TEXAS
Health and Human
Services Commission

Presentation to the Senate Finance Medicaid Subcommittee:
Prevention and Detection of Fraud, Waste and Abuse

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February 15, 2011

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Overview

The Texas health and human services system is responsible for ensuring the highest level of integrity and fiscal accountability in the programs it provides.

Through its fraud prevention and detection programs, the HHSC Office of the Inspector General (OIG) reports overall cost recoveries for Fiscal Year 2010 of $487 million, and cost avoidance of $348 million, which helps ensure the integrity of taxpayer-funded assistance for Texas' neediest citizens.

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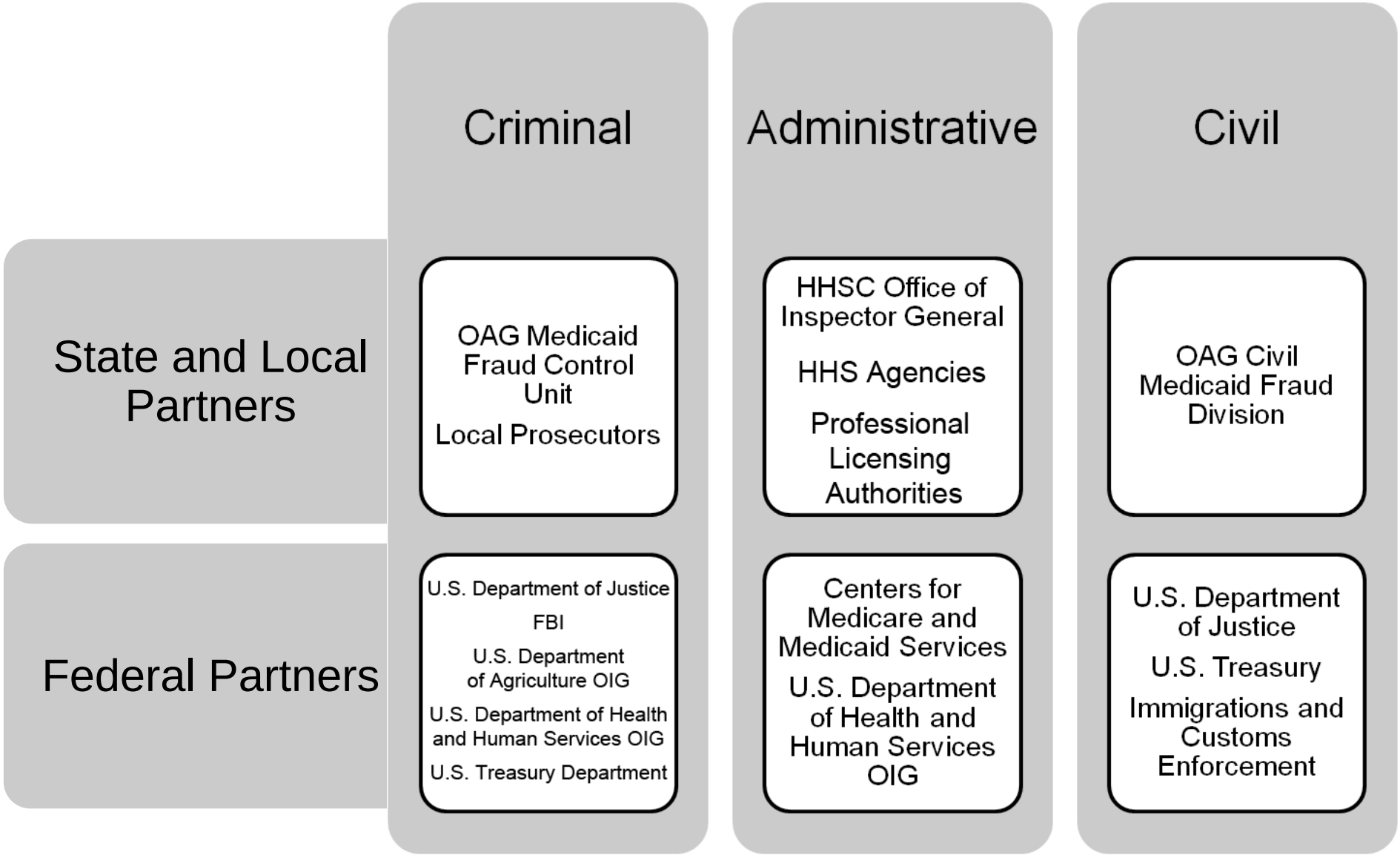
Federal, State and Local Partners



HHSC Fraud, Waste and Abuse Oversight and Coordination

There are four HHSC divisions with primary fraud prevention and detection responsibilities within the public assistance programs:

- Office of the Inspector General
  - Primary responsibility over protecting the integrity and accountability of all HHS programs, as well as the beneficiaries of those programs, by identifying, investigating and correcting activities of waste, fraud or abuse.
- Medicaid Division
  - Ensures the proper payment of Medicaid claims and conducts quality assurance reviews of paid and denied claims to ensure the integrity of the Medicaid claims payment system.
- Office of Eligibility Services (OES)
  - Ensures only eligible clients receive public assistance benefits.
- Internal Audit
  - Assesses the risk of fraud during annual risk assessments and individual audits; communicates fraud findings identified during internal and external audits to executive management, OIG, and appropriate program managers; and coordinates with CMS on federal audit and review initiatives designed to identify and collect Medicaid and CHIP overpayments.

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Medicaid Fraud, Waste and Abuse Coordination

HHSC and the Office of Attorney General

- OAG Medicaid Fraud Control Unit
  - OIG works with MFCU under a statutorily required memorandum of understanding. OIG is obligated to refer every case or complaint that may indicate criminal conduct to MFCU.
    - Each allegation received by OIG begins with an integrity review to determine whether OIG should conduct a full-scale investigation. If this review indicates criminal conduct, the matter is also referred to MFCU.
    - OIG and MFCU coordinate their respective cases through regular monthly meetings. OIG focuses on administrative enforcement, while MFCU focuses on criminal violations.
    - When MFCU secures a conviction against a provider, OIG excludes the provider from participation in the Medicaid program.
    - OIG consults MFCU on provider enrollment requests that may impact on a MFCU investigation.
- OAG Civil Medicaid Fraud Division
  - HHSC General Counsel works with the Civil Medicaid Fraud Division to provide assistance as requested.
    - When a civil case results in a settlement or other monetary recovery, OIG's Sanctions Section coordinates putting that money back into the Medicaid program.

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Fraud Prevention Programs

- OIG Provider Education Campaign:
  - Provides training to providers on compliance requirements that are conditions of participation in the Medicaid program (i.e., self-reporting of overpayments, provider employee education on whistleblower protections, and how to report fraud, waste and abuse to the OIG).

- OES Internal Controls:
  - Requires eligibility staff to run Data Broker on most applications to assess eligibility from various data sources before benefits are issued; requires increased case file reviews to ensure that eligibility is properly determined, and finger-imaging is conducted as required to detect duplicate participation and deter fraud.

- OES Employee Training:
  - Implementing improved fraud awareness training, including a video from the OIG on how to report fraud; requires all new hires to acknowledge in writing their obligation to identify and report suspected fraud, waste and abuse.

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Fraud Prevention Programs

- Medicaid Provider Education and Training:
  - Educates providers on fraud, waste and abuse through the Medicaid Provider Procedures Manual, Medicaid bulletins, provider workshops, periodic provider messages, and through onsite visits.
  - Notifies providers and other entities that receive or make annual Medicaid payments of $5 million or more that they must educate employees, contractors, and agents about federal and state fraud and false claims laws, and the whistleblower protections.
- Medicaid Proof-of-Concept Pilots to Test Accuracy of Systems:
  - Tests accuracy of current pre-payment and post-payment claim reviews, and improves ability to identify suspicious claims before payment is made.
- Medicaid Billing Coordination System (BCS):
  - Identifies within 24 hours whether another entity has primary responsibility for paying a claim and submits the claim to the primary payer; all private health insurers allow HHSC access to health insurance enrollment databases (HHSC implemented a pharmacy claims BCS in 2009).

Fraud Prevention Programs

- Internal Audit:
  - Evaluates and makes recommendations to improve or implement management controls within business processes designed to mitigate the risk of fraud.

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Fraud Detection Programs: Client Focus

- Medicaid/OES Data Matches:
  - Updates on a daily basis the Medicaid claims payment information with the state's eligibility information to ensure claims are paid only for eligible clients.
- OIG Data Matches:
  - Determines if clients have undisclosed or undeclared income or are disqualified by law (death, imprisonment, etc.) from receiving benefits.
- OIG Limited Program:
  - Selected Medicaid clients are assigned to designated primary care providers/pharmacies when evidence indicates the client has committed abuse, misuse, or suspected fraudulent actions related to a Medicaid benefit or service.
- OIG Medicaid Fraud and Abuse Detection System (MFADS):
  - Analyzes established patterns and trends of provider billing and client utilization activities, particularly any outliers, which may lead to recoveries, provider education, referrals to other state agencies, and legal action.
  - Used daily by OIG staff to pull pre-defined automated analyses of claim activity and related data, as well as to extract custom reports of paid claim data and related information for human intelligence analysis.

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Fraud Detection Programs: Client Focus

- OIG Foreign-National Fraud Initiative
  - Joint initiative between HHSC OIG and the Houston Fraud Detection National Security/United States Citizenship & Immigration Services to uncover beneficiaries who have entered into a "sham marriage" with a foreign national to circumvent immigration law.
  - Since the inception of the pilot in 2005, more than 150 cases have been confirmed as public assistance benefit fraud, immigration fraud, or both.

- OIG Fraud Hotline and Texas 2-1-1
  - The public can report suspected cases of fraud, waste and abuse by clients or providers by: calling the OIG hotline (1-800-436-6184), dialing 2-1-1, or completing an online form at https://oig.hhsc.state.tx.us/. These are the primary avenues of referral for cases of fraud, waste, and abuse.

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Fraud Detection Programs: Provider Focus

- Medicaid Provider Enrollment Process:
  - Verify with the respective licensing board that the applying provider holds an active license (traditional Medicaid and managed care providers).
  - Check provider name and information against exclusion lists to verify the provider is eligible to enroll in Medicaid (traditional Medicaid and managed care providers).
  - Search National Practitioner Database for malpractice cases reported in the last five years (Medicaid managed care providers only).
  - Perform an initial onsite visit, followed by regular visits every two years (Medicaid managed care providers only).
  - Submit application to the OIG for a criminal background check (all provider types and programs). OIG also checks for licensure actions and restrictions, performs research to confirm the accuracy of disclosures on the enrollment application, and performs on-site inspections of Durable Medical Equipment (DME) providers that apply for enrollment.
  - Conduct credentialing for managed care providers to ensure adherence to the National Committee for Quality Assurance guidelines.

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Fraud Detection Programs: Provider Focus

- OIG Surveillance and Utilization Review:
  - Utilization review identifies providers with practice patterns that are inconsistent with federal/state requirements, and fall outside the norm of provider peer groups.
  - Inappropriate service utilization may result in recoupment of overpayments and/or sanctions, or other administrative actions.

- OIG Research, Analysis, and Detection (RAD) Unit
  - Performs a variety of utilization review activities to monitor FFS and PCCM Medicaid services and performs pre-payment review of claims submitted by certain providers.

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Fraud Detection Programs: Service/Claim Focus

- Medicaid Claims Processing Edits/Audits:
  - Provider and Client Eligibility Verification
    - 400 edits to verify that the medical visit occurred and an enrolled provider appropriately treated a Medicaid client.
    - One type of edit validates that the procedure or service is appropriate for the type of provider filing the claim. For example, if a chiropractor filed a claim to be reimbursed for performing heart surgery, the edit would deny the claim.
  - Health Insurance Portability and Accountability Act (HIPPA) Edits
    - 1,000 edits to ensure electronic claim forms contain valid data, as defined by HIPPA; claims that do not meet the guidelines are returned to the submitter.
    - HIPPA edits are similar to Provider and Client Eligibility Verification edits, but HIPPA edits focus on electronic claims. HIPPA edits validate that the procedure or service is appropriate for the type of provider filing the claim. For example, an occupational therapist would not be reimbursed for a special spectacles fitting.
  - Benefit and Service Validation
    - 500 automated checks that compare the data on the current claim to prior claims for the patient to ensure that services performed were appropriate.
    - For example, if a provider submitted a claim for the amputation of the client's left arm, but an audit finds that the client's left arm was amputated four years before, the claim would be denied.

Fraud Detection Programs: Service/Claim Focus

- Medicaid Claims Processing Edits/Audits, continued
  - Medicaid Medical Policy Development:
    - Benefits Management Workgroup develops and reviews Medicaid medical benefits policy to determine coverage for services and allows HHSC to place appropriate limitations and restrictions on claim payments.
  - Medicaid Prior Authorization/Pre-certification:
    - Certain services require a provider to submit a prior authorization (PA) request to allow HHSC to assess medical necessity before the service is provided.
    - If a provider's PA request is denied, and the provider submits a claim for the service, the claims processing system denies the claim.
    - Examples of services requiring PAs include, but are not limited to:
      - Durable medical equipment (wheelchair, etc.)
      - Private Duty Nursing (PDN) (medically necessary skilled nursing for clients who require individualized, continuous skilled care)
      - Physical/Occupational therapy
      - Scheduled surgeries

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Fraud Detection Programs: Service/Claim Focus

- Medicaid Durable Medical Equipment Verification:
  - Implementing a verification process for high-cost durable medical equipment (DME) products that cost $2,500 or more.
- Medicaid Claims Payment Quality Assurance:
  - A post-payment quality assurance review of a statistically valid sample of adjudicated claims (paid and denied) is conducted on a monthly basis to identify training or system issues.
- OIG Third Party Recovery:
  - Compares known health insurance coverage against paid claims history using the Texas Automated Recovery System (TARS) to identify potentially recoverable funds.
- OIG Women, Infants, and Children Program (WIC) Vendor Monitoring
  - Conducts onsite visits of grocery stores to ensure compliance with WIC state and federal regulations.
- OIG Review of Resource Utilization Groups (RUGs) Assessments
  - OIG conducts on-site reviews of nursing facilities to confirm whether the level of need that the facility assessed for each resident is consistent with the appropriate RUGs level to ensure the correct amount is paid to the facility for the resident's care.

Fraud Detection Programs: Service/Claim Focus

Internal Audit coordinates two Centers for Medicare and Medicaid Services (CMS) programs that were implemented to reduce payment errors and to eliminate fraud, waste, and abuse in Medicaid and CHIP:

- Payment Error Rate Measurement (PERM)
  - CMS uses the results of medical payment reviews, performed by CMS contractors, and eligibility reviews, performed by HHSC Office of Family Services staff, to measure improper payments in the Medicaid and CHIP programs.

- Medicaid Integrity Program (MIP)
  - CMS contractors review Medicaid provider actions, audit individual provider's claims, identify and collects overpayments, and educate providers and others on Medicaid integrity issues.

Fraud Detection Programs: Service/Claim Focus

Additional audits and reviews related to eligibility determination, claims adjudication, and payment processing in Medicaid include the following:

Audits and Reviews by Oversight Entities:

- State Auditor's Office
- KPMG
- United States Department of Health and Human Services Office of Inspector General
- United States Department of Agriculture Office of Inspector General
- United States Government Accountability Office
- Texas Comptroller of Public Accounts Cost Recovery Audits
- Texas Education Agency School Health and Related Services (SHARS) Reviews

Audits and Reviews Procured by HHSC:

- Disproportionate Share Hospital Audits
- Upper Payment Limit Audits
- Statement on Standards for Attestation Engagements (SSAE 16) Reviews of Service Organizations
- Managed Care Financial Statistical Report Reviews
- Audits of Medicaid/CHIP Division Contractors
- Credit Balance Audits/Reviews
- Diagnosis Related Group (DRG) Cost Containment Initiative (contingency audits of DRG claims)

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New Fraud Prevention and Detection Initiatives

- HHS Employee Communication to Reinforce Reporting Responsibility
  - Ongoing periodic notification sent by the Executive Commissioner to ensure all employees understand their obligation to report suspected activities of fraud, waste and abuse

- OIG Public Awareness Campaign:
  - Raises awareness of fraud, waste and abuse in public assistance programs through aggressive outreach and ensure the public knows how to report suspected activities of fraud, waste and abuse to the OIG.

- OIG Revisions to Internal Policy to Clearly Establish Oversight Responsibilities:
  - Improves communication between OIG and HHS program managers, clearly delineates responsibilities regarding program integrity measures, and ensures program integrity requirements are being addressed in compliance with state and federal law.

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New Fraud Prevention and Detection Initiatives

- OIG Fraud Hotline and Website Redesign
  - Improves how OIG receives and processes calls from its fraud reporting hotline; OIG is also in the process of creating a more user-friendly website.

- OIG EBT Fraud Prevention Initiative:
  - Improves outreach and coordination with local law enforcement agencies through distribution of a poster that explains how OIG can assist with EBT trafficking and related issues.

  - Distributed to forty-seven local prosecutors the nation's first *Prosecutor's Predicate Manual for Welfare Fraud*, which is a model "trial notebook" to assist local prosecution authorities with cases that are referred by OIG. OIG is preparing to make this confidential resource available through its website to all local prosecutors.

- OIG Redesign of Investigation Processes:
  - Improves OIG processes for recipient investigations to maximize efficiency and productivity within existing resources; focuses resources on cases with the strongest supportive evidence and highest likelihood for monetary recovery.

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New Fraud Prevention and Detection Initiatives

- OIG Computer-Based Training for Providers:
  - Computer-based training modules for the provider community are under development to serve as self-paced education that will be available to the provider at the provider's convenience.
  - Topics will include understanding requirements for information disclosure at enrollment; explaining the requirements and procedures for reporting discovered overpayments; and understanding how to fulfill the requirement to have an internal compliance program as well as best practices for an effective compliance program.

- OIG Electronic Library:
  - Creates a central resource tool of all OIG policies and procedures to serve as the foundation for an OIG total quality assurance program.