Presentation to House Committee on Government Efficiency & Reform

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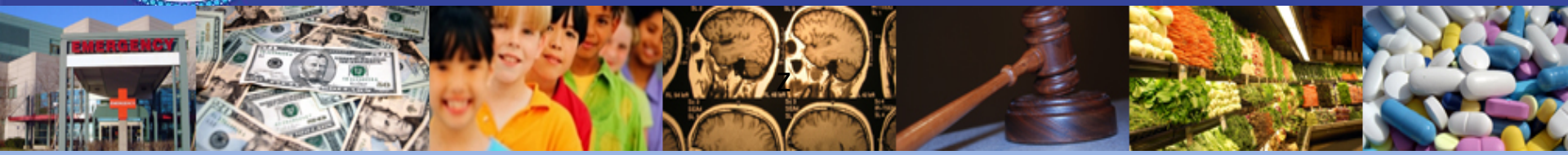
Texas Health and Human Services Commission

Office of Inspector General



Overview

Created in 2003, OIG is legislatively tasked with preventing, detecting, and deterring fraud, waste, and abuse in the Texas Health and Human Services System.

Prevention, Detection, Pursuit

OIG performs its work in three ways:

- **Preventing** fraud, waste, and abuse before it starts.
- **Detecting** fraud, waste, and abuse after it occurs.
- **Pursuing** those who seek to abuse and defraud the system.

OIG Functions

Auditing, investigating, and reviewing the use of state and federal funds

- Monitor the use of contract and grant funds administered by a person or state entity receiving the funds from a Health and Human Services agency.
- Ensure that the use of all state and federal money is in accordance with state and federal law.

Researching, detecting, and identifying fraud, waste, and abuse to ensure accountability and responsible use of resources

- Ensure accountability and the responsible use of resources.
- Includes provider-self reporting, public fraud reporting hotline, automated detection technology, and human and artificial intelligence.

OIG Functions

Conducting investigations, reviews, and monitoring cases internally

- OIG investigates allegations of fraud, waste and abuse committed by program recipients, HHS employees, Medicaid providers, criminal incidents at state supported living centers, and fraud or misuse of vital statistic records.
- OIG takes enforcement action based on results of each investigations or review.
- Some cases may be referred to outside entities.

Issuing sanctions and performing administrative actions against providers and recipients

- Includes provider exclusion from participating in the Medicaid program, assessment of penalties against a provider, and recoupment of money paid to a program recipient or provider.
- While some violations may not be intentional, federal law still requires OIG to recoup the amount overpaid to a provider.

OIG Functions

Providing education, technical assistance, and training to the provider community

- OIG routinely offers presentations to providers to help promote best practices and sustain improved relationships with the provider community.

Recommending policies that enhance the prevention and detection of fraud, waste, and abuse

- OIG studies and recommends new prevention and detection mechanisms and policies, as well as changes to existing processes and procedures.

OIG 2012-2013 Accomplishments

Reorganization

- Completed a major internal reorganization
- Devoted more resources to Medicaid provider investigations, which results in a greater probability of recoupment
- Devoted resources to conduct investigations in State Hospitals
- Created a Managed Care Audit Unit

Productivity

- Increased Provider Investigations Completed from 12 in FY11 to 108 in FY12
- Shortened investigative timeframes from 4 years to 8-10 weeks
- Completed 36 orthodontia investigations representing a potential overpayment amount of $303 million dollars
- Completed 707 hospital reviews in FY12, identifying over $31 million in net overpayments for recovery
- Conducted 1,036 State Supported Living Center Investigations in FY12

OIG Internal Focus

Revisiting Priorities, Structure, Expectations, Timeliness

- Emphasize accountability both internally and externally
- Increase level of transparency
- Assess effectiveness and efficiency across OIG and make changes where necessary
- Use cross functional teams consisting of auditors, investigators, nurses, analysts, statisticians/actuaries and IT staff to ensure the best outcomes
- Improve responsiveness and timeliness in all areas

Improve internal and external relationships with State and Federal partners

- Work cooperatively with the Office of Attorney General (OAG), Centers for Medicare & Medicaid Services (CMS), local law enforcement and federal partners
- Meet regularly with stakeholders, managed care organizations (MCOs), and Enterprise staff
- Accept training and speaking invitations from providers and associations
- Improve relevance to agency operations

OIG Initiatives

Implemented ACA-Required Credible Allegation of Fraud (CAF) Holds

- Stopping payments when there is a credible allegation of fraud
- Failure to implement creates financial risk for the State; implementation creates prepayment protection for Title XIX expenditures
- As of February 11, 2013, 103 providers were subject to a payment hold
- Internal review process prior to hold and due process afforded to providers after hold is issued

Adopted New Provider Enrollment Rules Effective December 31, 2012

- Strengthens OIG's ability to prevent providers likely to engage in fraud, waste or abuse from enrolling in the program

Secured Federal CMS Funding for Graph Pattern Analysis Technology

- FY13 deployment will enable OIG to measure and track even small changes in trends and patterns of spending within Title XIX expenditures

OIG Initiatives

Planning stages for prepayment analytics RFP later this year as part of a new, multi-pronged approach to addressing fraud, waste, and abuse

Revised program requirements for Lock-In program

- Designates health care providers or pharmacies for those recipients who have abused Medicaid services or drugs.
- Coordinates the lock-in program with managed care organizational processes.

OIG External Focus

- Orthodontia Investigations
- General Dentistry
- DME (Durable Medical Equipment)
- Transportation
- Solicitation
- Hearing Aids
- Utilization Review
- Managed Care
- SNAP (Supplemental Nutrition Assistance Program)
- Comprehensive Outpatient Rehabilitation Facility (CORF)/ORF Therapies

CAF Holds

Payment Holds Due to a Credible Allegation of Fraud (CAF)

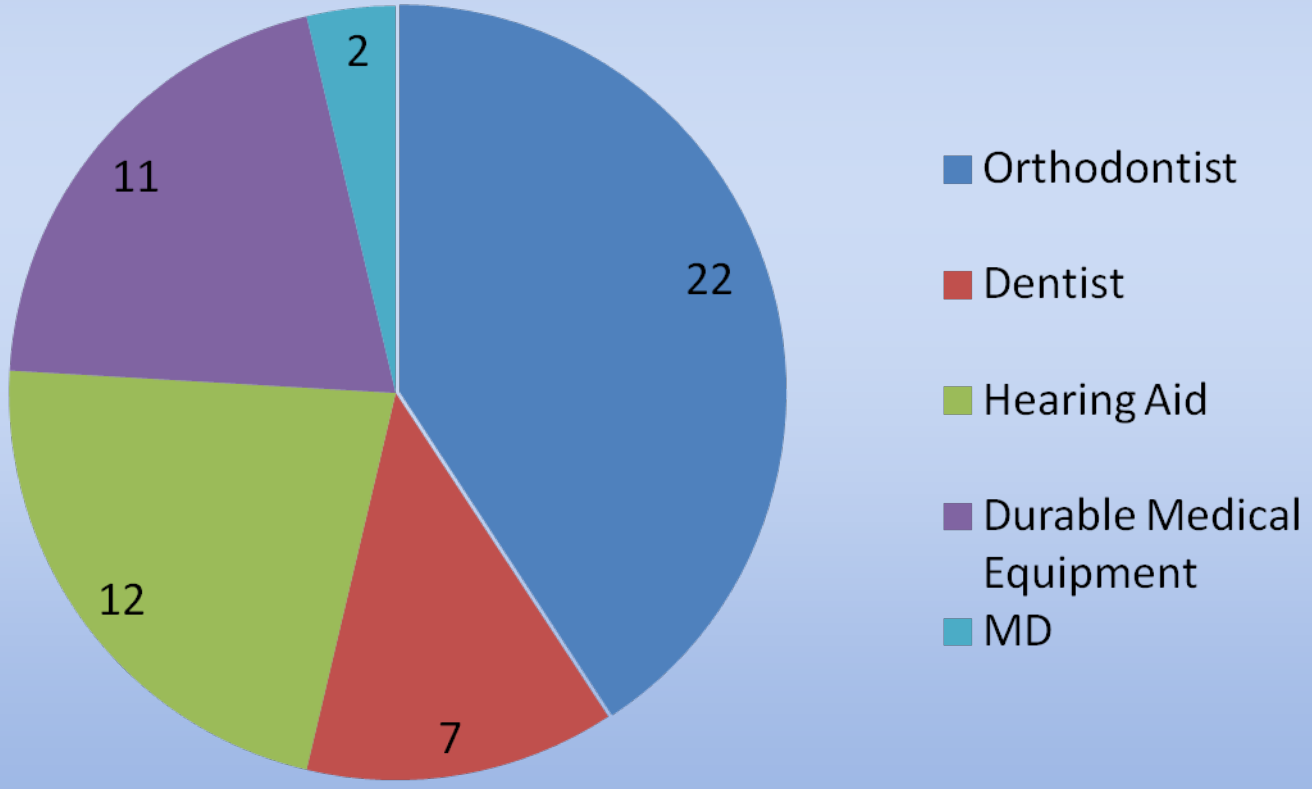
- New federal laws implemented in March 2011 require that OIG suspend all Medicaid payments to a provider after we verify a "credible allegation of fraud" under the Medicaid program.

- A "credible allegation of fraud" is "an allegation, which has been verified by the state, from any source." These sources include hotline complaints, data mining, patterns identified through audits, and law enforcement investigations. These allegations must have "indicia of reliability."
  - Supreme Court has defined "indicia of reliability": as statements which bear "particularized guarantees of trustworthiness.
  - Not absolute proof or preponderance – closer to probable cause or reasonable suspicion.
  - OIG evaluates all facts and circumstances, but generally requires three independent verification points which often include expert review.
  - Four levels of investigative review: investigator, manager, director and Deputy Inspector General. All cases referred to legal staff for formal implementation.

- All credible allegations of fraud are referred to the Attorney General's Medicaid Fraud Control Unit.

CAF Holds

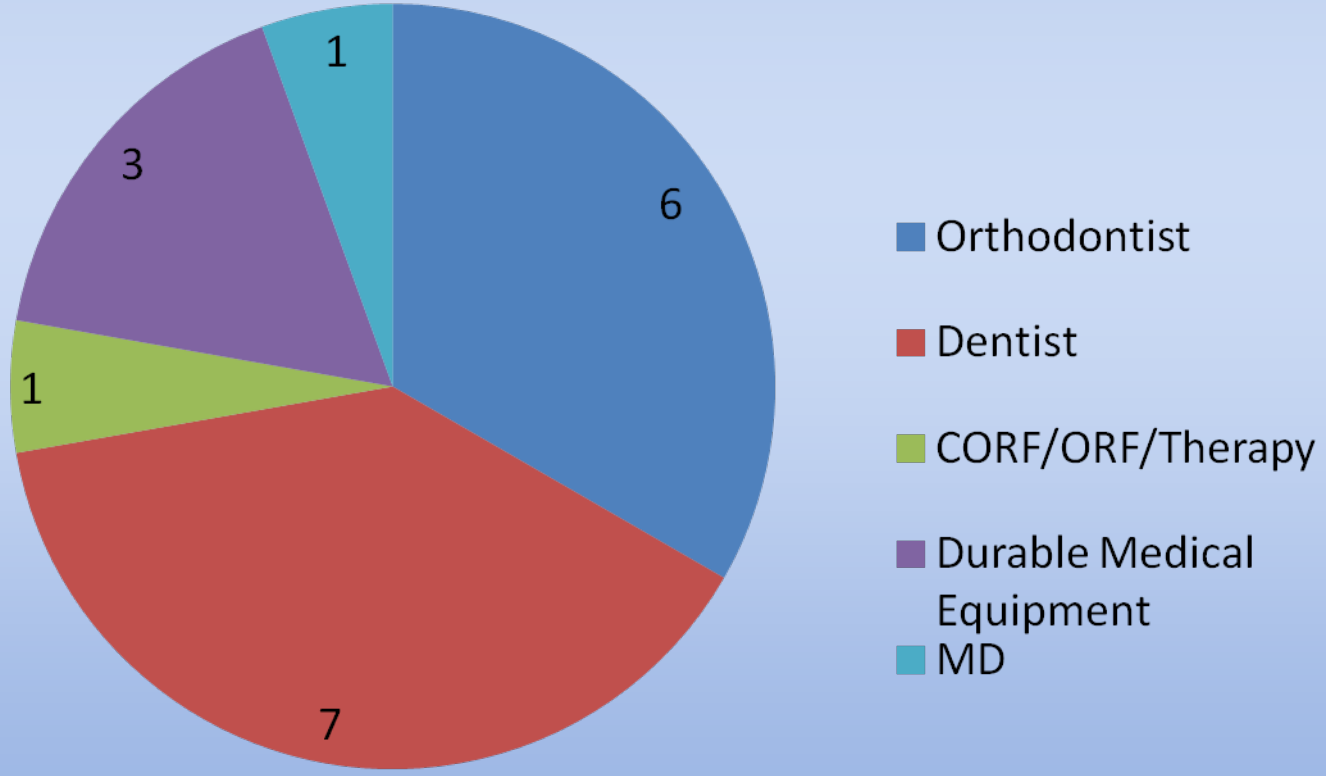
CAF Payment Holds Initiated by OIG – SFY 2012
By Provider Type



SFY 2012 Total: 54

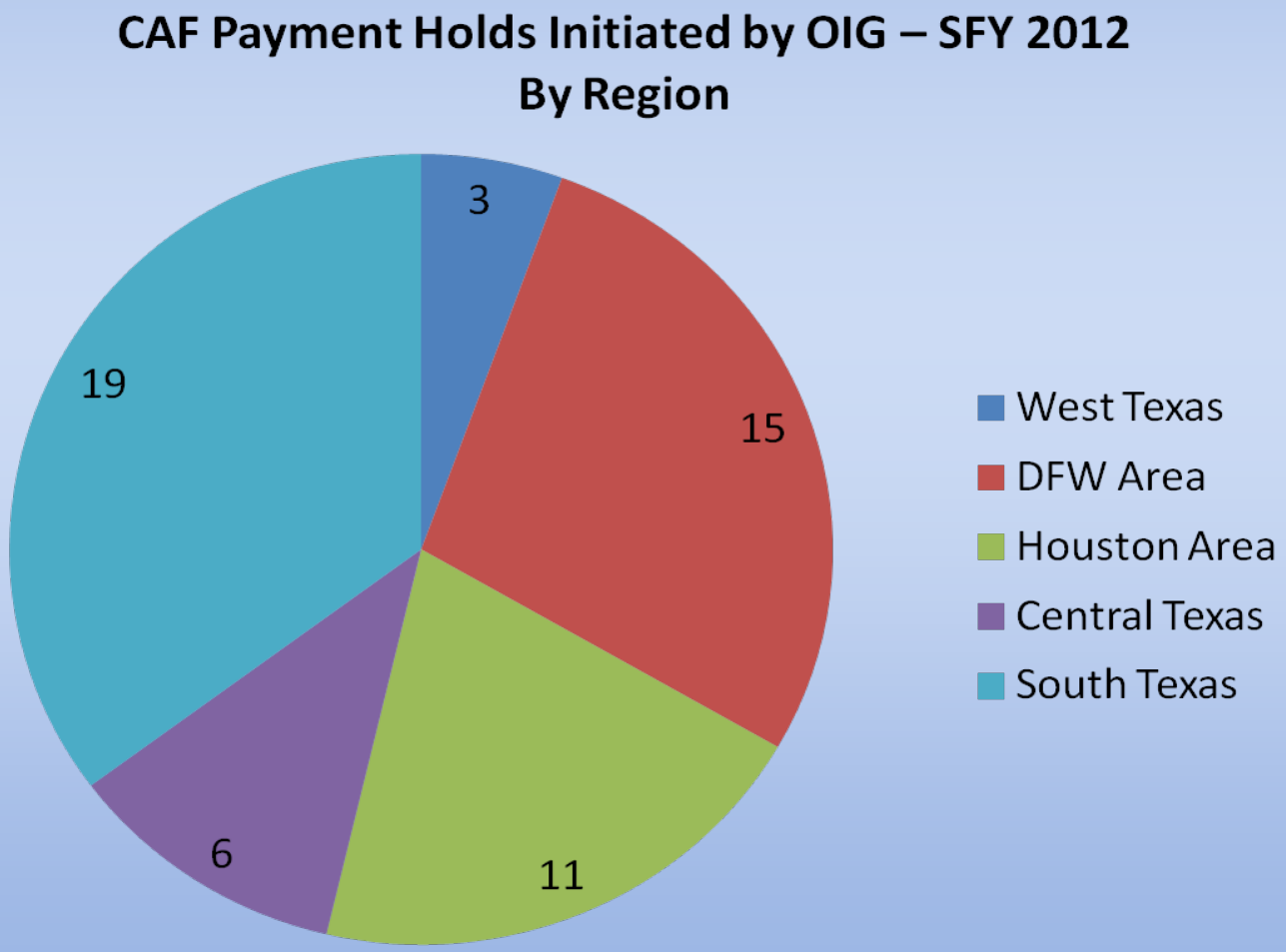
CAF Holds

CAF Payment Holds Initiated by OIG – SFY 2013
By Provider Type



SFY 2013 Total: 18

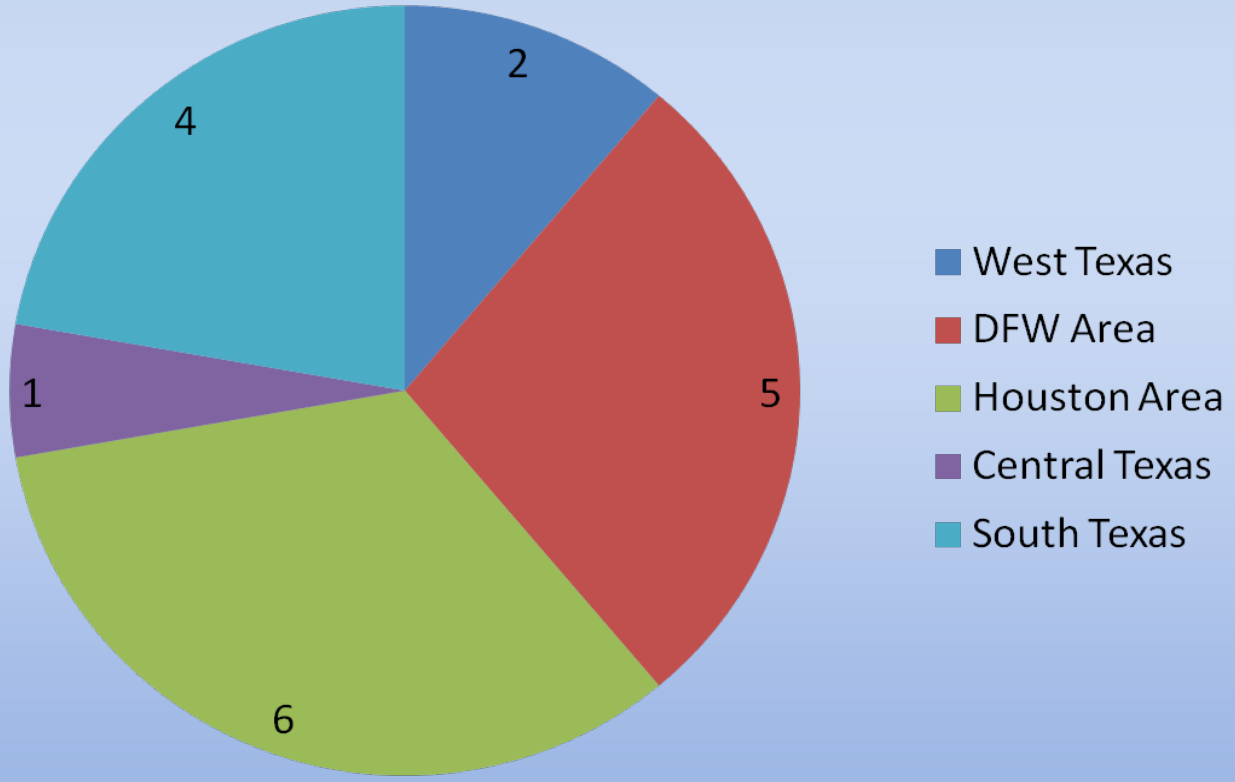
CAF Holds



SFY 2012 Total: 54

CAF Holds

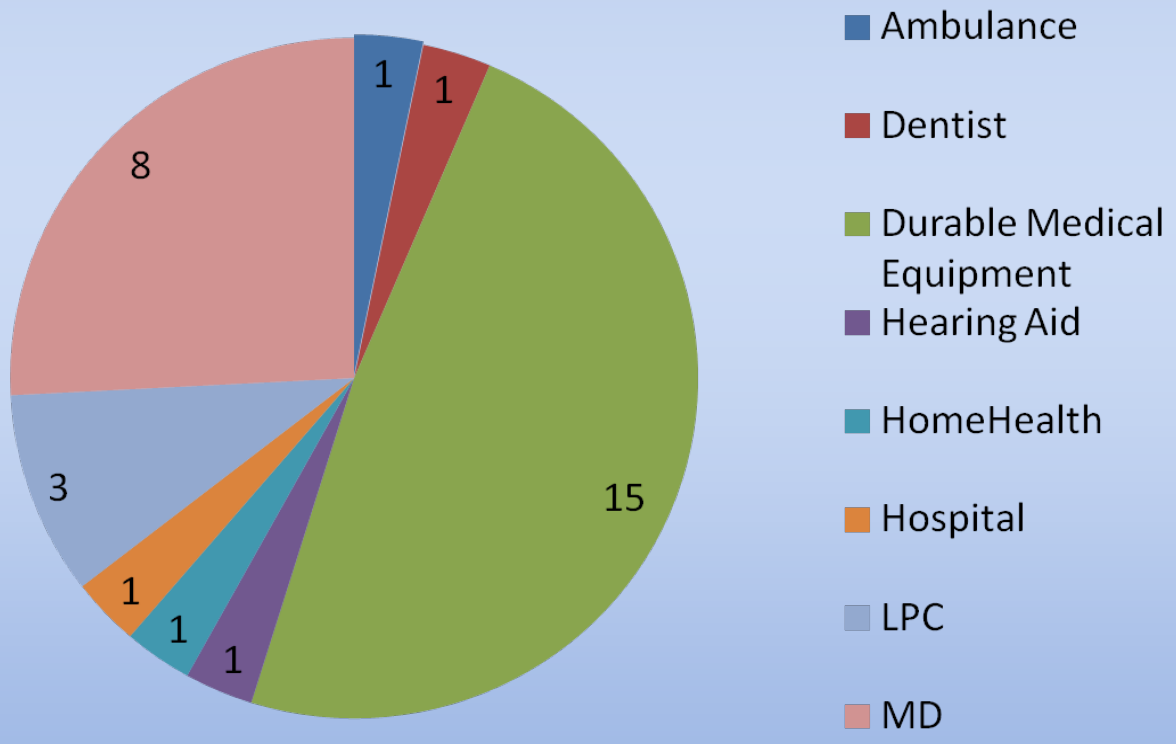
CAF Payment Holds Initiated by OIG – SFY 2013
By Region



SFY 2013 Total: 18

CAF Holds

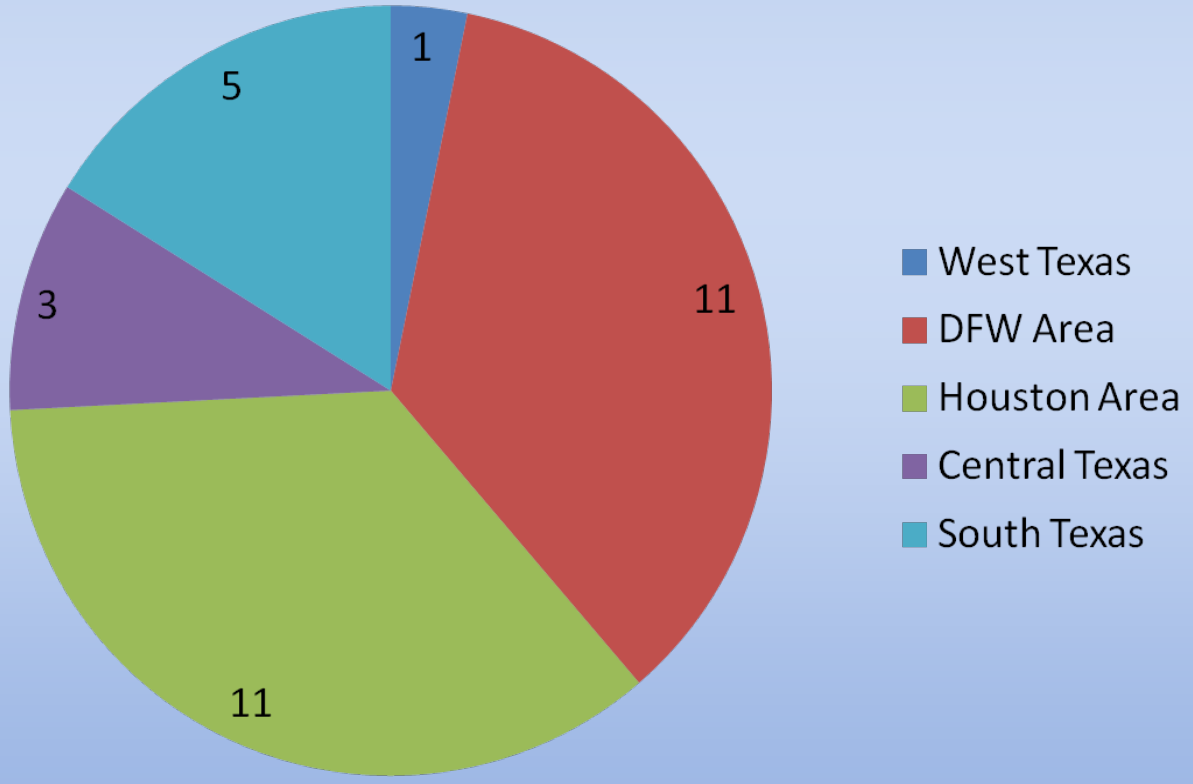
CAF Payment Holds Initiated by OIG Due to Attorney General Indictments - By Provider Type



SFY 2012/2013 Total: 31

CAF Holds

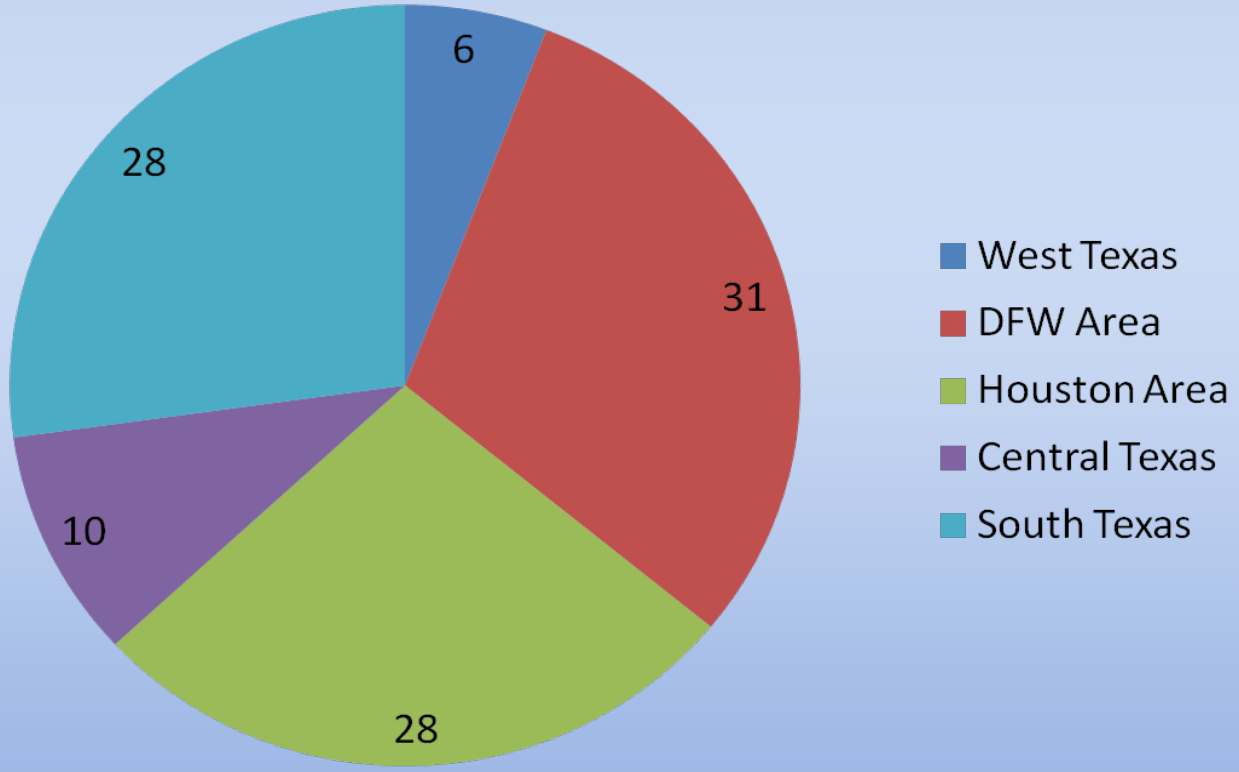
CAF Payment Holds Initiated by OIG Due to Attorney General Indictments - By Region



SFY 2012/2013 Total: 31

CAF Holds

CAF Payment Holds Initiated by OIG and the Attorney General By Region



SFY 2012/2013 Total: 103

Due Process

Texas Administrative Code (TAC) rules afford due process rights to providers whose payments have been suspended.

- The provider may request an informal review, contested case hearing, or both.
- Payment suspensions must be heard at the State Office of Administrative Hearings (SOAH).
- The HHSC Appeals Division hears contested case hearings related to the amount of the overpayment.

CAF Holds

Time Frames

- The amount of time from when a CAF hold is implemented to case resolution varies widely.
  - If the provider does not challenge the hold, the matter is resolved in 15 days.
  - If the provider requests both an informal review and a contested case hearing on appeal, the process may take months.
- Criminal cases can take months or years to develop and prosecute. To date:
  - Two providers who were placed on CAF hold have been convicted of fraud.
  - Another two cases have gone to contested case hearing. In both of those cases, SOAH upheld OIG's authority in suspending the provider's payments.
  - Six other providers have resolved the payment suspensions by agreement.
  - In FY 2013, another four providers have been scheduled for CAF hold hearings.
  - The remaining cases are working through the appellate process.

Medicaid Orthodontia Claims

- OIG data analysis has identified more than 50 probable overutilizers of orthodontia services.
- Analysis by experts indicates orthodontic overutilization rates range from 39 percent to 100 percent with an average error rate of 93 percent.
- OIG has completed more than 36 investigations with over $303 million in identified potential overpayments and has placed 28 orthodontic providers on payment hold based upon credible allegations of fraud.

Medicaid Non-Orthodontia Claims

- OIG data analysis has identified 89 probable overutilizers of non-orthodontic dental services.
- Analysis by experts suggests error rates ranging from 25 percent to 99 percent, averaging 55 percent, and resulting in identified potential overpayments of $154 million.
- Special emphasis on transportation and injury cases.
- OIG continues to work with Medicaid/CHIP to identify systemic or process flaws that can lead to overutilization of dental services.

Hearing Aid Initiative Cases

- Analysis by experts indicates hearing aid overutilization rates range from 84 percent to 100 percent with an average error rate of 98 percent.
- OIG has completed 21 of 24 investigations with over $101 million in identified potential overpayments and has placed 13 hearing aid providers on payment hold based upon credible allegations of fraud.

To Report Fraud, Waste, or Abuse Call

1-800-436-6184