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Center for Program Integrity

Texas Focused Program Integrity Review

Final Report

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**Texas Focused PI Review Final Report
December 2016**

Table Of Contents

Objective of the Review 1
Background: State Medicaid Program Overview 1
Methodology of the Review 2
Results of the Review 2
 Section 1: Managed Care Program Integrity 2
 Section 2: Nemt Oversight..... 15
Recommendations..... 16
 Section 3: Status Of Corrective Action Plan 17
Technical Assistance Resources 19
Conclusion 20
Official Response From Texas 21

Texas Focused Program Integrity Review Final Report December 2016

Objective of the Review

The Centers for Medicare & Medicaid Services (CMS) conducted a focused review of Texas to determine the extent of program integrity oversight of the managed care program and the medical transportation program (MTP) at the state level and to assess the program integrity activities performed by selected managed care organizations (MCOs), dental maintenance organizations (DMOs), and MTPs under contract with the state Medicaid agency. The review also included a follow up on the state's progress in implementing corrective actions related to CMS's previous comprehensive program integrity review conducted in calendar year 2010.

Background: State Medicaid Program Overview

The Texas Health and Human Services Commission (HHSC) administers the Texas Medicaid programs. The Medicaid programs in Texas are: STAR, STAR+PLUS, and STAR Health. The type of Medicaid coverage provided to beneficiaries is determined by their location and health issues. The STAR program provides Medicaid coverage to most of the Medicaid population in Texas. Enrollees in STAR Medicaid receive their services through the MCO of their choice. Most Medicaid services in Texas and all Children's Health Insurance Program (CHIP) services are delivered through managed care. There are 21 MCOs participating in the managed care program.

The HHSC contracts with MCOs licensed by the Texas Department of Insurance and pays them a monthly capitated rate to coordinate health services for the Medicaid and CHIP Division (MCD) enrollees. The total Medicaid beneficiary enrollment in these programs for August 2015, was 3,749,802 with state and federal total Medicaid expenditures of \$32.2 billion in federal fiscal year (FFY) 2014. During FFY 2014, MCO expenditures totaled \$12.5 billion.

In addition, NorthSTAR is a program that contracts with the North Texas Behavioral Health Authority (NTBHA) and ValueOptions to provide behavioral health services in the seven counties around the Dallas/Fort Worth area. On December 31, 2016, NorthSTAR will be discontinued and the MCOs will become responsible for providing behavioral health services within their plans, as they do in the rest of the state.

The Texas non-emergency medical transportation (NEMT) services program has been in existence since 1974. Under the State Plan, the MTP is charged with the responsibility of program administration and oversight of the delivery of NEMT services to ensure necessary transportation for clients to and from visits with enrolled Medicaid providers complies with federal NEMT rules and regulations; is efficient and cost-effective; and meets the transportation needs of the client.

The state administers the Texas Medicaid and Healthcare Partnership (TMHP), a group of contractors under the leadership of Accenture. The TMHP enrolls most providers in the Medicaid program including providers in the MCOs. The TMHP does not process claims for MCOs. However, the TMHP does collect encounter data from the MCOs for the HHSC's use in evaluation of quality and utilization of managed care services; validation of MCO financial reporting; and providing detailed information for rate setting activities.

Texas Focused Program Integrity Review Final Report December 2016

Methodology of the Review

In advance of the onsite visit, CMS requested that Texas, the MCOs, and the DMOs selected for the focused review complete a review guide that provided the CMS review team with detailed insight into the operational activities of the areas that were subject to the focused review. The review team has reviewed these responses and materials in advance of the onsite visit.

During the week of September 22, 2015, the CMS review team visited the HHSC. It conducted interviews with numerous state staff involved in program integrity and managed care. The CMS review team also conducted interviews with three MCOs, two DMOs, their special investigations units (SIUs), and the MTP. In addition, the CMS review team conducted sampling of program integrity cases and other primary data to validate the state and the selected MCOs' program integrity practices.

Results of the Review

The CMS review team identified areas of concern with the state's managed care program integrity oversight, thereby creating risk to the Medicaid program. CMS will work closely with the state to ensure that all of the identified issues are satisfactorily resolved as soon as possible, particularly those that remain from the earlier review. These issues and CMS's recommendations for improvement are described in detail in this report.

Section 1: Managed Care Program Integrity

Overview of the State's Managed Care Program

As mentioned earlier, Texas MCO expenditures totaled \$12.5 billion during FFY 2014. This represents medical premiums, pharmacy premiums, and delivery supplemental payments for all 21 MCOs.

Summary Information on the Plans Reviewed

The CMS review team interviewed three MCOs, two DMOs, and the MTP, as part of its review. At the time of this review, the CMS review team interviewed the following MCOs: Sendero Health Plans (Sendero), FirstCare, and Christus Health Plan (Christus). The MCNA Dental (MCNA) and DentaQuest DMOs were also interviewed. For the purpose of this report, the global term of "MCOs" will be used to refer to both the MCOs and the DMOs interviewed collectively. Additionally, an interview was conducted with the state's MTP which is responsible for NEMT program administration and oversight for beneficiaries who are Medicaid eligible only.

During 2008, the HHSC-Office of the Inspector General (OIG) created and filled a fully dedicated SIU coordinator position. The HHSC-OIG's SIU coordinator is responsible for review of the MCOs' annual fraud, waste, and abuse plans to ensure that they contain the required elements outlined in the Texas Administrative Code and Government Code. Also, the SIU coordinator reviews the MCOs' investigations submitted on the monthly *Open Case List* report and handles additional SIU coordination activities.

Christus is an acute care organization providing family health plans for over 25 years with 65 hospitals located in Texas, Louisiana, Chile, and Peru. Christus contracted with the state in 2012

Texas Focused Program Integrity Review Final Report December 2016

and had no previous Medicaid experience. Christus originally contracted with Aetna to provide an SIU; however, the arrangement ended in March 2015. The SIU was moved in-house to improve the investigations process. Christus pays its providers on a fee-for-service (FFS) basis.

DentaQuest has been doing business with the state since 2012. DentaQuest identifies its utilization review (UR) staff as its equivalent to an SIU. Of the eighteen staff members who comprise the UR department, there are 2.25 FTEs dedicated to program-related activities in Texas. DentaQuest pays its network providers on a FFS basis, with the exception of federally qualified health centers which are paid using an encounter rate.

FirstCare has been doing business with the state since the 1990s. The most recently renewed contract became effective in 2012. FirstCare has an in-house SIU that investigates fraud, waste, and abuse issues. The SIU is part of FirstCare's Corporate Compliance Department which is responsible for program integrity activities. FirstCare stated that there had been turnover in the compliance department. The current compliance and SIU departmental staff had been in the organization for only a maximum of nine months. FirstCare hired an investigator in February 2015, and a corporate compliance manager was hired in March 2015. The MCO reported that the SIU staff currently has 1.5 FTEs dedicated to program integrity activities. The Corporate Compliance Department supports these activities at its corporate office in Austin, Texas and its local offices in Lubbock, Abilene, and Amarillo, Texas. FirstCare pays its network provider on a FFS basis. The Recovery Audit Unit is responsible for identifying and/or collecting overpayments.

The MCNA is a DMO contracted with the state since March 2012. The MCNA pays its providers on a FFS basis. The MCNA's administrative office is housed in San Antonio, Texas. The MCNA has 14 employees dedicated to program integrity activities. The SIU is housed in a corporate location in Fort Lauderdale, Florida.

Sendero was formed in 2011 as a nonprofit organization in central Texas with a focus on improving access to publicly-funded health insurance programs. Sendero submitted a proposal to the HHSC and was awarded the contract for the management of the STAR and CHIP programs in September 2011, and began providing services on March 1, 2012. Sendero's contract serves eight counties in the Travis service area. Sendero's highest percentage of expenditure (77 percent) is under its Medicaid and CHIP programs.

**Texas Focused Program Integrity Review Final Report
December 2016**

Below is summary data for the MCOs reviewed as of September 2015:

Table 1A.

MCO Name	Christus
Beneficiary enrollment total	6,486–STAR and 578–CHIP
Provider enrollment total	549–Within service area and 3,542–Outside of service area
Year originally contracted	2012
Size and composition of SIU	1-Compliance Officer; 2–Consultants; 1-Fraud Examiner/Audit Consultant; 1-Network Management FTE; 1-Claims Examiner; 1–Analyst; 1–Operations FTE; 1-Pharmacy Operations Director

Table 1B.

MCO Name	DentaQuest
Beneficiary enrollment total	1,597,176
Provider enrollment total	4,583
Year originally contracted	2012
Size and composition of UR department*	1-Fraud Prevention & Recovery Vice President (VP); 1-UR Manager; 1-Dental Director; 14-Fraud/Waste/Abuse Investigators, 1-UR Coordinator

*The above description applies to the organizational structure of the UR department. DentaQuest has 2.25 FTEs fully dedicated to program integrity activities.

Table 1C.

MCO Name	FirstCare
Beneficiary enrollment total	93,753
Provider enrollment total	9,624
Year originally contracted	Last renewed–2012
Size and composition of compliance department**	1 – SIU Investigator; 1-Corporate Compliance & Government Programs Senior VP; 1-Corporate Compliance Manager; 1-Senior Recovery Audit Specialist

**The above description applies to the organizational structure of the compliance department. FirstCare has 1.5 FTEs fully dedicated to program integrity activities.

Table 1D.

MCO Name	MCNA
Beneficiary enrollment total	1,308,613
Provider enrollment total	4,828
Year originally contracted	2012
Size and composition of SIU***	1-SIU Manager; 3-Fraud Analysts; 4–Investigators; 4 - Clinical Reviewers; 2-IT Reporting Analysts

***MCNA has 14 FTEs fully dedicated to program integrity activities.

**Texas Focused Program Integrity Review Final Report
December 2016**

Table 1E.

MCO Name	Sendero Health Plans
Beneficiary enrollment total	11,523
Provider enrollment total	2,710
Year originally contracted	2012
Size and composition of compliance department*	8 FTEs: Team of investigators; coding review, training, and specialty research staff

*Sendero maintains a fraud, waste, and abuse plan. However, during 2015 the MCO did not maintain any internal staff to fulfill SIU functions and to supplement the 3rd party contracted services.

Table 2.

MCOs	SFY 2012	SFY 2013	SFY 2014
Christus	N/A**	STAR claims – \$22.8 million CHIP claims – \$1.5 million	STAR claims – \$13.9 million CHIP claims – \$762,538
DentaQuest	N/A**	\$650.0 million	\$525.0 million
FirstCare	\$36.5 million	\$417.5 million	\$269.3 million
MCNA	N/A**	\$523.7 million	\$445.9 million
Sendero	N/A**	\$46.1 million	\$38.8 million

**For MCO financial reporting purposes, SFY 2012 ended on February 29, 2012. Christus, DentaQuest, MCNA, and Sendero contracts commenced on March 1, 2012.

State Oversight of MCO Program Integrity Activities

The HHSC-OIG and the HHSC-MCD each have program integrity oversight responsibilities of the MCOs. The MCD has programmatic oversight of the MCO contracts, quality, and other monitoring activities. The HHSC-OIG is authorized to investigate, suspend, review, audit, and inspect providers, recipients, and MCOs when potential fraud, waste, and abuse is suspected or reported. The HHSC-OIG refers instances of contract noncompliance to the MCD or NorthSTAR program staff in the Department of State Health Services (DSHS), as appropriate. Also, the HHSC-OIG collaborates with the MCD to write managed care contract language related to fraud, waste, and abuse. There are a total of 128 full time equivalent (FTE) positions, including the Director of Managed Care Operations, tasked with oversight over all MCOs collectively. Positions allocated to program integrity activities are found throughout the HHSC-OIG.

The HHSC-OIG’s Audit Division staff conducts comprehensive audits of managed care plans. This division selects MCOs for audit using a risk assessment tool; the most recent audit, as of the time of this review, was issued on May 26, 2015. In addition, the HHSC-OIG recently created the Inspections & Evaluations Division to conduct reviews and inspections of Health and Human Services programs, systems, or functions. The division focuses on systemic issues, and provides practical recommendations to improve effectiveness and efficiency in order to detect and prevent fraud, waste, and abuse, and to ensure the greatest benefit to the citizens of Texas. The MCD performs annual MCO compliance reviews and ensures the satisfactory submission of MCO contract deliverables on a weekly, monthly, quarterly, bi-annual, and annual basis.

Additionally, the state contracts with an external quality review organization (EQRO). The EQRO reviews quality of care and does not review the MCOs’ compliance with fraud and abuse-

Texas Focused Program Integrity Review Final Report December 2016

related provisions. The CHIP reviews complaints through the Department of Insurance and the HHSC's Office of the Ombudsman collects and reports complaints from the MCOs' beneficiaries.

MCO Investigations of Fraud, Waste, and Abuse

As required by 42 CFR 455.13, 455.14, 455.15, 455.16, and 455.17, the state does have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

The Texas MCO contracts contain fraud, waste, and abuse language located in several sections. The MCO contract provides information related to fraud, waste, and abuse activities, and outlines reporting/investigating procedures with instructions for addressing suspected fraud and abuse. The MCO contract does require the reporting of suspected provider fraud, waste, or abuse to the state Medicaid agency and the Texas Medicaid Fraud Control Unit (MFCU) simultaneously.

Fraud and abuse oversight is conducted by the following areas in the HHSC-OIG: Business Operations; Audit; Lock-in Program; Data Analytics & Fraud Detection; Medicaid Provider Integrity; and General Investigations. Programmatic and/or contract oversight is conducted by the following MCD areas: Health Plan Management; Program Management; Finance Management; Utilization Management Review; Vendor Drug Program; Contract Compliance and Support; and Operations Coordination. Programmatic oversight and contract monitoring for the NorthSTAR program is conducted by NorthSTAR program staff in the DSHS areas of the Mental Health and Substance Abuse Division, and the NorthSTAR Medicaid Unit. Fraud and abuse oversight for the NorthSTAR program is conducted by NTBHA.

All Texas MCOs are required to have a compliance program that is responsible for investigating fraud, waste, and abuse. Four out of the five MCOs interviewed had either an SIU or a compliance department with dedicated staff for the oversight of their program integrity activities. There was concern that Sendero did not have an SIU or compliance department. However, after the review team's interview with Sendero, it was determined that the MCO contracted with HMS for access to the Fraud, Waste, and Abuse Portal. Also, additional services such as investigations, monitoring, and targeted queries were available from HMS and could be requested on a case-by-case basis by the MCO. Sendero maintains a fraud, waste, and abuse plan; however, by both contract and state law, all MCOs are required to establish and maintain SIUs to investigate potential fraud, waste, and abuse.

During SFY 2014 and 2015, Sendero did not maintain any internal staff to fulfill SIU functions and to supplement the HMS contracted services. Nor did Sendero request that HMS conduct any investigations; create any special reports; or run any targeted queries. During the review period, Sendero claimed that prepayment edit reviews have resulted in approximately \$34 million in denied claims; however, no documentation was provided related to these cost avoidance activities. In June 2015, Sendero hired a fraud, waste, and abuse program specialist who is responsible for the member verifications; prepayment release claims review; and monitoring of provider billing practices using the HMS portal. When abnormalities are identified, the program specialist engages HMS to complete a more comprehensive claims review and medical record review, if necessary.

Texas Focused Program Integrity Review Final Report December 2016

The HHSC-OIG regularly monitors the MCOs' program integrity activities with monthly and quarterly calls, as well as trainings and conferences. The MCOs send reports to the HHSC-OIG on a weekly, monthly, or quarterly basis to enable tracking of MCO program integrity activities and to identify whether or not the same providers are under investigation by the state or the other MCOs. Also, it allows the state to manage the MCOs' activities related to cases of suspected fraud. Referrals from the MCOs to the MFCU are tracked using a referral database.

Christus's SIU activities were conducted under an administrative services only arrangement with Aetna Better Health. However, Aetna Better Health's contract was terminated on March 1, 2015, due to lack of suspected fraud referrals. At the time of the review, the SIU was moved in-house along with the data mining function. Christus plans to expand its SIU to include staff fully dedicated to data mining and investigative activities. Materials to educate beneficiaries regarding fraud and abuse are contained in the enrollee handbook; this includes information on reporting suspected fraud, waste, and abuse. Fraud and abuse information is also located on the MCO's website. All inquiries and comments are forwarded directly to the corporate compliance department. To date, no calls were received by the MCO's from the hotline. Also, no complaints have been received from Aetna Better Health.

DentaQuest has 18 FTEs that comprise both the corporate and local UR department with 2.25 of those FTEs fully dedicated to Texas Medicaid program integrity activities. The Texas UR staff conducts data mining and investigative activities for the HHSC. No vendors are used to perform program integrity activities. All program integrity functions are handled in-house and are conducted by the corporate office in Wisconsin and/or by the local office in Austin, Texas. The Wisconsin staff conducts desk audits, data mining, and running algorithms. The Texas staff conducts onsite reviews, data mining, and investigations.

FirstCare has an SIU as part of its compliance department, which is responsible for program integrity activities and is supported by both its corporate office, located in Austin, Texas, and its local offices in Lubbock, Abilene, and Amarillo, Texas. FirstCare handles all complaints from internal referrals, fraud inbox, fraud hotline, external referrals, member referrals, and audits. FirstCare contracts with two vendors to support tasks such as audits of providers and implementing the National Correct Coding Initiative (NCCI) edits. FirstCare is in the process of replacing one of its vendors with a vendor that has the ability to provide investigative support for fraud, waste, and abuse through data mining, tracking and trending, and identifying outliers. On September 30, 2015, FirstCare provided a statement indicating that there had been turnover in the Corporate Compliance Department and that the current staff had been in the organization for nine months. FirstCare hired an SIU investigator in February 2015, and a corporate compliance manager in March 2015. No historical documentation of previous reviews, audits, or investigative cases could be located; only a tracking matrix from 2010 with four cases was available. FirstCare closed the cases that were still open due to length of time and the lack of documentation.

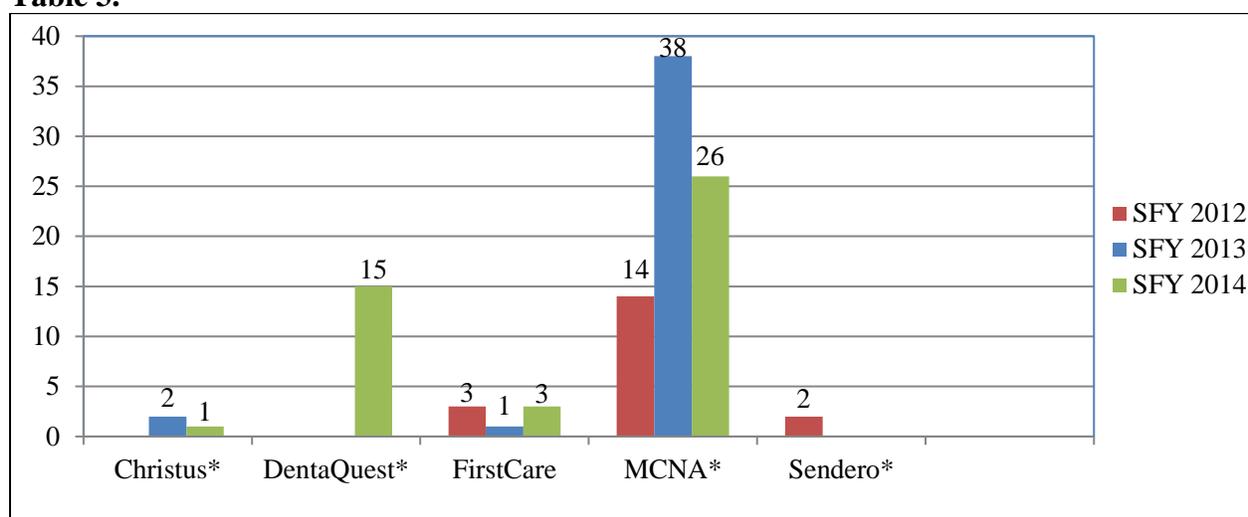
The majority of MCNA's SIU cases are Medicaid cases, but the SIU investigates all lines of business in Texas. The SIU is housed at its corporate location in Fort Lauderdale, Florida. Florida-based investigators conduct preliminary reviews and administrative reviews of dental records. Texas-based clinical reviewers conduct medical necessity reviews and deliver provider education in conjunction with their provider relations team.

Texas Focused Program Integrity Review Final Report December 2016

Sendero identified HMS as their contractor equivalent to an SIU. However, during the interview with HMS representatives, their main function was stated as reviewing clean claims at the time of payment and, if applicable, reducing claim amounts paid to providers. Some claims may require a medical record review to determine adjustment, but no further investigative activity is conducted. All program integrity functions are handled by Sendero's chief operating officer/compliance officer at the local Austin, Texas office. Sendero has 38 employees; no employees are dedicated to program integrity activities in Texas. Sendero is required by the state, as are all Texas MCOs, to enroll Medicaid network providers through the HHSC, while it does not require CHIP providers to be enrolled by the state prior to credentialing.

The table below shows the number of cases that each MCO reported; these cases were handled by either its compliance department or SIU and were referred to the state.

Table 3.



*Christus, DentaQuest, MCNA, and Sendero were not contracted until March 2012.

No investigations were referred for Christus during SFY 2012; no investigations were referred for DentaQuest during SFYs 2012 and 2013; and no investigations were referred for Sendero during SFYs 2013 and 2014.

Both the MFCU and the HHSC-OIG receive the MCOs' monthly *Open Case List* reports which contain all referrals, in addition to other cases that are in progress or have never been referred. The MCOs are required by 1 Texas Administrative Code (TAC) §353.502(c)(5)(d) to report and refer all suspected cases of fraud, waste, or abuse to the HHSC-OIG and list the referral requirements. The exception is expedited referrals.

During the review period, there were discrepancies in the number of referrals reported to the onsite team by both the state and the MCOs. The state reported that Sendero had not forwarded any referrals and Sendero stated that they had reported two referrals. The state needs to create a better reporting mechanism between the MCOs and the state, so that case referrals are clearly defined and result in a more consistent accounting of suspected fraud case referrals leading to both parties reflecting identical totals.

Texas Focused Program Integrity Review Final Report December 2016

MCO Compliance Plans

The CMS review team found that the state requires the MCOs to have a compliance program consistent with the regulation at 42 CFR 438.608. The Texas managed care contract is compliant with the regulatory language under 42 CFR 438.608.

Although the HHSC-OIG does not have direct oversight of the MCO network providers, they conduct investigations of providers suspected of fraud. The HHSC requires MCOs to conduct onsite reviews of their providers. The HHSC-OIG investigated one MCO dental plan which was eventually closed. In addition, the state may provide assistance and work investigations in conjunction with the MCOs.

Encounter Data

The TMHP collects encounter data from the MCOs for use in evaluation of quality and utilization of managed care services. Managed care providers are required to submit encounter data on a monthly basis. In addition, pharmacy encounter data must be submitted no later than 25 calendar days after the date of adjudication. The submission must include all encounter data and adjustments processed by the MCOs.

Encounter data is used by the state for rate setting and quality improvement evaluation. Before MCO encounter claims data can be used, it is necessary to establish that the data is complete, accurate, and valid. Texas's EQRO has a process that validates the completeness, accuracy, and validity of encounter claims data prior to any rate setting or quality improvement evaluation. The HHSC-OIG indicated that they are evaluating better utilization of encounter data through discussions with other states.

Meetings and Trainings

Historically, the HHSC-OIG has not held formal training sessions for MCO staff. However, the HHSC-OIG has provided training to the MCOs during the MCO-SIU Quarterly Meetings, which have been held since October 2012. In addition, the HHSC-OIG recently held two meetings with key MCO staff to discuss their plans' impact on the HHSC-OIG's office and how to interact more effectively together; additional meetings are planned for the future.

From interviews with both the state and the MCOs, communication between the MCD and the HHSC-OIG divisions requires improvement with regard to providers and provider types are at risk for potential fraud. Also, it was indicated during the onsite interviews that the MCD rarely attends the HHSC-OIG's quarterly meetings covering Medicaid providers identified as at risk for fraud. Likewise, limited communication between the two divisions has resulted in a lack of awareness of complaints related to their Medicaid network providers, which has caused difficulties in investigation coordination between the state Medicaid agency and the MCOs. Meetings held in August 2015 were attended by staff from both divisions in an effort to improve communication.

The HHSC-OIG and the MCD jointly conduct annual fraud, waste, and abuse training for staff responsible for processing Medicaid claims. The most recent training was on October 30, 2014. The HHSC-OIG's quality review unit holds periodic conference calls on the Lock-In Program

Texas Focused Program Integrity Review Final Report December 2016

approximately every two months and provided a Lock-In Program workshop on June 22, 2012, and presentations on April 13, 2015, and May 14, 2015.

Christus attends all quarterly meetings with the HHSC-OIG. In addition, Christus conducts provider training onsite with one-on-one education with each provider. The subject matter pertains to participation review, contract or administration questions, new processes, and open provider question and answer sessions. Additionally, employees are required to complete fraud, waste, and abuse training, and sign an attestation on an annual basis.

DentaQuest reported attending all MCO meetings held by the HHSC-OIG, including the quarterly SIU meetings with the HHSC-OIG and the HHSC-OIG mandatory trainings. Additionally, DentaQuest attended National Healthcare Anti-Fraud Association (NHCAA) conferences and webinars.

FirstCare reported attending several training and meetings to include the quarterly SIU meetings with the HHSC-OIG, the NHCAA, training for the role of analytics technology in fraud prevention, and the American Academy of Professional Coders (AAPC) conference.

The MCNA has attended all quarterly meetings with the HHSC-OIG and MFCU, since the inception of the contract on March 1, 2012. The MCNA encourages staff to receive additional training and education, as it relates to their job duties and functions. The SIU staff has attended the annual Certified Fraud Examiners conference, as well as a recent training given by NHCAA on the role of analytics in fraud prevention. All new hires must complete mandatory compliance training which includes fraud, waste, and abuse, and HIPAA, within 30 days of their start date and annually thereafter. The MCNA has continued to deliver education to participating network providers in the past FFY. New provider orientation is provided to all new providers joining MCNA within 30 days of enrollment and for auxiliary office staff as needed. In addition, MCNA provider portal training is performed as needed and is often in conjunction with the new provider orientation. This orientation and portal training is offered onsite, via phone, or by webinar, based on the scheduling needs and at the convenience of the provider.

Sendero attends training and meetings to include the quarterly SIU meetings with the HHSC-OIG; the NHCAA; training for the role of analytics technology in fraud prevention; and the AAPC conference.

Overpayment Recoveries, Audit Activity, and Return on Investment

If an MCO discovers fraud or abuse in the Medicaid or CHIP programs, the MCO must immediately notify both the HHSC-OIG and the Office of the Attorney General (OAG). At that time, the MCO shall also begin recovery efforts with the following exception. If the amount of the recovery exceeds \$100,000, the HHSC-OIG or the OAG notifies the MCO within ten days regarding authorization for the MCO to proceed with recovery efforts. In cases where the MCO is not authorized to pursue the overpayment, the HHSC-OIG will investigate and pursue overpaid claims. An MCO may retain any monies recovered that have resulted from their own efforts. This is per TAC §353.505 and Texas Government Code §531.1131.

In addition, the state indicated that it is the responsibility of the MCOs to pursue any overpayments associated with fraud, waste, and abuse, as required by state statute. If the HHSC-OIG becomes involved in an investigation based on a referral from an MCO, the state will assess

**Texas Focused Program Integrity Review Final Report
December 2016**

an overpayment. If the HHSC-OIG recovers any money paid by the MCO that made the referral, it must be returned to the plan and only the cost of the investigation and collection proceedings may be retained by the HHSC-OIG. This is per 1 TAC §353.505(e).

The following tables show the respective amounts reported by each of the MCOs interviewed for the past three SFYs.

Table 5A.

SFY	Preliminary Investigations (Not Referred to HHSC-OIG)	Full Investigations (Referred to HHSC-OIG)	Total Overpayment s Identified	Total Payments Recovered
2012*	0	0	\$0	0
2013	0	0	\$0	\$0
2014	1	0	\$500	\$500

*Christus's contract began in March 2012.

Table 5B.

SFY	Preliminary Investigations (Not Referred to HHSC-OIG)	Full Investigations (Referred to HHSC-OIG)	Total Overpayment s Identified	Total Payments Recovered
2012*	5	0	**	\$0
2013	64	0	**	\$201,765
2014	60	15	**	\$289,826

*DentaQuest's contract began in March 2012.

**DentaQuest's recoveries are an offset to future paid claims; therefore, it is typically a dollar-for-dollar match between the monies identified and amounts recovered.

Table 5C.

SFY	Preliminary Investigations (Not Referred to HHSC- OIG)	Full Investigations (Referred to HHSC-OIG)	Total Overpayment s Identified	Total Payments Recovered
2012	5	4	\$9,832	\$0
2013	2	2	\$0	\$0
2014	7	5	\$18,087	\$15,250

Table 5D.

SFY	Preliminary Investigations (Not Referred to HHSC- OIG)	Full Investigations (Referred to HHSC-OIG)	Total Overpayments Identified	Total Payments Recovered
2012*	7	9	\$152,934	\$0
2013	59	29	\$1.4 million	\$12,387
2014**	32	21	\$495,585	\$31,322

*MCNA's contract began in March 2012.

**All cases referred to HHSC-OIG through April 15, 2015.

**Texas Focused Program Integrity Review Final Report
December 2016**

Table 5E.

SFY	Preliminary Investigations(Not Referred to HHSC-OIG)	Full Investigations (Referred to HHSC-OIG)	Total Overpayments Identified	Total Payments Recovered
2012**	0	0	\$0	\$0
2013	0	0	\$0	\$0
2014	0	0	\$0	\$0

*Sendero reported no overpayments to the state based on suspected fraud, waste, or abuse.

**Sendero’s contract began in March 2012.

The MCNA’s SIU is responsible for collecting any overpayments identified during investigations or audits conducted by them. However, outside of MCNA’s SIU function, the claims department routinely audits claims processing activities, identifies overpayments, and initiates recoupments.

The information reported by FirstCare was gathered from MCO *Open Case List* reports submitted on a monthly basis to the HHSC-OIG and the MFCU. For SFY 2012, the SIU identified \$9,832 in overpayments after the SIU’s review of records requested from two of the four cases. For SFY 2013, no overpayments were identified as a result of the SIU medical record reviews and investigations conducted for either of the two cases. For SFY 2014, the state Medicaid agency’s recovery department did attribute additional monies recovered to FirstCare, based upon SIU investigations; there was an additional \$105.82 collected during this time period.

Overall, the overpayment amounts recovered by the MCOs are low for a \$12.5 billion Medicaid managed care program. With the exception of DentaQuest and MCNA, the number of investigations being conducted by MCOs is either very few or nonexistent. (DentaQuest investigations represent a sample record review and recovery with the goal of provider billing behavior modification and a decline in utilization for the coding issues subject to the audit. These uncalculated savings that extend beyond the sample review and recovery were not measured by DentaQuest and reported during the audit period; however, the MCO maintains that observations from past experience indicate that this savings category is often larger than the realized recoveries. DentaQuest has taken steps to begin measuring these savings in 2016, but documentation was not available with regard to their cost avoidance measures during the onsite review.)

In addition, investigations conducted by Christus, FirstCare, and MCNA yielded either very low or no monetary recoveries. During SFY 2013, MCNA identified \$1.4 million in overpayments, and all cases were referred to the HHSC-OIG. The majority of cases referred were accepted as full scale investigations by the HHSC-OIG. When the HHSC-OIG accepts a case, MCNA is directed not to pursue recovery efforts. The MCNA collected \$12,387 during the SFY 2013 for those cases that were not accepted by the HSHC-OIG. Sendero reported no investigations or recoveries whatsoever. Sendero attributes these results to cost avoidance measures; however, the MCO did not have an internal SIU staff for several years.

Payment Suspensions

The HHSC-OIG confirmed that it directs the MCOs’ SIUs to place providers under a payment suspension when credible allegations of fraud are determined by the HHSC-OIG as defined in 42

Texas Focused Program Integrity Review Final Report December 2016

CFR 455.23. The MCO contract provides that the MCO must cooperate with the HHSC-OIG when the HHSC-OIG imposes payment suspensions or payment holds. When the HHSC-OIG sends notice that payments to a provider have been suspended, the MCO must also suspend payments to the provider. This payment suspension is in place while the HHSC-OIG or governmental authorities investigate a credible allegation of fraud, waste, or abuse by an MCO network provider.

Christus does not determine credible allegations of fraud or initiate suspensions. When notified by the HHSC-OIG, Christus places the provider on payment hold and relays that information back to the HHSC-OIG. To date, none of the providers identified by the HHSC-OIG have been in Christus's network nor have they paid any claims to providers identified by the HHSC-OIG.

DentaQuest refers all credible allegations of fraud immediately upon identification to the HHSC-OIG in compliance with 42 CFR 455.23, and DentaQuest's *Fraud Prevention and Recovery Policy 700.003*. DentaQuest will initiate suspensions of network providers in situations of imminent harm to members or the program based on a credible allegation of fraud, and suspend payments upon notification from the state.

FirstCare does not have a suspension policy. It will suspend payments upon notification from the state.

Payment suspension does not occur often with MCNA. Payment holds are initiated upon a credible allegation of fraud; willful misrepresentation; or abuse for which an investigation is pending against that provider or facility. Payment suspensions are reported to the state monthly on the HHSC's *Open Case List* report. During SFY 2015, nine providers were placed on payment hold. Prior to SFY 2015, MCNA only placed providers on hold pursuant to credible allegation of fraud (CAF) hold requests received from the HHSC-OIG.

Sendero has not suspended payments to any providers and does not determine credible allegations of fraud or initiate suspensions. It will hold provider payments, upon notification from the HHSC-OIG. Sendero attributes their pre-payment edit review process as preventing inappropriate claims payments that resulted in approximately \$34 million in denied claims during the review period; however, no documentation was provided to substantiate these cost avoidance measures.

Terminated Providers and Adverse Action Reporting

The managed care contract requires the MCOs to exclude/terminate providers from the MCO network that have been identified as having HHSC-OIG sanctions; failing to renew license or certification registration; possessing a revoked professional license or certification; or being terminated by the state Medicaid agency. On a monthly and quarterly basis, the MCO shall report to the HHSC-OIG all instances of suspected provider fraud, abuse, or waste.

The HHSC-OIG indicated that they do not terminate providers; they only disenroll MCO providers. During the onsite review, it was learned that Texas is not entering terminated providers into the TIBCO system. After the interview, the state noted that they will begin to enter the MCOs' terminated providers into the TIBCO system. The HHSC-OIG receives terminated provider information from the MCOs in their quarterly compliance reports.

**Texas Focused Program Integrity Review Final Report
December 2016**

The table below depicts the number of terminated providers reported by each of the MCOs.

Table 6.

MCOs	Total # of Providers Disenrolled or Terminated in Last 3 Completed FFYs		# of Providers Terminated For Cause in Last 3 Completed FFYs	
	2012 – 2014	315	2012 – 2014	1
Christus	2012	47	2012	0
	2013	24	2013	0
	2014	51	2014	1
DentaQuest	2012	723	2012	3
	2013	710	2013	5
	2014	582	2014	2
FirstCare	2012	106	2012	0
	2013	357	2013	0
	2014	292	2014	2
MCNA	2012	29	2012	0
	2013	294	2013	0
	2014	242	2014	0
Sendero	2012	29	2012	0
	2013	294	2013	0
	2014	242	2014	0

Overall, the number of providers terminated for cause by the MCOs appears to be very low, compared to the number of providers in each of the MCOs’ networks and the number of providers disenrolled or terminated for any reason.

Federal Database Checks

The regulation at 42 CFR 455.436 requires that the state Medicaid agency must check the exclusion status of the provider, persons with an ownership or control interest in the provider, and agents and managing employees of the provider on the U.S. Department of Health and Human Services-Office of Inspector General’s List of Excluded Individuals and Entities (LEIE); the Excluded Parties List System (EPLS) on the System for Award Management (SAM); the Social Security Administration’s Death Master File (SSA-DMF); the National Plan and the Provider Enumeration System upon enrollment and reenrollment; and check the LEIE and EPLS no less frequently than monthly.

The state contracts with the TMHP to complete the federal database checks for most providers. However, state staff completes the federal database checks for pharmacy providers. Additionally, the TMHP contract also requires them to send out the state’s explanation of benefits (EOB). The HHSC-OIG and the MFCU also utilize the TMHP during their investigations to send out targeted EOBs.

During the interview with Christus, the MCO was unable to confirm if monthly checks of the LEIE and EPLS were performed. Additionally, the MCO confirmed organizational level checks of the federal databases were conducted for employees and vendors, but not for owners, agents, and managing employees in accordance with 42 CFR 438.610.

Texas Focused Program Integrity Review Final Report December 2016

According to the documentation from FirstCare, the MCO checks all the required databases; however, the document did not address the frequency for each of the checks. During the interview, FirstCare was unable to confirm if monthly checks of the LEIE and EPLS were performed. Additionally, the MCO confirmed organizational level checks of all applicable federal databases were conducted for employees and vendors, but not for owners, agents, and managing employees.

The MCNA depends on the state for initial enrollment of Medicaid providers. The MCO then credentials and re-credentials providers and checks the databases every month thereafter. However, the SSA-DMF is not checked upon initial enrollment.

Sendero does not check all the required databases for individual and entities. The LEIE, EPLS, and SSA-DMF checks were not performed in accordance with 42 CFR 455.436. During the interview, the MCO confirmed that organizational level checks of the federal databases for owners, agents, and managing employees are not conducted.

In addition, each MCO plan is required to credential and recredential their providers. The plans are not consistent with the organizational level checks of federal databases for directors, partners, and others in accordance with 42 CFR 438.610. During interviews with the MCOs, the frequency for each of the checks was not always addressed and monthly checks of the LEIE and SAM were not able to be confirmed. Also, not all plans could confirm whether the SSA-DMF was checked.

Section 2: NEMT Oversight

The 83rd Regular Session (2013) of the Texas Legislature changed the manner in which NEMT services are delivered in an effort to improve transportation service delivery to clients; contain program costs; and reduce the incidence of fraud, waste, and abuse, effective September 1, 2014. Program administration and contract oversight is managed by MTP.

During interviews with the review team, it was learned that the MTP does have written policies and procedures addressing program integrity activities and related functions, such as referring suspected fraud and direction not to deprive recipients of MTP services during the investigation of a provider. The MTP assesses liquidated damages, rather than suspending provider payments.

The MTP and contracted vendor staff utilize a state portal to report suspected fraud, waste, and abuse to the HHSC-OIG. The MTP and contracted vendor staff may also report suspected fraud, waste, or abuse via the State Auditor's Office hotline or online fraud reporting page.

At the time of the review, two cases had been referred to the HHSC-OIG and were under investigation. The MTP staff reported that there has been ongoing communication with the HHSC-OIG regarding both referred cases. The HHS-OIG never initiated a payment hold action based on a credible allegation of fraud for either of these two cases; therefore, no contact was made with law enforcement as required under 42 CFR 455.23. When a payment hold action is initiated by the HHSC-OIG, law enforcement is contacted in writing to determine if the payment hold would compromise the criminal investigation. The required written response from law

Texas Focused Program Integrity Review Final Report December 2016

enforcement would be sent to the HHSC-OIG and maintained by the HHSC-OIG. There is no requirement for MTP to receive or maintain the written responses from law enforcement.

Since 2012, the HHSC-OIG has provided annual trainings on fraud, waste, and abuse to the MTP. Sign in sheets were provided for April 18, 2013 and April 19, 2013. No recent HHSC-OIG training sign in sheet documentation was provided by the state Medicaid agency.

The TMHP enrollment process exempts drivers who are not brokers or contracted by the state from the enrollment process. The NEMT drivers are neither enrolled by the TMPH nor monitored by the state MTP staff. This practice leaves the state vulnerable to potential fraud as the non-contracted or brokered NEMT providers are neither enrolled nor screened.

Recommendations

- The state should amend the MCO contract to include comprehensive fraud, waste, and abuse language that fully addresses all program integrity regulatory requirements for payment suspensions, and the performance of database checks.
- Develop and implement policies and procedures to facilitate stronger program integrity oversight of MCO program integrity activities. The policies and procedures should also address measures necessary to increase oversight for MCOs identified as not expending sufficient effort towards identifying and recovering overpayments to providers.
- The state should ensure that the MCOs establish and maintain an SIU that meets contractual requirements. Along with the efforts of third party contractors, the SIUs should assist in the identification of potential fraud, waste, and abuse, to increase MCO recoveries of overpayments to providers.
- Improve communication between the MCD and the HHSC-OIG through attendance and participation at regularly scheduled meetings that facilitate the active sharing of program integrity information with regard to providers/provider types at risk for fraud; complaints against network providers; and investigation coordination.
- A process for monitoring the MCOs' compliance plans should be implemented to ensure that each MCO is actually adhering to their compliance plan.
- The state should obtain evidence from its MCOs in support of any statements attributing a decline in overpayments as the direct result of cost avoidance activities or proactive measures in place. Some tangible examples of cost avoidance include a walk-through of the Medicaid Management Information System edits; written policies and procedures specifically addressing cost avoidance activities; documentation from contractors regarding measures instituted and resulting in cost avoidance; screenshots, documentation, tracking spreadsheets, samples, etc. from systems that demonstrate cost avoidance measures; or an explanation of any methodology employed that has resulted in deterring overpayments to providers.
- The state should create a better reporting process between the MCOs and the state, so that case referrals are clearly defined and result in a more consistent accounting of suspected fraud case referrals leading to both parties reflecting identical totals. The state should not rely on disenrollment as the primary method to remove providers terminated from the MCO networks.
- The state must enter terminated providers into the TIBCO system, upon receiving their information from the MCOs.

Texas Focused Program Integrity Review Final Report December 2016

- The state should confirm that all MCO delegates are searching the LEIE; EPLS; SSA-DMF; and National Plan & Provider Enumeration System upon contract execution, and check the LEIE and EPLS monthly thereafter for the names of any person with an ownership or control interest or who is an agent or managing employee.
- The state should develop written policies and procedures for the MTP to address program activities, related activities, and functions such as suspending provider payments; and terminating NEMT providers from the program.
- The state should develop and implement a process to address NEMT enrollment, NEMT provider screening, and oversight.

Section 3: Status of Corrective Action Plan

Texas's last CMS program integrity review was in February 2010, and the report for this review was issued in April 2011. The report contained five findings and six vulnerabilities. During the on-site review in February 2010, the CMS review team conducted a thorough review of the corrective actions taken by Texas to address all issues reported in calendar year 2011. The findings of this review are described below.

Findings

1. *The HHSC-OIG notice of payment withholding does not include all of the required information.*

Status at time of the review: Corrected in February 2010, while the MIG review team was onsite, the HHSC-OIG modified its template for payment hold notices to include language that references 42 CFR § 455.23.

2. *The state does not capture all required ownership, control, and relationship information in its FFS operations and from the fiscal agent, Medicaid MCOs, and transportation service area providers. (Repeat Finding)*

Status at time of the review: Corrected

On March 25, 2011, the Affordable Care Act requirements took effect for newly enrolling providers and on March 25, 2012, the requirements took effect for all providers. However, these changes in federal law first required passage of state-level statutory authority for the HHSC to implement the requirements. This occurred when the Texas Legislature, as part of its 82nd regular legislative session, passed the necessary state-level statutory authority which became effective on September 1, 2011.

Effective in 2012, the HHSC also assigned to the OIG the responsibility for ensuring implementation of the requirements of the legislation which reflects the new disclosure and screening requirements from the FFS, fiscal agent, and MCOs. The Medical Transportation Service Area Provider new application form containing all of the required disclosures became effective in May 2015 and began with reenrollment of all providers.

3. *Transportation and Vendor Drug Program provider enrollment applications do not require disclosure of certain business transactions upon request. (Repeat Finding)*

**Texas Focused Program Integrity Review Final Report
December 2016**

Status at time of the review: Corrected

- The state modified all Transportation Service Area Provider contracts to require compliance with *42 CFR § 455.105(b)(c)*.
- Vendor Drug Program contracts were modified to require compliance with *42 CFR § 455.105(b)(c)*.

4. *Texas MTP provider enrollment applications do not capture required criminal conviction information. (Repeat Finding)*

Status at time of the review: Corrected

The state has modified provider enrollment applications and contracts to meet the full criminal conviction disclosure requirements of the regulation.

5. *The state does not report adverse actions taken on MTP provider applications to the HHS-OIG.*

Status at time of the review: Corrected

The state has developed and implemented procedures to collect and report all actions taken against and limits placed on providers applying to participate in the program to HHS-OIG.

Vulnerabilities

1. *Not capturing managing employee information in the transportation program and for MCO network providers.*

Status at time of the review: Corrected

Texas Medicaid requires all managed care network providers to first enroll through the primary fiscal agent; managing employee information is obtained in connection with those enrollments. Therefore, it is unnecessary to again require disclosure of such information in connection with the provider then joining an MCO network. The HHSC-OIG concurs with the finding and recommendation with respect to the MTP and corrective actions have been successfully implemented.

2. *The state does not collect disclosure of ownership, control, and relationship information from managed care providers.*

Status at time of the review: Corrected

This vulnerability was corrected in above finding number two.

3. *The state does not verify with managed care beneficiaries whether services billed by providers were received. (Repeat Vulnerability)*

Status at time of the review: Corrected

Texas Focused Program Integrity Review Final Report December 2016

This action was implemented in 2011. The HHSC-OIG requested that each MCO include its solution for the above finding in the annual waste, fraud, and abuse plan, and that it must be filed with and approved by the HHSC-OIG. This is now a requirement in their fraud, waste, and abuse compliance plans.

4. The state does not have adequate written policies and procedures.

Status at time of the review: Corrected

Policies and procedures were drafted through collaboration between the HHSC-OIG, the HHSC Managed Care Operations, and the Medicaid participating MCOs.

5. The state does not conduct complete exclusion searches.

Status at time of the review: Corrected

Developed and implemented policies and procedures for appropriate maintenance of disclosure information to ensure that the FFS program, contracted MCOs, transportation broker, and network providers conduct exclusion searches using the LEIE (or the Medicare Exclusion Database) and the EPLS at the time of provider enrollments, re-enrollments, and at least monthly thereafter in accordance with SMDLs #08-003 and #0001.

6. Not reporting to HHS-OIG adverse actions taken on managed care provider applications.

Status at time of the review: Not corrected

Texas will begin reporting the required information to the HHS-OIG, moving forward. However, the state does not currently notify the HHS-OIG regarding adverse actions taken against managed care providers.

Technical Assistance Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance resources for Texas to consider utilizing:

- Use the program integrity review guides posted in the Regional Information Sharing Systems as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the Regional Information Sharing Systems for information provided by other states including best practices and managed care contracts.
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute which can help address the risk areas identified in this report. Courses that may be helpful to Texas are based on its identified risks include those related to managed care. More information can be found at <http://www.justice.gov/usao/training/mii/>.
- Regularly attend the Fraud and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity

Texas Focused Program Integrity Review Final Report December 2016

oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. The CMS annual report of program integrity reviews includes highlights of states that have been cited for noteworthy and effective practices in managed care. These reports can be found at <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/StateProgramIntegrityReviews.html>

- Access the Toolkits to Address Frequent Findings: 42 CFR 455.436 Federal Database Checks website at <http://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/fftoolkit-federal-database-checks.pdf>.

Conclusion

The CMS focused review identified areas of concern and instances of non-compliance with federal regulations which should be addressed immediately.

We require the state to provide a CAP for each of the recommendations within 30 calendar days from the date of the final report letter. The CAP should address all specific risk areas identified in this report and explain how the state will ensure that the deficiencies will not recur. The CAP should include the timeframes for each correction along with the specific steps the state expects will take place, and identify which area of the state Medicaid agency is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the CAP such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of the letter. If the state has already taken action to correct compliance deficiencies or vulnerabilities, the CAP should identify those corrections as well.

CMS looks forward to working with Texas to build an effective and strengthened program integrity function.



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

CHARLES SMITH
EXECUTIVE COMMISSIONER

February 16, 2017

Ms. Laurie Battaglia
Director, Division of State Program Integrity
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Mailstop: AR-21-55
Baltimore, Maryland 21244-1850

Subject: Texas Focused Program Integrity Review Final Report Corrective Action Plan

Dear Ms. Battaglia:

The Texas Health and Human Services Commission (HHSC) received a final report entitled "Texas Focused Program Integrity Review Final Report" from the Centers for Medicare and Medicaid Services Center for Program Integrity Investigations and Audits Group. The cover letter, dated December 7, 2016, requested that HHSC provide a corrective action plan for each recommendation in the report, including any outstanding items from the prior 2010 review, as well as an explanation for any corrective action that will not be implemented within 90 days from the date of the letter.

I appreciate the opportunity to respond. Please find the attached HHSC management response which (a) includes comments related to the content of the findings and recommendations, (b) details actions HHSC has completed or planned, and (c) provides explanations for corrective actions that will not be completed within 90 days from the date of the final report cover letter.

If you have any questions or require additional information, please contact David M. Griffith, Deputy IG for Audit, HHSC Inspector General. Mr. Griffith may be reached by telephone at (512) 491-2806 or by e-mail at David.Griffith@hhsc.state.tx.us.

Sincerely,

A handwritten signature in black ink, appearing to read "J. J. Snyder".

Jamie Snyder

Associate Commissioner, Medicaid and CHIP Services Department

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