AGA-Austin Chapter
Program & Luncheon Meeting Minutes
Meeting Date: April 12, 2012

The meeting was called to order at 11:55 a.m.

Regular Business

Mara Ash, President, announced the candidates, counted the votes, and performed the swearing in as follows:

Priscilla Suggs – President-Elect
Mari Queller – Treasurer

Autumn Bellfield, the candidate voted in as Secretary, was unable to attend the event. Autumn's swearing in will take place prior to the May audio conference at the ERS Building.

Debi Weyer announced that the May event will consist of two back-to-back audio conferences for a total of four CPE. At a total cost of $50 (member) for both conferences, the average cost per CPE hour is a very affordable $12.50. The titles of the two audio conferences are:

- Major Challenges to the Public Sector Auditing Profession
- Find Strength in Numbers: Sampling Techniques to Improve Financial Audit, Control, and Program Performance

Program Speaker

Debi Weyer introduced Douglas Wilson from the Texas Health and Human Services Commission, Office of Inspector General.

Douglas is a graduate of Texas State University with a Bachelor of Business Administration Degree in Accounting. He has over 25 years experience in state government and is a Certified Public Accountant and a Certified Inspector General.

Douglas has worked for the Office of the Attorney General, the Texas Commission on Alcohol and Drug Abuse, and the Texas Department of State Health Services in the areas of auditing, accounting, grants administration, contracting, investigations, licensing, and enforcement. He joined the Office of Inspector General in 2009. Prior to joining the Office of Inspector General, Doug served as Deputy Director for the Medicaid Fraud Control Unit, Deputy for Licensing and Enforcement, and Director of the Grants Management Division.

Implementing Medicaid Managed Care

During the first special session of 2011, the Legislature passed Senate Bill 7, an omnibus bill that pushed major reforms onto the Texas Medicaid system. The legislature was directed to consider "legislation related to health care cost containment, access to service through managed care, and the creation of economic and structural incentives to improve the quality of Medicaid services." Changes included:

- Eliminating the "valley exemption" from managed care – previously, Cameron, Maverick, and Hidalgo Counties were prohibited from being included in the managed care system
- Enabling providers to be licensed as a health care collaborative
- Encouraging Managed Care Organizations (MCO) to provide preventative care services
- Implementing a new pharmacy benefit plan
- Studying ways to reduce non-emergency room use for non-emergent conditions

MCO's are paid a capitated rate per covered person, instead of the fee for service model. Medicaid funds are paid directly to the MCO, which passes the funds on to subcontractors. This model incentivizes MCO's to prevent fraudulent or wasteful treatments. This model, unfortunately, has not totally eliminated fraudulent practices.

Common Fraud, Waste, and Abuse Schemes

The following are common fraud, waste, and abuse schemes in a fee for service environment:

- Billing for unnecessary services
- Unbundling
- Alteration of documents
- Billing for services not rendered

- Up-coding/Unsubstantiated diagnoses
- Billing for services not a benefit of Medicaid
- Solicitation of recipients
- Outpatient services billed as inpatient

Fraud, waste, and abuse schemes are different in a managed care environment. They include:

- Contract Procurement Fraud
  - Misrepresenting the credentials of a participating provider
  - Misrepresenting the MCO's financial solvency
  - Falsifying or maintaining an inadequate provider network
  - Collusion among providers
- Marketing and Enrollment Fraud
  - Enrolling ineligible or non-existent recipients in order to receive more reimbursements
  - Cherry-picking healthy applicants, or avoiding the enrollment of applicants with pre-existing health issues (pregnant women, for example)
  - Providing kickbacks or bonuses to enrollees as an incentive to enroll with a certain MCO
  - Failing to notify the state when a participant dies
- Forced Underutilization of Services
  - Delaying or denying care or services to enrollees,
  - Creating prior authorization requirements that are difficult or unreasonable in an effort to avoid paying for certain procedures
  - Delaying first contact with clients, or delaying the assignment of a primary care physician
  - Failure to serve individuals with cultural or language barriers
  - Creating cumbersome appeals processes
  - Maintaining an ineffective grievance process
  - Delays in providing referrals to specialists
  - Providing incentives to illegally limit services
- Claims Submission and Billing Fraud
  - Misrepresenting the MCO's Medicaid Loss Ratio
  - Illegally shifting costs
  - Falsifying encounter data
  - Billing for ineligible consumers or services never rendered
  - Providing inappropriate physician incentive plans
  - Reporting phantom visits and improper cost reporting
  - Inappropriate cost-shifting to carved out services

The OIG provides comprehensive fraud, waste, and abuse training to Managed Care Organizations, Pharmacy Benefit Managers, and Special Investigative Units.

Stopping Fraud and Waste: MCO's Role

Each MCO must:
- Establish and maintain a Special Investigative Unit within the Managed Care Organization to investigate fraudulent claims and other types of program abuse by recipients and service providers.
- Adopt a plan to prevent and reduce fraud and abuse and annually file that plan with the HHSC-OIG for approval 60 days prior to the start of the State fiscal year.

MCO investigative units must:
- Report to OIG any detection activity that finds an overpayment of $100,000 or more, and any finding of intentional fraud, regardless of dollar amount.
- Report monthly to OIG a list of all investigations.

The MCO plan must:
- State a formal commitment to detecting, investigating, preventing, and reporting fraud and abuse.
- Ensure that regular reviews and audits to guard against fraud and abuse are conducted.
- Assess and strengthen controls to ensure claims are submitted correctly and payments are made properly.
- Attempt to educate employees, network providers, and beneficiaries about fraud and abuse, and how to report either.
- Organize resources to respond to complaints; establish procedures to process complaints.
- Establish procedures for reporting information to HHSC and OIG.
- Develop procedures to monitor the service patterns of providers, subcontractors, and beneficiaries.

OIG Initiatives

Advanced Data Analysis and Pattern Recognition Technology
- Ability to sift through years of data, finding and identifying in minutes behaviors that previously would take months or years to discover—if ever.
- Ability to monitor service utilization, access to care, and quality of care.
- Data can be used to evaluate and update the capitation payment rates paid to MCO's.
- Monitoring of each MCO and their provider contract performance, and management and enforcement of managed care contracts.

Ensuring Payment from Third Parties
- Ensure that all responsible parties pay their fair share of a recipient's expenses—if a patient has private insurance, OIG ensures that it pays before Medicaid does.
- Medicaid is the 'payer of last resort' meaning that Medicaid should only pay for care when all other means are exhausted, which include third party insurers, workers compensation, absent parents, other public programs.

Payment Holds due to a Credible Allegation of Fraud
- Suspend all Medicaid payments to a provider after OIG verifies 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.", including hotline complaints, data mining, patterns identified through audits, and law enforcement investigations. Allegations must have "indicia of reliability.
- All credible allegations of fraud are referred to the Attorney General's Medicaid Fraud Control Unit.

Increased Audit Efficiency
- Reorganized Compliance division, which is responsible for audits and reviews of providers, long term care facilities, and other Medicaid programs.
- Created a new Managed Care Audit Unit to review claims administration, contract administration, quality of care, credentialing, member services, case management, and utilization and financial operations.

Conclusion and Adjournment

Number attending: 44 (including the speakers)

Future CPE events: **May 9, 2012** **4 CPE** **Audio Conference (2)**
8:30 a.m. – 12:30 p.m.
Location: ERS Board Room,
200 E. 18th Street, Austin

The meeting was adjourned at 1:00 p.m.

Lynne Pfeffer Date: May 15, 2012
Secretary