Title 4, Subtitle 1, § 531.113 (September 1, 2003). See also Texas Administrative Code Title 1, Part 15, § 353.502 and § 370.502 (March 1, 2012).

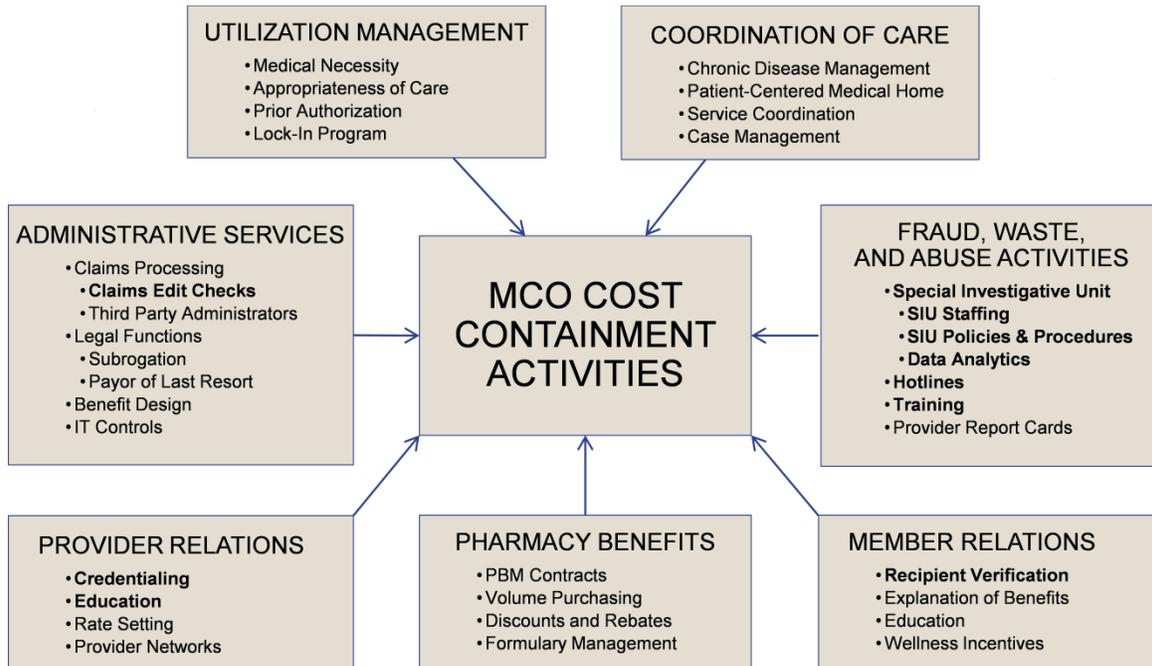
⁴ SIU investigations are also referred to as “cases”.

The following six Texas MCOs indicated that they maintained a contract with HMS for SIU services during the audit period:

- Sendero Health Plans, Inc.
- Scott and White Health Plan
- UnitedHealthcare Community Plan of Texas, L.L.C.
- Community Health Choice
- Cook Children's Health Plan
- El Paso First Health Plans, Inc.

Christus Health Plan also had a contract with HMS during the audit period. Christus Health Plan is excluded from this report because it did not meet a contract provision requiring a minimum of 20,000 members prior to implementation of the contract. HMS did not perform SIU services on behalf of Christus Health Plan during the audit period.

SIUs support MCO cost containment efforts through prevention and detection of fraud, waste, and abuse. MCOs maintain many functions and activities outside of SIUs to control costs, and SIUs may conduct activities related to other business areas of the MCO in addition to Medicaid and CHIP. As a result, the functional and organizational structure of cost containment activities varies across MCOs. Figure 1 below provides a partial overview of many types of activities MCOs employ to help reduce costs and impact fraud, waste, and abuse. This information is not meant to represent a complete set of activities, nor does it represent the structure of the business units at any specific MCO.

Figure 1. MCO Functions and Activities Related to Cost Containment

Source: IG Audit Division

Activities shown in bold in Figure 1 designate some areas of focus for this series of MCO SIU performance audits. This performance audit evaluated HMS SIU efforts related to:

- Detection activities, such as complex data analysis, identification of potential fraud and abuse warranting a preliminary investigation, and intake of fraud referrals from the MCO.
- Investigation efforts, such as conducting preliminary investigations, full-scale investigations, and SIU case management.

The IG Audit Division also evaluated the efforts of the six MCOs contracted with HMS regarding:

- Disposition of fraud, waste, and abuse investigations, including referrals to IG, corrective action plans, and monetary recovery.
- Reporting of SIU activities to IG including a monthly report of ongoing investigations and annual reporting of SIU recoveries.

Texas Health and Human Services (HHS) agencies administer public health programs for the State of Texas. Within HHS, HHSC Medicaid/CHIP Division oversees Medicaid and CHIP,

which are jointly funded state-federal programs providing medical coverage to eligible individuals. In 2013, approximately 4.3 million individuals enrolled in Medicaid or CHIP.⁵

HHSC Medicaid/CHIP Division is responsible for overall management and monitoring of the Uniform Managed Care Contract for the six MCOs evaluated in this audit. IG is responsible for approving each MCO's annual fraud, waste, and abuse plan,⁶ and evaluating and sometimes investigating any fraud referrals it receives from MCOs. Each MCO is required to refer suspected fraud, waste, and abuse to IG. When IG determines it will not pursue an SIU referral, the MCO is responsible for recovery of any Medicaid or CHIP overpayments associated with the referral.

Medicaid serves primarily low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid. In federal fiscal year 2013, Texas spent \$26.8 billion on Medicaid and CHIP. This represented 27 percent of the entire 2013 Texas state budget.⁷ Medicaid and CHIP programs deliver health care services (including medical, dental, prescription drug, disability, behavioral health, and long-term support services) to eligible individuals. CHIP provides services to individuals in Texas through a managed care model. Texas Medicaid provides services to some individuals through a traditional fee-for-service model,⁸ but most are enrolled through a managed care model.⁹ For providing these services, MCOs receive capitation payments, monthly prospective payments HHSC makes to MCOs for the provision of covered services. HHSC makes capitation payments to MCOs at fixed, per member, per month, rates based on members' associated risk groups.¹⁰ These payments include state and federal funds.

⁵ This is the 2013 average monthly number of enrollees in Medicaid and CHIP.

⁶ Texas Government Code, Subtitle I, Subchapter C, § 531.113 (September 1, 2003).

⁷ Texas Medicaid and CHIP expenditures in 2013 are "all funds" (which include state and federal dollars), but excludes Medicaid funding for Disproportionate Share Hospital, Upper Payment Limit, Uncompensated Care, and Delivery System Reform Incentive Payment funds. Medicaid and CHIP amounts are for the federal fiscal year, and the state budget reflects the state fiscal year which begins one month prior to the federal fiscal year.

⁸ Medicaid fee-for-service was the original service delivery model for Texas Medicaid introduced in 1967. In this model, enrolled Medicaid providers are reimbursed retrospectively for a Medicaid eligible health care service or services provided to a Medicaid eligible patient.

⁹ Medicaid managed care was first introduced in pilot programs in Texas in 1993. In this model, the state contracts with MCOs who contract with Medicaid providers for the delivery of health care services to Medicaid enrollees. MCOs must provide the same services under managed care as provided under the traditional fee-for-service model.

¹⁰ A "risk group" is a group of MCO members that have a similar health status and are expected to have a similar Medicaid or CHIP spending pattern. HHSC applies an acuity risk adjustment to capitation rates to recognize the anticipated cost differential among multiple health plans in a service area due to the variable health status of their respective memberships. Final capitation payments are based on this acuity risk-adjusted premium for each combination of service area and risk group.

In 2013, 100 percent of CHIP enrollees were in managed care. Collectively, approximately 84 percent of the combined Medicaid and CHIP populations (3.6 million individuals) were enrolled in managed care.

The IG Audit Division conducted this performance audit of SIU activities at HMS in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Unless otherwise described, any year referenced is the state fiscal year, which covers the period from September 1 through August 31.

The IG Audit Division presented audit results, issues, and recommendations to the HHSC Medicaid/CHIP Division, HMS, and to each MCO reviewed in a draft report dated August 16, 2016. Each was provided with the opportunity to study and comment on the report. HHSC Medicaid/CHIP Division management responses to the recommendations contained in the report are included in the report following each recommendation. MCO comments are included in Appendix C. HHSC Medicaid/CHIP Division concurred with the IG Audit Division recommendations, and will facilitate development of corrective action plans designed to improve MCO SIU functions.

ISSUES AND RECOMMENDATIONS

HMS is a subcontractor providing SIU functions to Texas MCOs. HMS offers a variety of services, including detection and investigation of potential fraud, waste, and abuse. The IG Audit Division reviewed six MCOs contracted with HMS, they include:

- Sendero Health Plans, Inc.
- Scott and White Health Plan
- UnitedHealthcare Community Plan of Texas, L.L.C.
- Community Health Choice
- Cook Children's Health Plan
- El Paso First Health Plans, Inc.

HMS offers various SIU services to MCO clients. An MCO selects from a range of possible services that may include the following:

- Detection services through the HMS Fraud, Waste, and Abuse Portal
- Preliminary investigation services that include recommended actions for the MCO¹¹
- Full-scale investigation services that include recommended actions for the MCO
- Monitoring of providers for aberrant billing patterns
- Preparation of MCO's deliverables for IG
- Recovery of identified overpayments

The HMS Fraud, Waste, and Abuse Portal is a data analytics tool maintained and administered by HMS. HMS provides data analytics for claims analysis to detect potential fraud, waste, and abuse. This includes algorithms, standardized queries, and other techniques that would identify and report suspected fraud and other abnormal claims to the SIU for further research. Specifically, the HMS Fraud, Waste, and Abuse portal enables MCOs to detect potential fraud, waste, and abuse through approximately 120 customizable reports and 30 behavioral scenarios.

MCOs contracted with HMS submit their respective claims data to HMS. The HMS claims data standardizes and runs edit checks so that HMS and MCO SIU personnel can analyze the data utilizing the HMS Fraud, Waste, and Abuse Portal.

¹¹ HMS recommendations may include closing cases due to unsubstantiated allegations, letters to providers notifying them of overpayments, provider education, full-scale investigation, ongoing monitoring, and referrals to IG or the Office of Attorney General's Medicaid Fraud Control Unit.

MCOs working with HMS tended to fall into three levels of service utilization:

- **Basic.** MCOs that utilized the most basic HMS SIU services had access to the HMS Fraud, Waste, and Abuse Portal. These MCOs had the ability to run queries on their own to detect fraud, waste, and abuse through the portal, but did not request that HMS run any queries on their data.
- **Intermediate.** MCOs that fell into this category collaborated more with HMS. Both the MCO and HMS would run queries in the HMS Fraud, Waste, and Abuse Portal to identify suspicious indicators. Based on query results, MCOs either conducted investigations on their own or requested that HMS conduct a preliminary investigation or full-scale investigation. HMS provided results of its investigations and recommendations for MCO action.
- **Extensive.** MCOs that fell into this category contracted to have HMS perform the majority of its SIU activities. HMS staff (a) ran queries on the HMS Fraud, Waste, and Abuse Portal to identify and investigate suspicious indicators, (b) conducted preliminary and full-scale investigations, and (c) summarized investigation results with recommendations for MCO action. The MCO reviewed HMS recommendations and decided how to proceed. These MCOs contracted with HMS for full-scale investigations, provider monitoring, and recovery efforts. HMS prepared MCO reports for submission to IG.

An MCO may outsource its entire SIU function to HMS. All contracts with HMS allow MCOs to request additional support from HMS in the form of custom reports, targeted queries, and investigations at any time for an additional fee. When HMS is responsible for selecting and investigating cases of suspected fraud, waste, and abuse, it targets completion of 10 to 12 preliminary investigations per month. HMS determines what to investigate by reviewing provider scorecards, running data analytic queries, and identifying outliers in claims for certain services.

HMS designed its processes to meet the requirements of the Texas Administrative Code related to SIU functions. The IG Audit Division assessed the sufficiency of HMS SIU services by (a) reviewing the policies and procedures which guide SIU activities, (b) interviewing responsible management that were knowledgeable about processes, and (c) verifying that procedures were followed.

In addition, the IG Audit Division reviewed relevant IT controls for HMS data analytics used in reporting suspected fraud, waste, and abuse; and assessed the reliability, accuracy, and completeness of HMS systems and data analytic tools used for the HMS SIU function. SIU functions provided by HMS, and assessed during this audit, met minimum requirements set forth by the Texas Administrative Code.¹²

¹² Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.501-505 (March 1, 2012).

MCO Oversight and Utilization of HMS SIU Services

The MCOs under contract with HMS during the audit period maintain fraud, waste, and abuse plans; the fundamental contractual and regulatory SIU requirement for MCOs. The plans describe how each MCO can strengthen program integrity by monitoring service providers, auditing claims, identifying and recovering overpayments, and educating members and providers.

During this audit, the IG Audit Division evaluated HMS SIU services, and the related SIU activities at each respective MCO, and identified issues related to:

- The level of SIU activity
- Utilization of the HMS Fraud, Waste, and Abuse Portal for data analytics
- Recovery of identified overpayments
- Reporting recoveries to IG

Under its contracts, HMS has accessed Medicaid claims data for six Texas MCOs, with combined Medicaid and CHIP medical claims dollars¹³ of \$2.1 billion in 2014, and \$2.9 billion in 2015. The combined average monthly membership was 654,257 Medicaid and CHIP members during 2014, and 754,635 Medicaid and CHIP members during 2015. Table 1 shows medical claims dollars by program.

Table 1: Combined Medical Claims Dollars by Program for HMS MCOs in 2014 and 2015

Program	2014	2015	Total
Medicaid	\$ 1,905,386,203	\$ 2,732,701,943	\$ 4,638,088,146
CHIP	\$ 156,973,202	\$ 123,244,066	\$ 280,217,268
Total	\$ 2,062,359,405	\$ 2,855,946,009	\$ 4,918,305,414

Source: HHSC Financial Statistical Report (FSR) 2014 Year-End 334-Day FSR and HHSC FSR 2015 Year-End 90-Day

¹³ “Medical claims dollars” are the total amounts submitted to MCOs by health care providers as payment requests for medical services performed. MCOs pay these medical claims as expenses for delivering covered health care services to members. Medical claims dollars include claims with a date of service that falls within the referenced year, and may or may not have been paid during the referenced year. Medical claims dollars for 2014 and 2015 include both medical and pharmacy amounts, but do not include MCO administrative costs. The informational report previously published for this audit did not include pharmacy amounts in medical claims dollars.

Section 1: SENDERO HEALTH PLANS, INC.

Sendero Health Plans, Inc. (Sendero) contracted with HMS for access to the Fraud, Waste, and Abuse Portal. Additional services such as investigations, monitoring, and targeted queries could be requested on a case by case basis. Sendero did not maintain any internal staff to fulfill SIU functions and to supplement the HMS contracted services during the audit period.

During the audit period, Sendero used the Fraud, Waste, and Abuse Portal on just three days in August 2015. Sendero did not request that HMS conduct any investigations, create any special reports, or run any targeted queries.

There Was No Active SIU During the Audit Period

Though Sendero is maintaining a fraud, waste, and abuse plan, it did not have an active SIU and did not identify any fraud, waste, or abuse in 2014 or 2015. By contract and state law, MCOs are required to establish and maintain SIUs to investigate potential fraud, waste, and abuse by members and health care service providers.¹⁴

Three investigations opened during the audit period originated from non-SIU sources.¹⁵ Consequently, during the two-year period under review, Sendero did not:

- Initiate any fraud, waste, or abuse investigations.
- Utilize data analytics to detect fraud, waste, and abuse.
- Refer any potential cases to IG or to the Office of Attorney General's Medicaid Fraud Control Unit.
- Recover any Medicaid or CHIP overpayments occurring due to fraud, waste, or abuse.

During the same two-year period, Sendero's health care providers were paid \$82.3 million medical claims dollars. Table 2 shows medical claims dollars, numbers of investigations, referrals to IG, and amounts recovered by year.

¹⁴ Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015); Texas Government Code, Title 4, Subtitle 1, § 531.113 (September 1, 2003). See also Texas Administrative Code Title 1, Part 15, § 353.502 and § 370.502 (March 1, 2012).

¹⁵ Non-SIU sources may include hotlines, client referrals, customer service, program management, network development, peer review, and provider relations.

Table 2: Sendero Medicaid and CHIP Medical Claims Dollars and SIU Performance Results

Year	Medical Claims \$	MCO Investigations ¹⁶	HMS Investigations	Total Recoveries	# of Referrals
2014	\$ 40,438,368	2	0	\$ 0	0
2015	\$ 41,883,578	1	0	\$ 0	0
Total	\$ 82,321,946	3	0	\$ 0	0

Source: HHSC 2014 Year-End 334-Day and HHSC 2015 Year-End 90-Day FSR; HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - 2014 and 2015; IG Investigations Referral Data; Sendero Monthly Open Case Lists for 2014 and 2015

Data Analytic Techniques Were Not Utilized to Detect Fraud, Waste, or Abuse

Sendero did not perform activities needed to detect fraud, waste, and abuse. Sendero's contract provided access to the HMS Fraud, Waste, and Abuse Portal. During the audit period Sendero employees used the HMS portal on three days in August 2015, viewing three reports, a single provider detail, and three message codes. This activity did not result in Sendero detecting, investigating, or referring any potential fraud, waste, or abuse during the audit period.

Texas Administrative Code requires SIUs to detect and identify "Medicaid program violations and possible waste, abuse, and fraud overpayments through data matching, analysis, trending, and statistical activities...monitoring of service patterns for providers, subcontractors, and recipients...[and] use of edits or other evaluation techniques."¹⁷

Data analytics provides essential analysis of claims trends related to fraud, waste, and abuse. Post-payment claims analysis is a critical component of an effective SIU function. By not utilizing data analytics, Sendero is less likely to detect indications of fraud, waste, or abuse that would prompt further investigation and possible recovery.

Recommendations 1.1 - 1.2

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Sendero to strengthen its resource and infrastructure commitment to SIU activities by requiring Sendero to:

- 1.1 Perform fraud detection and investigation activities in accordance with Texas Administrative Code and the Uniform Managed Care Contract.
- 1.2 Utilize available contracted services, including data analytic techniques available through the HMS Fraud, Waste, and Abuse Portal, to identifying unusual trends and

¹⁶ This includes the number of investigations initiated during the referenced year, regardless of whether they were closed during the current or subsequent years.

¹⁷ Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c) (March 1, 2012).

anomalies in provider claims, applying data analytics to perform post-payment reviews, and initiating investigations of potential fraud, waste, and abuse when warranted.

The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel Sendero to perform SIU activities.

HHSC Medicaid/CHIP Division Management Response

The Medicaid/CHIP Division is in agreement with the recommendation and will allow Sendero ten (10) days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of the following:

- *Perform fraud detection and investigation activities in accordance with Texas Administrative Code and the Uniform Managed Care Contract.*
- *Utilize available contracted services, including data analytic techniques available through the HMS Fraud, Waste, and Abuse Portal, to identify unusual trends and anomalies in provider claims, apply data analytics to perform post-payment reviews, and initiate investigations of potential fraud, waste, and abuse when warranted.*

The Medicaid/CHIP Division expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Sendero. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Sendero to effectively perform SIU activities.

Prior to approving actions within the CAP, the Medicaid/CHIP Division will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: December 2016

Section 2: SCOTT AND WHITE HEALTH PLAN

Scott and White Health Plan (Scott and White) contracted with HMS for access to the HMS Fraud, Waste, and Abuse Portal. Scott and White maintained limited staff to support SIU functions and to supplement the HMS contracted services during the audit period. Scott and White's SIU consisted of three staff with minimal time dedicated to SIU activities:

- A Director of Claims Cost Containment (5 percent of time dedicated to SIU)
- A Coding Audit Specialist (10 percent of time dedicated to SIU)
- A Business Analyst (15 percent of time dedicated to SIU)

During the audit period, Scott and White used the HMS Fraud, Waste, and Abuse Portal on just one day in August 2015. Scott and White did not request that HMS conduct any investigations, create special reports, or run targeted queries.

SIU Activities During the Audit Period Were Limited

Though Scott and White is maintaining a fraud, waste, and abuse plan, SIU activities during the audit period were limited. By contract and state law, MCOs are required to establish and maintain SIUs to investigate potential fraud, waste, and abuse by members and health care service providers.¹⁸

During the audit period Scott and White closed four investigations, one of which resulted in a referral to IG. These investigations originated from non-SIU sources.¹⁹ Consequently, during the two-year period under review, Scott and White did not:

- Initiate fraud, waste, or abuse investigations through use of HMS data analytics.
- Utilize HMS data analytics to detect fraud, waste, and abuse.
- Conduct investigations based upon information provided through HMS.
- Recover any Medicaid or CHIP overpayments due to fraud, waste, or abuse.

During the same two-year period, Scott and White health care providers were paid \$205.9 million medical claims dollars. Table 3 shows medical claims dollars, numbers of investigations, referrals to IG, and amounts recovered by year.

¹⁸ Uniform Managed Care Contract, Special Investigative Units, Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015); Texas Government Code, Title 4, Subtitle 1, § 531.113 (September 1, 2003). See also Texas Administrative Code Title 1, Part 15, § 353.502 and § 370.502 (March 1, 2012).

¹⁹ Non-SIU sources may include hotlines, client referrals, customer service, program management, network development, peer review, and provider relations.

Table 3: Scott and White Medicaid Medical Claims Dollars and SIU Performance Results

Year	Medical Claims \$	MCO Investigations ²⁰	HMS Investigations	Total Recoveries	# of Referrals
2014	\$ 115,620,661	4	0	\$ 0	1
2015	\$ 90,276,530	0	0	\$ 0	0
Total	\$ 205,897,191	4	0	\$ 0	1

Source: HHSC 2014 Year-End 334-Day and HHSC 2015 Year-End 90-Day FSR; HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - 2014 and 2015; IG Investigations Referral Data; Scott and White Monthly Open Case Lists for 2014 and 2015

Data Analytic Techniques Were Not Adequately Utilized to Detect Fraud, Waste, or Abuse

Scott and White did not adequately perform data analytics to detect fraud, waste, and abuse. Scott and White’s contract provided access to the HMS Fraud, Waste, and Abuse Portal, however, during the audit period Scott and White employees used the HMS portal just one day in August 2015, viewing eleven reports. This activity did not result in Scott and White detecting, investigating, or referring any potential fraud, waste, or abuse during the audit period.

Texas Administrative Code requires SIUs to detect and identify “Medicaid program violations and possible waste, abuse, and fraud overpayments through data matching, analysis, trending, and statistical activities...monitoring of service patterns for providers, subcontractors, and recipients...[and] use of edits or other evaluation techniques.”²¹

Data analytics provides essential analysis of claims trends related to fraud, waste, and abuse. Post-payment claims analysis is a critical component of an effective SIU function. By not utilizing data analytics, Scott and White is less likely to detect indications of fraud, waste, or abuse that would prompt further investigation and possible recovery.

Recommendations 2.1 - 2.2

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Scott and White to strengthen its resource and infrastructure commitment to SIU activities by requiring Scott and White to:

- 2.1 Perform fraud detection and investigation activities in accordance with Texas Administrative Code and the Uniform Managed Care Contract.
- 2.2 Utilize available contracted services, including data analytic techniques available through the HMS Fraud, Waste, and Abuse Portal, identifying unusual trends and

²⁰ This includes the number of investigations closed during the referenced year, regardless of whether they were opened during the current or previous years.

²¹ Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.502(c) (March 1, 2012).

anomalies in provider claims, applying data analytics to perform post-payment reviews, and initiating investigations of potential fraud, waste, and abuse when warranted.

The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel Scott and White to perform SIU activities.

HHSC Medicaid/CHIP Division Management Response

The Medicaid/CHIP Division is in agreement with the recommendation and will allow Scott and White ten (10) days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of the following:

- *Perform fraud detection and investigation activities in accordance with Texas Administrative Code and the Uniform Managed Care Contract.*
- *Utilize available contracted services, including data analytic techniques available through the HMS Fraud, Waste, and Abuse Portal, to identify unusual trends and anomalies in provider claims, apply and abuse when warranted.*

The Medicaid/CHIP Division expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Scott and White. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Scott and White to effectively perform SIU activities.

Prior to approving actions within the CAP, the Medicaid/CHIP Division will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: December 2016

Section 3: UNITEDHEALTHCARE COMMUNITY PLAN OF TEXAS

UnitedHealthcare Community Plan of Texas, L.L.C. (United) has fully outsourced its SIU function to HMS. HMS conducts detection, investigation, and reporting activities on behalf of United. These activities include:

- Detection services through the HMS Fraud, Waste, and Abuse Portal.
- Preliminary investigations services that include recommendations for United.
- Full-scale investigations services that include recommendations for United.
- Monitoring of providers for aberrant billing patterns.
- Preparation of United deliverables for IG.
- Recovery of identified overpayments upon United's request.

In addition to functions outsourced to HMS, United maintained two staff positions: a Texas Compliance Officer, and a Texas Fraud, Waste, and Abuse Manager, to support SIU functions.

HMS closed 121 investigations in 2014 for United and 164 investigations in 2015. Although overpayments were identified, there were no recoveries associated with these 285 investigations. While United reported recoveries totaling \$396,301 in 2014 and 2015, this amount reflects the SIU efforts of OptumRX, United's pharmacy benefit manager, not the outcome of United or HMS SIU activities. During the two-year audit period, United health care providers were paid approximately \$2.6 billion in medical claims dollars. Table 4 shows medical claims dollars, number of investigations, and amounts recovered by year.

Table 4: United Medicaid and CHIP Medical Claims and SIU Performance Results

Year	Medical Claims \$	HMS Investigations ²²	Recoveries from HMS SIU	Total Recoveries ²³
2014	\$ 929,121,329	121	\$ 0	\$ 173,948
2015	\$ 1,643,818,308	164	\$ 0	\$ 222,353
Total	\$ 2,572,939,637	285	\$ 0	\$ 396,301

Source: HHSC 2014 Year-End 334-Day FSR and HHSC 2015 Year-End 90-Day FSR; HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - 2014 and 2015; United Monthly Open Case Lists for 2014 and 2015

²² This includes the number of investigations opened and closed by HMS during the referenced year only.

²³ These recoveries represent the SIU efforts of OptumRX, United's pharmacy benefit manager.

Overpayments Identified as a Result of SIU Investigations Were Not Recovered

United reported \$1.1 million of overpayments in its monthly report to IG. United has not pursued or collected these overpayment amounts. As previously stated, United reported to IG recoveries of \$173,948 and \$222,353 in 2014 and 2015 respectively. However, these recoveries represent the efforts of OptumRX, pharmacy benefit manager for United. Table 5 shows closed investigations with overpayments and identified overpayments by year.

Table 5: Overpayments Reported to IG by United

Year	Closed Investigations with	
	Overpayments	Identified Overpayments
2014	17	\$ 903,613
2015	9	\$ 212,579
Total	26	\$ 1,116,192

Source: United Monthly Open Case Lists for 2014 and 2015

Texas Administrative Code requires MCOs to attempt recovery of suspected overpayments. It states: “If a managed care organization (MCO) suspects fraud or abuse has occurred in the Medicaid or CHIP program, based on information, data, or facts obtained by the MCO, it must: ...begin payment recovery efforts...”²⁴

In addition to the investigations with overpayments identified in Table 6, United referred 26 suspected cases of fraud, waste, and abuse to IG in 2014 and 2015. IG returned eight cases to United to continue investigating and pursuing recoveries. Table 6 shows cases referred to IG, cases returned to United, and estimated overpayments.

Table 6: United Referrals of Suspected Fraud, Waste, and Abuse to IG

Year	Referrals to IG	Estimated Overpayments ²⁵	Referrals Returned by IG to United	Estimated Overpayment for Returned Cases
2014	18	\$ 5,918,140	5	\$ 1,095,154
2015	8	\$ 964,843	3	\$ 649,450
Total	26	\$ 6,882,983	8	\$ 1,744,604

Source: IG Investigations Referral Data

The eight referrals returned to United included an estimated \$1.7 million in overpayments, as estimated by United. United’s \$1.7 million estimate was based on extrapolation. The non-extrapolated overpayment, as represented by the IG Audit Division review of seven of the

²⁴ Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.505(a) (March 1, 2012).

²⁵ The estimated overpayment is identified by the MCO at the time of referral. The figure is not substantiated and may represent extrapolation or be the result of a preliminary investigation.

eight referrals, was \$3,522 on a dollar for dollar basis. United did not pursue recoveries for the eight returned referrals on either an extrapolated or dollar for dollar basis.

One contract amendment between United and HMS²⁶ established that HMS would "perform recoupment services for United for incidents where an overpayment has been identified and recoupment is approved by United."²⁷ United and HMS engaged in two pilot efforts to recoup overpayments, but neither pilot was fully developed.

Recoupment of overpayments is necessary to deter fraud, waste, and abuse in the system, and needed to allow for adjustment of capitation rates to reflect accurate medical expenses.

Recommendation 3

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require United to put corrective actions in place to ensure United recovers identified overpayments as required by Texas Administrative Code.

The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel United to perform SIU activities.

HHSC Medicaid/CHIP Division Management Response

The Medicaid/CHIP Division is in agreement with the recommendation and will allow United ten (10) days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of the following:

- *Ensure identified overpayments are recovered in accordance with the Uniform Managed Care Contract and the Texas Administrative Code, as applicable.*

The Medicaid/CHIP Division expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from United. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel United to effectively perform SIU activities.

Prior to approving actions within the CAP, the Medicaid/CHIP Division will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

²⁶ The amendment establishes that Allied Management Group Special Investigation Unit would perform recoupment services for United. Allied Management Group was purchased by Health Management Systems in 2010.

²⁷ Fifth Amendment to Special Investigation Services Agreement, AMG-SIU - UHC Community Plan TX 5th Amendment (September, 2012).

Responsible Individual: Director, Health Plan Management

Target Implementation Date: December 2016

Section 4: COMMUNITY HEALTH CHOICE

Community Health Choice (Community Health) has supplemented in-house staff with HMS Services. HMS conducts detection, investigation, and reporting activities on behalf of Community Health. Activities may include:

- Detection services through the HMS Fraud, Waste, and Abuse Portal.
- Preliminary investigation services that include recommendations for Community Health.
- Full-scale investigation services that include recommendations for Community Health.
- Monitoring of providers for aberrant billing patterns.
- Preparation of Community Health Choice deliverables for IG.

Community Health's internal SIU included two staff positions. These staff maintained differing time commitments to the SIU: an Internal Audit Manager (25 percent of time to SIU) and a Compliance Auditor (100 percent of time to SIU) to oversee and coordinate HMS efforts in support of the SIU function.

The combined efforts of HMS and Community Health resulted in 68 closed investigations in 2014 and 31 closed investigations in 2015. For the two-year period under review, Community Health recovered a total of \$44,609 and referred 3 potential fraud, waste, and abuse cases to IG, all of which occurred in 2015. During the same period, Community Health health care providers were paid \$1.3 billion medical claims dollars. Table 7 shows medical claims dollars, numbers of investigations, referrals to IG, and amounts recovered by year.

Table 7: Community Health Medicaid and CHIP Medical Claims Dollars and SIU Performance Results

Year	Medical Claims \$	MCO Investigations ²⁸	HMS Investigations ²⁹	Total Recoveries ³⁰	# of Referrals
2014	\$ 609,318,626	0	68	\$ 0	0
2015	\$ 664,226,363	3	28	\$ 44,609	3
Total	\$ 1,273,544,989	3	96	\$ 44,609	3

Source: HHSC 2014 Year-End 334-Day and HHSC 2015 Year-End 90-Day FSR; HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - 2014 and 2015; IG Investigations Referral Data; Community Health Monthly Open Case Lists for 2014 and 2015

The number of SIU investigations closed from 2014 to 2015 decreased, as did the total number of cases opened. In 2014, Community Health and HMS opened 87 and closed 68 investigations, while in 2015, it opened 9 and closed 28 investigations. According to responsible management, Community Health changed its operational relationship with HMS in 2015 to take a more active role in SIU activities. Community Health formed a Fraud, Waste, and Abuse Committee to review preliminary investigation results from HMS and determine whether HMS recommendations for full-scale investigations should be approved.

During the same period total recoveries increased from \$0 in 2014 to \$44,609 in 2015. These recoveries resulted from 11 investigations.

Annual Recoveries Reported to IG Were Overstated

Community Health overstated the amounts recovered as a result of SIU investigations by \$197,978. Community Health incorrectly reported recoveries of \$163,873 in 2014 and \$78,714 in 2015 to IG. Community Health management indicated that amounts reported to HHSC included recoveries made by its claims department in addition to SIU recoveries. Table 8 shows reported recoveries, actual recoveries, and overstated recoveries by year.

²⁸ MCO Investigations include the number of investigations closed during the referenced year, regardless of whether they were opened during the current or previous years.

²⁹ HMS Investigations include the number of investigations opened and closed by HMS during the referenced year only.

³⁰ This includes the amounts recovered during the referenced year. Investigations may have been opened during the current or prior years.

Table 8: Community Health SIU Reported and Actual Recoveries

Year	Reported Recoveries	Actual Recoveries ³¹	Overstated Recoveries
2014	\$ 163,873	\$ 0	\$ 163,873
2015	\$ 78,714	\$ 44,609	\$ 34,105
Total	\$ 242,587	\$ 44,609	\$ 197,978

Source: HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - 2014 and 2015

Texas Administrative Code requires MCOs to report the amount of money recovered from SIU efforts. It states: “An MCO must submit a quarterly report to the HHSC-OIG detailing the amount of money recovered.”³²

Inaccurate or imprecise reporting by Community Health hinders IG efforts to fairly and consistently measure SIU performance and fight fraud, waste, and abuse.

Recommendation 4

The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Community Health to report complete and accurate information to IG regarding Community Health’s SIU recoveries of identified overpayments.

The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel Community Health to effectively perform SIU activities.

HHSC Medicaid/CHIP Division Management Response

The Medicaid/CHIP Division is in agreement with the recommendation and will allow Community Health ten (10) days from receipt of the final audit report to submit a corrective action plan (CAP) that includes implementation of the following:

- *Ensure reporting of complete and accurate information to the IG regarding SIU's recoveries of identified overpayments.*

The Medicaid/CHIP Division expects immediate actions to begin and would allow 90 days for all actions within the CAP to be fully implemented. Monthly updates detailing the status of each milestone will be expected from Community Health. Additionally, Medicaid/CHIP Division leadership will consider tailored contractual remedies to compel Community Health to effectively perform SIU activities.

³¹ This includes the amounts recovered during the referenced year. Investigations may have been opened during the current or prior years.

³² Texas Administrative Code, Title 1, Part 15, Chapter 353, Subchapter F, § 353.505(f) (March 1, 2012).

Prior to approving actions within the CAP, the Medicaid/CHIP Division will request the IG Investigations Division perform a joint review of the CAP since it currently reviews MCO SIU plans related to fraud, waste, and abuse.

Responsible Individual: Director, Health Plan Management

Target Implementation Date: December 2016

Section 5: COOK CHILDREN'S HEALTH PLAN

Cook Children's Health Plan (Cook) has supplemented in-house staff with HMS services. HMS conducts detection, investigation, and reporting activities on behalf of Cook. Activities may include:

- Detection services through the HMS Fraud, Waste, and Abuse Portal.
- Preliminary investigation services that include recommendations for Cook.
- Full-scale investigation services that include recommendations for Cook.
- Monitoring of providers for aberrant billing patterns.
- Preparation of Cook deliverables for IG.

The combined efforts of HMS and Cook have resulted in 4 closed investigations in 2014 and 40 closed investigations in 2015. For the two-year audit period under review, Cook recovered a total of \$139,142 and referred a total of 2 suspected incidents of fraud, waste, and abuse to IG. During the same period, Cook health care providers were paid \$505 million medical claims dollars. Table 9 shows medical claims dollars, numbers of investigations, referrals to IG, and amounts recovered by year.

Table 9: Cook Medicaid and CHIP Medical Claims Dollars and SIU Performance Results

Year	Medical Claims \$	HMS Investigations ³³	Total Recoveries ³⁴	# of Referrals
2014	\$ 246,164,726	4	\$ 134,042	1
2015	\$ 258,804,087	40	\$ 5,100	1
Total	\$ 504,968,813	44	\$ 139,142	2

Source: HHSC 2014 Year-End 334-Day and HHSC 2015 Year-End 90-Day FSR; HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - 2014 and 2015; IG Investigations Referral Data; Cook Monthly Open Case Lists for 2014 and 2015

IG Audit Division testing of (a) SIU functions performed by HMS on behalf of Cook and (b) Cook's related SIU oversight of and coordination with HMS did not identify areas of noncompliance with regulatory requirements.

³³ This includes the number of investigations opened and closed by HMS during the referenced year only.

³⁴ This includes the amounts recovered during the referenced year. Investigations may have been opened during the current or prior years.

Section 6: EL PASO FIRST HEALTH PLANS, INC.

El Paso First Health Plans, Inc. (El Paso First) has outsourced its SIU function to HMS. HMS conducts detection, investigation, and reporting activities on behalf of El Paso First. These activities include:

- Detection services through the HMS Fraud, Waste, and Abuse Portal.
- Preliminary investigation services that include recommendations for El Paso First.
- Full-scale investigation services that include recommendations for El Paso First.
- Monitoring of providers for aberrant billing patterns.
- Preparation of El Paso First deliverables for IG.

El Paso First maintains two staff positions, a Compliance Director and a Special Investigation Claims Auditor to support its internal SIU efforts and to oversee and coordinate SIU activities performed by HMS.

HMS closed 37 investigations in 2014 and 61 investigations in 2015 on behalf of El Paso First. During the two-year audit period, El Paso First recovered a total of \$102,401 and referred one suspected case of fraud, waste, and abuse to IG. During the same period, El Paso First health care providers were paid \$278.6 million medical claims dollars. Table 10 shows medical claims dollars, numbers of investigations, referrals to IG, and amounts recovered by year.

Table 10: El Paso First Medicaid and CHIP Medical Claims Dollars and SIU Performance Results

Year	Medical Claims \$	HMS Investigations ³⁵	Total Recoveries ³⁶	# of Referrals
2014	\$ 121,695,694	37	\$ 51,191	0
2015	\$ 156,937,144	61	\$ 51,210	1
Total	\$ 278,632,838	98	\$ 102,401	1

Source: HHSC 2014 Year-End 334-Day and HHSC 2015 Year-End 90-Day FSR; HHSC OIG Annual Report on Certain Fraud and Abuse Recoveries by Managed Care Organizations (MCOs) - 2014 and 2015; IG Investigations Referral Data; El Paso First Monthly Open Case Lists for 2014 and 2015

IG Audit Division testing of (a) SIU functions performed by HMS on behalf of El Paso First and (b) El Paso First's related SIU oversight of and coordination with HMS did not identify areas of noncompliance with regulatory requirements.

³⁵ This includes the number of investigations opened and closed by HMS during the referenced year only.

³⁶ This includes the amounts recovered during the referenced year. Investigations may have been opened during the current or prior years.

CONCLUSION

The IG Audit Division completed an audit of SIU processes at HMS and related oversight and coordination activities of MCOs that contract with HMS for SIU services. The audit included an evaluation of policies and practices associated with detecting, investigating, and reporting fraud, waste, and abuse. The IG Audit Division conducted a site visit from April 18, 2016 through April 22, 2016 at an HMS facility in Irvine, California.

HHSC and MCOs share accountability for ensuring that state and federal dollars are used to deliver cost-effective health care services to eligible Medicaid and CHIP enrollees. An effective SIU function is essential to ensure that:

- State and federal funds spent on managed care are used appropriately.
- Suspected fraud is detected, investigated, and when substantiated, reported to IG or the Office of Attorney General's Medicaid Fraud Control Unit.
- Funds lost to fraud, waste, and abuse are recovered and reported to HHSC.
- Capitation rates established for Medicaid and CHIP accurately reflect the cost of providing health care services to eligible beneficiaries.

Based on the results of its audit of SIU processes at HMS and the efforts of MCOs, the IG Audit Division concludes that:

- SIU activities at HMS are designed to comply with Texas SIU regulations.
- SIU investigations resulted in limited recoveries.
- Data analytics, when utilized, were a significant source of preliminary investigations and identified overpayments.
- Some MCOs performed minimal or no SIU activities during the audit period.
- Overpayments identified by HMS were not always recovered.
- Some recoveries were overstated.
- Two Texas MCOs contracted with HMS were in compliance with Texas SIU regulations for the SIU activities evaluated in this audit.

The IG Audit Division offered recommendations to HHSC Medicaid/CHIP Division which, if implemented, will:

- Ensure MCOs establish and maintain an SIU that meets regulatory and contractual requirements.
- Increase use of data analytics, efforts at detection, and identification of potential fraud, waste, and abuse.

- Increase MCO recovery of overpayments from providers and improve the accuracy of reported recoveries.

The IG Audit Division would like to thank management and staff at the HHSC Medicaid/CHIP Division, HMS, Sendero, Scott and White, United, Community Health, Cook, and El Paso First for their cooperation and assistance during this audit.

Appendix A: OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to evaluate the effectiveness of outsourced HMS SIU functions in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

Scope

The scope of the performance audit of HMS SIU functions included the period of September 2013 through August 2015 as well as review of relevant SIU activities through June 2016. The scope of this audit included review of:

- Policies and practices supporting the detection and recovery activities of the SIU.
- Policies and practices supporting the reporting of SIU activities and results to HHSC.
- Data and information technology systems that support SIU processes and reporting.

Methodology

To accomplish its objective, the IG Audit Division collected information for this audit through discussions and interviews with responsible management at HMS, and through request and review of the following information from HMS and Texas MCOs contracted with HMS:

- A description of the SIU function and organizational structure.
- A list of SIU employees, including their names, titles, and a description of their qualifications.
- Policies and practices associated with prevention and detection of fraud, waste, and abuse.
- Data related to SIU performance, including investigations, recoveries, and referrals in 2014 and 2015.
- A description and flowchart of the SIU investigation process.
- Data and information systems that support the SIU activities and data processing necessary to produce reports for submission to HHSC.

The IG Audit Division issued an engagement letter to each of the six MCOs contracted with HMS; provided information about the upcoming SIU audit; and conducted fieldwork at HMS' facility in Irvine, California from April 18, 2016 through April 22, 2016. While on-site, the IG Audit Division interviewed responsible SIU personnel, evaluated policies and practices relevant to the SIU function, and reviewed relevant SIU activities, including those related to detection, investigation, and reporting.

While at HMS' facility, the IG Audit Division reviewed documentation and records related to the SIU function. No original records were removed from HMS' premises. Upon request, HMS and six MCOs sent additional documents that were requested during the audit, but were not available during the on-site review, to the IG Audit Division offices for review.

Professional judgment was exercised in planning, executing, and reporting the results of this audit. The IG Audit Division used the following criteria to evaluate the information provided:

- Fraud, Waste, and Abuse Compliance Plans for the six MCOs in this report
- HMS SIU Policies and Procedures
- Uniform Managed Care Manual
- Uniform Managed Care Contract Terms and Conditions
- Texas Administrative Code
- Texas Government Code
- Code of Federal Regulations

The IG Audit Division (a) reviewed relevant IT controls for the HMS data analytics used in reporting suspected fraud, waste, and abuse; and (b) assessed the reliability, accuracy, and completeness of HMS systems and data analytic tools used for the HMS SIU function. The IG Audit Division determined the data from HMS was sufficiently reliable for the purposes of the audit. In order to make this determination, the IG Audit Division:

- Interviewed HMS officials knowledgeable about the data.
- Reviewed existing information about the data and related IT systems.
- Reviewed the access management process for appropriateness.
- Validated that the queries and parameters used to produce SIU reports were appropriately modified.
- Interviewed the HMS personnel who oversee data analytics and provide support to MCOs.
- Reviewed the testing and approval process for changes to configuration and query logic for HMS data analytics.

The IG Audit Division conducted this performance audit in accordance with generally accepted government auditing standards issued by the Comptroller General of the United States. Those standards require that auditors plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for the issues and conclusions based on audit objectives. The IG Audit Division believes that the evidence obtained provides a reasonable basis for the issues and conclusions based on audit objectives.

Appendix B: SAMPLING METHODOLOGY

The IG Audit Division examined SIU activities for the period from September 2013 through August 2015. After an initial assessment of risk across SIU activities and MCO performance outcomes, the IG Audit Division performed testing.

SIU Investigations through HMS

The IG Audit Division completed a high-level review of 100 percent of investigations conducted by HMS for the six contracted MCOs reviewed during the audit period. In addition, the IG Audit Division verified that SIU procedures and Texas Administrative Code requirements for investigations had been met by reviewing a judgmental sample³⁷ of investigations.

³⁷ Judgmental sampling is a non-probability sampling method where the auditor selects the sample based on certain characteristics, such as dollar amount, timeframe, or type of transaction.

Appendix C: MANAGED CARE ORGANIZATION COMMENTS



August 22, 2016

Steve Sizemore, CIA, CISA, CGAP
Audit Director
Texas Health and Human Services Commission
Office of Inspector General
Mail Code 1326
P.O. Box 85200
Austin, Texas 78708-5200

Dear Mr. Sizemore:

Sendero Health Plans is in receipt of the draft Audit of Managed Care Organization Special Investigative Units Performance report. The report outlines the timeframe covered by the audit as state fiscal years 2014 and 2015, and the effectiveness of Sendero Health Plans' special investigative unit's performance in (a) preventing, detecting, and investigating fraud, waste, and abuse and (b) reporting reliable information on SIU activities, results, and recoveries to HHSC.

Audit Findings:

Sendero is responding to the findings of the audit, namely, that though Sendero "is maintaining a fraud, waste, and abuse plan, it did not have an active SIU and did not identify any fraud, waste, or abuse in 2014 or 2015." And that "Sendero did not perform activities needed to detect fraud, waste, and abuse"..."Sendero employees used the HMS portal on three days in August 2015, viewing three reports, a single provider detail, and three message codes. This activity did not result in Sendero detecting, investigating, or referring any potential fraud, waste, or abuse during the audit period."

Sendero's Response:

Sendero acknowledges that during state fiscal 2014 and 2015, it did not have an active SIU and did not report activities to OIG; however, Sendero did have controls in place to identify fraud, waste and abuse through a pre-payment edit review process that prevented inappropriate claims payment. During the audit period, Sendero's pre-payment edit reviews resulted in approximately \$34 million in denied claims.

Sendero experienced financial issues during state fiscal year 2014 that resulted in a loss of \$14M and were barriers to Sendero's ability to conduct operations in a manner desired. In state fiscal year 2015, Sendero underwent a reorganization that resulted in internal department reviews. One of the department reviews identified a gap in fulfilling responsibilities of fraud, waste and abuse to the degree desired. One of the changes was hiring a FWA Program Specialist.

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The FWA Program Specialist and the Chief Compliance Officer revised the Fraud, Waste, and Abuse Plan, created a FWA Audit Plan and received training from HMS on its portal in August 2015. The FWA Audit Plan was implemented in September 2015. Investigations were conducted between September and December 2015; however, the FWA Program Specialist resigned at the beginning of 2016. A new FWA Program Specialist was hired in February 2016; upon modifying the FWA Audit Plan and receiving training, the new FWA Program Specialist began utilizing the HMS portal conducting investigations, and reporting open cases in June 2016.

Sendero remains dedicated to STAR/CHIP and the care of the underserved in our community. Sendero understands and acknowledges the requirement to comply with all regulatory requirements in the Texas Administrative Code and the Uniform Managed Care Contract ((Section 8.1.19.1, Version 2.6 (September 1, 2013) through Version 2.16 (September 1, 2015)) as they apply to the activities and functions of the special investigative unit. Sendero continues to enhance its efforts to identify and pursue actions against providers whose billing practices may be fraudulent, wasteful and/or abusive.

Please contact Connie McFadden, Chief Operations Officer/Chief Compliance Officer, if you have any questions. Connie can be reached via email at connie.mcfadden@senderohealth.com or phone, 512-978-8134.

Respectfully,

A handwritten signature in black ink, appearing to read "Wesley Durkalski".

Wesley Durkalski
President/CEO
Sendero Health Plans, Inc.



August 23, 2016

VIA Electronic Delivery

Steve Sizemore, CIA, CISA, CGAP
Audit Director
Inspector General - Texas Health and Human Services Commission
11501 Burnet Rd. Bldg. 902
MC: 1310 Office 503
Austin, Texas 78758

Dear Mr. Sizemore:

In response to the Texas Office of Inspector General Report No. IG-16-015, dated August 16, 2016, (the "Report"), Scott and White Health Plan (SWHP) submits the following comments:

- SWHP appreciates the efforts of the Inspector General, which have brought a renewed focus on the SWHP Special Investigative Unit ("SIU").
- SWHP recognizes the need for improvement in its SIU efforts to identify and prevent Medicaid Fraud, Waste, and Abuse ("FWA"). Using HMS data mining reports and data analytics, the SWHP SIU began more thorough case identification in November, 2015. SWHP continues to focus on this area in an effort to develop robust SIU FWA activity.
- SWHP has already identified specific areas of concerns and has developed a robust corrective action plan, and is in the process of implementing the various aspects of that plan.

Thank you for the opportunity to comment on the audit report.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey C. Ingram".

Jeffrey C. Ingram
President and Chief Executive Officer
Scott and White Health Plan

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Please visit us at swhp.org



August 23, 2016

Mr. Hilary Evbayiro
Audit Manager
Inspector General – Audit Division
Health and Human Services Commission
P.O. Box 85200
Austin, TX 78708-5200 - Mail Code 1310

Dear Mr. Evbayiro:

**RE: AUDIT OF MEDICAID AND CHIP MCO SPECIAL INVESTIGATIVE UNITS:
COMMUNITY HEALTH CHOICE INC.**

Community lauds and supports the Office of the Inspector General's (OIG), initiative to bring needed and appropriate oversight to bear on the Medicaid and CHIP health programs in order to ensure that capital resources are utilized for the intended purposes, in this case, the payment for medical care to Texas' most vulnerable health population.

Please accept the below in response to IG Report No. IG-16-015 regarding the audit recommendations for Community Health Choice Inc.'s (Community) Special Investigative Unit (SIU) activities during state fiscal years 2014 and 2015.

Recommendation 1: 'The HHSC Medicaid/CHIP Division, through its contract oversight responsibility, should require Community Health to report complete and accurate information to IG regarding Community Health's SIU recoveries of identified overpayments.'

Community wishes to highlight that certain SIU functions occur outside Community's SIU unit. As a result, recoveries that although not specifically carried out by SIU, were triggered by activities of the SIU unit were reported. Community has implemented improvement procedures to delineate recoveries specifically initiated and finalized by the SIU Unit.

Recommendation 2: 'The HHSC Medicaid/CHIP Division should consider tailored contractual remedies to compel Community Health to effectively perform SIU activities.'

Community is effectively performing SIU activities and remains committed to continuous improvement. The data submitted for this audit demonstrates appropriate year over year improvement and effectiveness of the SIU activities, including investigations, undertaken by Community. Comparative data, tested by the OIG, supports and effectively demonstrates not only increased recoveries but more effective identification and prevention of Fraud Waste and/or Abuse (FWA).

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We will continue to seek ways of improving available tools and authority to continue our effective partnership with the Texas Health and Human Services Commission (THHSC), to reduce FWA in the Medicaid and CHIP health programs.

Sincerely,

A handwritten signature in black ink, appearing to read "Nike Otuyelu", with a large flourish extending to the left.

Nike Otuyelu
VP, Corporate Compliance & Risk Management
Community Health Choice Inc.

CC:
Ken Janda, CEO
Saira Shah, VP, General Counsel
Leroy Mayers, Manager, Internal Audit

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Appendix D: REPORT TEAM AND REPORT DISTRIBUTION

Report Team

The IG staff members who contributed to this audit report include:

- Steve Sizemore, CIA, CISA, CGAP, Audit Director
- Hilary Evbayiro, CPA, Audit Manager
- Jeff Jones, CPA, CIGA, Audit Project Manager
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Appendix E: IG MISSION AND CONTACT INFORMATION

Inspector General Mission

The mission of the IG is to prevent, detect, and deter fraud, waste, and abuse through the audit, investigation, and inspection of federal and state taxpayer dollars used in the provision and delivery of health and human services in Texas. The senior leadership guiding the fulfillment of IG's mission and statutory responsibility includes:

- Stuart W. Bowen, Jr. Inspector General
- Sylvia Hernandez Kauffman Principal Deputy IG
- Christine Maldonado Chief of Staff and Deputy IG for Operations
- Frank Bryan Counselor to the IG
- Quinton Arnold Senior Advisor and
Deputy IG for Inspections and Evaluations
- David Griffith Deputy IG for Audit
- James Crowley Deputy IG for Investigations
- Cynthia Reyna Chief Counsel

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- IG website: <https://oig.hhsc.texas.gov>

To Report Fraud, Waste, and Abuse in Texas HHS Programs

- Online: <https://oig.hhsc.texas.gov/report-fraud>
- Phone: 1-800-436-6184

To Contact the Inspector General

- Email: OIGCommunications@hhsc.state.tx.us
- Mail: Texas Health and Human Services Commission
Inspector General
P.O. Box 85200
Austin, Texas 78708-5200
- Phone: 512-491-2000