



# **Presentation to the Senate Committee on Health and Human Services: Initiatives to Reduce Fraud, Waste and Abuse**

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# Presentation Overview

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- I. **OIG Initiatives to Improve Fraud, Waste and Abuse Investigations**
  
- I. **HHSC Initiatives to Reduce Fraud, Waste and Abuse within Medicaid/CHIP**
  
- II. **DSHS Initiatives to Reduce Fraud, Waste and Abuse within Emergency Medical Services**

# OIG Initiatives

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- The Office of Inspector General (OIG), a division of the Texas Health and Human Services Commission (HHSC), works to prevent, detect and pursue fraud, waste and abuse in the Texas Health and Human Services system.
- S.B. 8, 83<sup>rd</sup> Regular Legislative Session, 2013:
  - Validated the OIG's authority to prevent, detect, audit, inspect, review and investigate fraud, waste and abuse across all HHS programs.
  - Authorized OIG to employ and commission five peace officers.
    - Administratively attached to the Department of Public Safety and required to receive approval from the Office of Attorney General prior to carrying out duties requiring peace officer status.
    - OIG has filled four of the five peace officer positions. The remaining position will be filled by September 1, 2014.
  - Required OIG to review its process for investigating fraud, waste and abuse in the Supplemental Nutrition Assistance Program (SNAP) program.
    - OIG has hired a new director to oversee SNAP investigations and review OIG's processes for investigating SNAP cases and to identify strategies for enhancing efforts in this area. OIG expects to have a full report outlining those strategies to the Legislature on or before September 1, 2014.
  - Strengthened OIG's authority to exclude providers from the Texas Medicaid program who have previously committed fraud or abuse.

# OIG Initiatives

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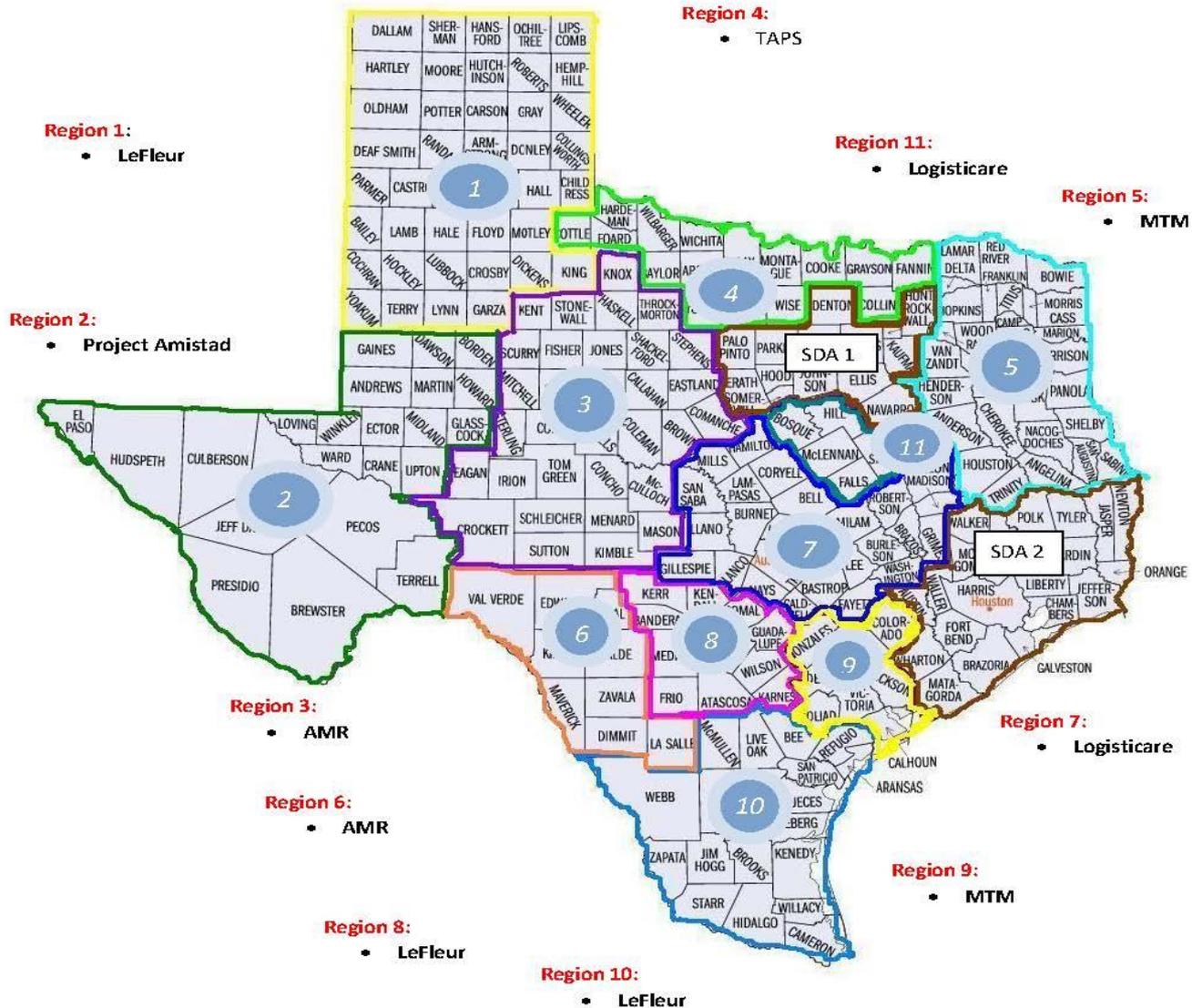
- Additional staff authorized by S.B. 1, 83<sup>rd</sup> Regular Legislative Session, 2013, will allow OIG to:
  - Reduce case backlog;
  - Increase utilization review (UR) nurse positions to conduct UR of hospital and nursing facility services; and
  - Increase third party liability positions to ensure private insurance benefits, rather than Medicaid benefits, are utilized when available.
- OIG has deployed an advanced graph pattern analysis technology (LYNXeon):
  - Used to increase the detection of Medicaid fraud, waste and abuse.
  - Utilizes direct data feeds from the Medicaid Management Information System (MMIS). HHSC has ingested over 76 months of data (January 1, 2008 through April 30, 2014).
  - Six FTEs in OIG's Data Analytics and Fraud Detection Unit.
- OIG is coordinating with Medicaid managed care organizations (MCOs) on Lock-In program referrals to prevent abuse and overutilization of prescription benefits.
- OIG is conducting audits of home health providers to ensure adequate documentation is in place for Medically Dependent Children and Comprehensive Care programs.

# HHSC Initiatives: Medical Transportation Program

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- The Medical Transportation Program (MTP) sets up non-emergency transportation services for Medicaid clients who have no other way to get to their health care visits.
- S.B. 8, 83<sup>rd</sup> Regular Legislative Session, 2013, directed HHSC to transition MTP into a full-risk, capitated model beginning September 1, 2014. Services will be provided on a regional basis through contracted managed transportation organizations (MTOs).
- Six vendors were selected to serve as MTOs in 11 regions:
  - American Medical Response(AMR)
  - Medical Transportation Management(MTM)
  - LeFleur of Texas
  - LogistiCare Solutions
  - Texoma Area Paratransit System (TAPS)
  - Project Amistad
- Implementation of the new MTP service delivery model remains on target for September 1, 2014.

# MEDICAL TRANSPORTATION PROGRAM MANAGED TRANSPORTATION ORGANIZATION (MTO) Final Regional Assignments



# HHSC Initiatives: Data Analysis Unit

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- S.B. 8, 83<sup>rd</sup> Regular Legislative Session, 2013, required HHSC to establish a data analysis unit to establish, employ and oversee data analysis processes designed to:
  - Improve contract management;
  - Detect data trends; and
  - Identify anomalies relating to service utilization, providers, payment methodologies, and compliance with requirements in Medicaid/CHIP contracts.
- Unit has been established and staff has been hired.
- Data will be used to develop dashboards and early alerts to better evaluate contractor performance.
- Members of the data analysis unit are being added to contract management teams to round out skill sets used to manage contracts.

# HHSC Initiatives: Provider Marketing

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- S.B. 8, 83<sup>rd</sup> Regular Legislative Session, 2013, prohibited certain provider marketing activities under Medicaid and CHIP, including “unsolicited personal contact” with Medicaid/CHIP clients and parents.
- S.B. 8 also required HHSC to establish a process for providers to submit their proposed marketing materials/activities to HHSC for review and approval.
- Rules implementing the marketing provisions of S.B. 8 went into effect on July 6, 2014.
- HHSC has also published guidelines on TMHP’s website to assist providers in assessing their compliance with the new rules and provide information on the option of submitting marketing activities to HHSC for review and approval.

# HHSC Initiatives: Prior Authorization Review

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- S.B. 348, 83<sup>rd</sup> Regular Legislative Session, 2013 required HHSC to establish an annual utilization review process for STAR+PLUS MCOs.
  - S.B. 1, Rider 66 appropriated HHSC funding for nine FTEs to implement the S.B. 348 utilization review process.
  - HHSC has established the Utilization Management and Review (UMR) unit:
    - All nine allocated positions have been filled.
    - The UMR team conducted introductory site visits with the five STAR+PLUS MCOs in March and April 2014.
    - All policies, processes and tools to be used in the reviews have been developed and tested.
    - Reviews will begin in FY 2015 for a statistically valid sample.
    - FY 2014 report is due to the Legislature by December 1, 2014.
- In addition, S.B. 8, 83<sup>rd</sup> Regular Legislative Session, 2013, required HHSC to periodically review the prior authorization and utilization review processes used within Medicaid fee-for-service and managed care to reduce the authorization of unnecessary services and inappropriate use of services.

# DSHS Initiatives: Emergency Medical Services

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- S.B. 8 and H.B. 3556, 83<sup>rd</sup> Regular Legislative Session, 2013, made changes to the licensure and regulation of emergency medical services (EMS) providers, including:
  - One year moratorium on new EMS provider licenses (9/1/13 - 8/31/14) with certain exemptions (municipality, county, hospital, volunteer EMS provider);
  - Letter of approval from municipality's governing body or county commissioner's court in which an applicant is applying to provide EMS;
  - Medical director requirement for all EMS providers;
  - Training and education requirements for EMS administrators of record (AOR);
  - Suspension, revocation and denial of EMS licenses based on actions by the provider's AOR, employee or other representative for certain offenses;
  - Letter of credit; and
  - \$50,000 surety bond for Medicaid/CHIP providers.
- DSHS will submit a report on the effect of the new regulations by December 1, 2014.
- As directed by S.B. 8, DSHS also conducted a review of its EMS policies in 2013, in collaboration with HHSC and the Texas Medical Board, and issued a joint report earlier this year with recommendations to reduce fraud, waste and abuse.