OFFICE OF INSPECTOR GENERAL

Texas Health and Human Services

QUARTERLY REPORT

Quarter 2, Fiscal Year 2025

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EXECUTIVE SUMMARY

I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the second quarterly report for fiscal year (FY) 2025, summarizing the excellent work the office performed during this period.

From December 1, 2024, to February 28, 2025, the Texas Health and Human Services (HHS) Office of Inspector General (OIG) recovered more than $93.4 million.

This quarterly report spotlights the many ways in which the OIG safeguards the integrity of state health and human services. Though only a small sampling of our work, each case, audit and initiative highlighted in this report reflects important victories for the people of Texas and the unwavering dedication of our employees.

Of note in this issue is a $17 million settlement with a Texas pediatric hospital group that self-disclosed potential errors to the OIG, avoiding costly penalties on top of the overpayment. Cases such as this underscore the value that all parties can achieve when working together in good faith and transparency. You can read more about this case on Page 6.

I would also call your attention to an audit on Page 10 that found a dental maintenance organization overstated expenses on its financial statistical report to HHS by almost $800,000 and incorrectly categorized more than $9 million in expenses. The agency highlights beginning on Page 8 also illustrate some of the initiatives undertaken in the second quarter to improve efficiency, collaboration and transparency within our work.

As we move into the third quarter, I anticipate continued outstanding performance from our entire team. I am honored to work alongside them in service to the people of Texas.

Raymond Charles Winter
Inspector General

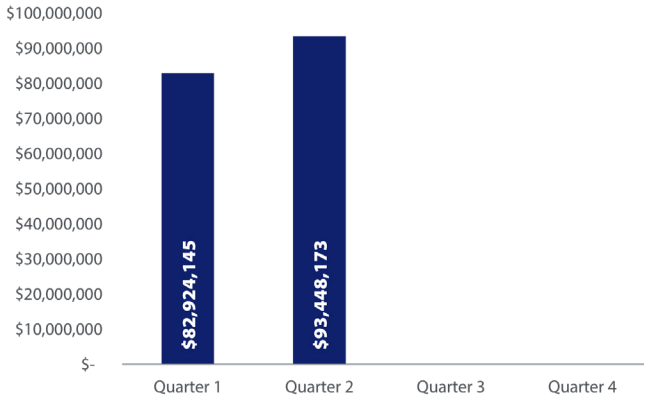
QUARTERLY METRICS

DOLLARS RECOVERED

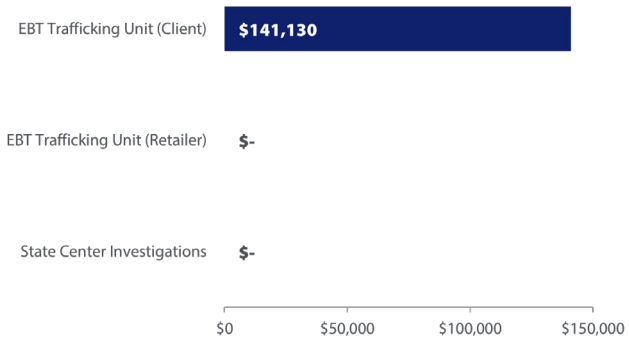
Dollars recovered are overpayments collected based on the results of an investigation, audit, inspection or review.

TOTAL DOLLARS RECOVERED	$93,448,173
PROVIDERS AND MANAGED CARE ORGANIZATIONS	**$87,606,224**
Audit and inspection overpayments	$3,548,002
OIG and MCO investigation overpayments	$10,591,176
Targeted queries overpayments	$1,160,186
Acute care review overpayments	$67,094
Hospital utilization review overpayments	$3,247,708
Nursing facility utilization review overpayments	$718,737
FFS Recovery Audit Contractor recoveries	$6,595,326
Third Party Recoveries	$61,677,995
CLIENTS	**$5,841,334**
Beneficiary overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$5,672,302
Voluntary repayments by beneficiaries	$27,902
Electronic Benefits Transfer trafficking beneficiary overpayments ★	$141,130
RETAILERS	**$615**
Electronic Benefits Transfer trafficking retailer recoveries ★	$0
WIC collections	$615
HHS EMPLOYEES AND CONTRACTORS	**$0**
State Centers Investigations Team recoveries ★	$0

TOTAL RECOVERIES BY QUARTER



★ PEACE OFFICER RECOVERIES



DOLLARS IDENTIFIED FOR RECOVERY

Dollars identified for recovery is a measure of the total potential overpayments found through OIG audits, inspections, investigations and reviews. These potential overpayments are estimates pending further analysis or additional information submitted by the subject of the potential recovery. Consequently, these potential overpayments have not been collected, and notice to providers, contractors or managed care organizations may be forthcoming.

TOTAL DOLLARS IDENTIFIED FOR RECOVERY	$55,558,414
PROVIDERS AND MANAGED CARE ORGANIZATIONS	**$34,317,871**
Audit and inspection overpayments	$1,065
OIG and MCO investigation overpayments	$5,492,689
Targeted queries overpayments	$1,486,053
Acute care review overpayments	$250,562
Hospital utilization review overpayments	$3,607,437
Nursing facility utilization review overpayments	$1,241,720
FFS Recovery Audit Contractor recoveries	$6,953,665
Third Party Recoveries	$15,284,680
CLIENTS	**$21,240,049**
Beneficiary overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$20,358,862
Voluntary repayments by beneficiaries	$0
Electronic Benefits Transfer trafficking beneficiary overpayments ★	$881,187
RETAILERS	**$494**
Electronic Benefits Transfer trafficking retailer recoveries ★	$0
WIC collections	$494
HHS EMPLOYEES AND CONTRACTORS	**$0**
State Centers Investigations Team recoveries ★	$0

COST AVOIDANCE

Cost avoidance results in resources being used more efficiently, either through an increase in available resources from reductions in inefficient expenditures or through avoidance of unnecessary expenditures for operational, medical, contract or grant costs.

TOTAL COST AVOIDANCE	$55,171,929
PROVIDERS AND MANAGED CARE ORGANIZATIONS	**$50,506,980**
Medicaid provider exclusions	$0
Fee-for-service front-end claims denial	$50,506,980
CLIENTS	**$4,664,949**
Client disqualifications	$1,910,800
Pharmacy Lock-In	$2,387,676
Disqualification of Electronic Benefits Transfer recipients ★	$366,473
RETAILERS	**$0**
WIC vendor monitoring	$0

PROVIDER INTEGRITY

TRENDS

The Provider Investigations team examines allegations of fraud, waste and abuse by Medicaid providers. Allegations are received through tips from the public, health care providers, managed care or dental maintenance organizations and are generated by the OIG's own activities. Tips may be reported anonymously through the OIG Fraud Hotline.

Provider Investigations Performance	
384	Preliminary investigations opened
377	Preliminary investigations completed
53	Cases transferred to full-scale investigation
46	Full-scale investigations completed
58	Cases referred to OAG Medicaid Fraud Control Unit
97	Open/active full-scale cases at end of quarter

The Intake Resolution Unit (IRU) conducts preliminary investigations into allegations as they are received. This quarter, the unit opened 384 preliminary investigations and completed 377. Managed care organizations, dental maintenance organizations and health care providers reported 46% of these allegations to the IRU. The top three provider types involved in preliminary investigations this quarter were physicians at 23%, attendants at 15% and home health agencies at 14%.

IRU transferred 14% of its preliminary investigations to Provider Field Investigations for further scrutiny as full-scale investigations. There were 46 full-scale investigations completed over the quarter. The top three provider types involved in full-scale investigations were physicians at 41%, behavioral health at 11% and hospitals at 9%.

OIG Provider Investigations also referred 58 cases to the Office of Attorney General's Medicaid Fraud Control Unit.

Provider integrity is also scrutinized by the Major Case Unit (MCU), a team of multidisciplinary forensic accounting and investigative experts who conduct or assist with the OIG's highest-profile and highest-dollar cases. This quarter, the MCU opened 20 cases, closed eight cases and is currently investigating 31 active cases. MCU investigations this quarter have primarily focused on health care provider fraud and assisting state and federal law enforcement in various criminal investigations, which have led to prosecutorial and administrative reviews.

CASE HIGHLIGHTS

Self-disclosure leads to $17 million settlement

In 2024, a group of pediatric hospitals notified the OIG that they were paid more for observation services than allowed by the Texas Medicaid Provider Procedures Manual. The OIG's self-disclosure team carefully examined the underlying issues that led to the report and verified the specific amount necessary to resolve the matter. In February 2025, the OIG and hospital group agreed to a settlement that will recover more than $17 million for taxpayers. Because the hospital group contacted the OIG to disclose and resolve the issue, it avoided costly penalties in addition to the overpayment. The OIG greatly appreciates the proactive approach taken by the hospitals as well as their collaboration throughout the process.

OIG secures $7.2 million in settlements with two statewide hospital systems for improper emergency department billing

In January, the OIG finalized settlements with two Texas hospital systems after an analysis of paid claims data revealed improper billing practices for various emergency department services.

Multiple hospitals within these systems billed for injection or infusion codes on the same dates as emergency department evaluation and management codes for the same patients. Medicaid includes the cost of an injection or infusion in the evaluation and management rate; therefore, these codes cannot be billed concurrently.

The hospitals also billed Medicaid for critical care codes that can only be reimbursed to physicians, double-billed evaluation and management codes, and billed observation services at the same time as evaluation and management services for the same patients.

As a result of these findings, one hospital system agreed to reimburse Medicaid approximately $3.48 million for the overpayments they received. The other hospital system resolved multiple billing issues totaling $3.75 million.

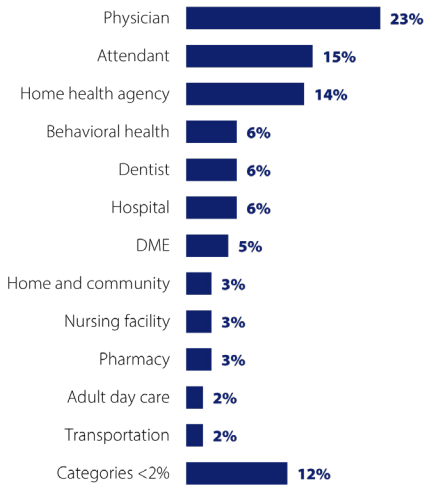
OIG settles with several home health agencies for improper billing

This quarter, the OIG settled cases with multiple home health providers whose medical records did not support using the UA modifier for some clients. The UA modifier provides additional reimbursement for ventilator-dependent patients or those with a tracheotomy. The first case involved a home health agency with several locations across Texas. The provider worked with the OIG to resolve these issues and the OIG agreed to a settlement of $82,498. The other two cases involved home health agencies based in San Antonio and Houston that also worked with the OIG to reach settlements of $15,556 and $775, respectively.

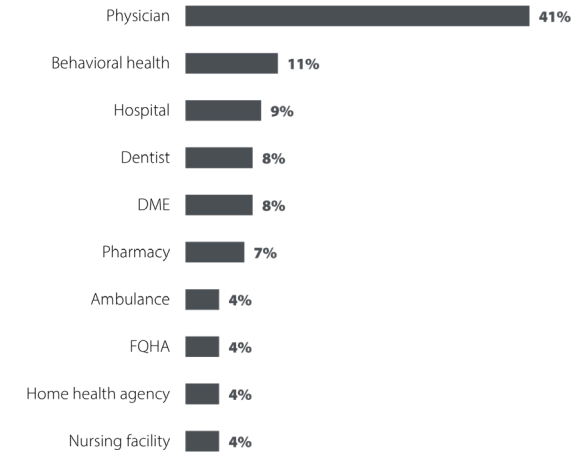
Failure to provide information in audit results in liquidated damages

A previous OIG audit of a managed care organization identified issues with the MCO's determination of fair market value for affiliate outsourced service expenses. MCOs using affiliate

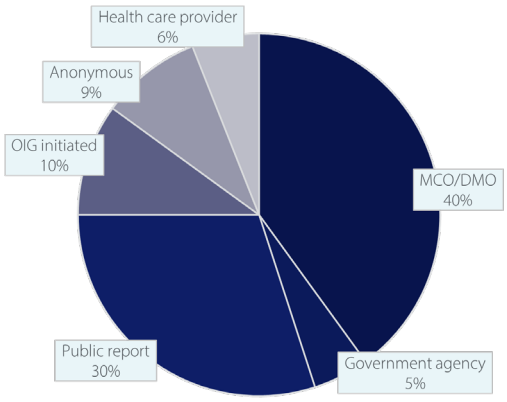
Preliminary Provider Investigations
(by type)



Full-Scale Provider Investigations
(by type)



Preliminary Investigation Referral Sources



organizations for services must establish fair market value to demonstrate that the amount paid to the affiliate is reasonable as compared to the amount that would have been paid to an unaffiliated organization. Despite the OIG's attempts to obtain the necessary information, the MCO did not provide evidence supporting whether the MCO reported affiliate expenses at fair market value. In December 2024, the MCO paid liquidated damages to resolve numerous compliance issues, including $220,000 for failing to provide information in the OIG audit.

Surveillance Utilization Review

$67,094	Acute care provider recoveries
$250,561	Acute care services identified overpayments
16	Acute care services cases closed
$3,247,708	Hospital and nursing home (UR) recoveries
3,306	Hospital (UR) claims reviewed
67	Nursing facility reviews completed
3,135	Average number of Lock-in Program clients

Provider Enrollment and Exclusions

6,781	Provider enrollment applications processed
15,975	Individual screenings processed
74	Medicaid providers excluded

OIG settles at-home COVID-19 test kit case with Rio Grande Valley pharmacy
In December 2024, the OIG entered into a $18,510 settlement agreement with an Edinburg pharmacy. An OIG investigation of claims data indicated that from January 2022 to December 2023, the pharmacy billed for COVID-19 test kits in amounts that exceeded the prescribing physician's written authorization, and the pharmacy could not provide the required prescriptions to support the at-home COVID-19 test refills billed to Medicaid.

OIG settles with Dallas home health care agency
In January 2025, the OIG settled with a Dallas home health care agency for $7,008. An OIG review of claims data and Medicaid client files indicated the provider had submitted and received payment for attendant care services while the recipient was in an inpatient facility and following their death.

AGENCY HIGHLIGHTS

OIG launches online payment system
The Texas OIG Payment System is now available through Texas.gov. Led by the OIG, the project was a collaborative effort involving HHS, the Texas Comptroller's Office and Texas Department of Information Resources. The new online system enhances efficiency by streamlining payment processing and offering providers an online alternative to manual payments. Providers and individuals who need to submit payments will receive instructions on using the new payment portal in their communications from the OIG.

The OIG releases video for new Medicaid providers
The OIG recently released a video for new Medicaid providers highlighting the rules and regulations they must follow. The educational video introduces viewers to the OIG and offers relevant information about provider responsibilities, records requirements, common coding and billing errors, exclusions lists and self-disclosure. The video will also be part of the provider enrollment process and is intended to prevent costly mistakes and transgressions that harm Texas taxpayers and medical providers alike.

New portal enhances Medicaid's tort recovery process
The OIG's Third Party Recoveries team and Texas Medicaid Business Operations contractor launched a new Medicaid tort portal in May 2024 to streamline recovery efforts and improve financial outcomes. In January 2025, the contractor reported to OIG and HHS staff that the portal has enhanced case management for personal injury attorneys handling Medicaid-related tort claims and user adoption has steadily increased. The system has reduced processing time by 50% by enabling direct engagement between attorneys and the contractor, providing easier access to case information, and allowing online submission of required forms.

Dental marketing kickback project underway
The MCU is assisting the OIG's Medicaid Program Integrity Unit with a dental marketing kickback project by converting cell phone records into workable datasets that can be used to trace communication and payment patterns between suspected marketers. The MCU is also employing its financial forensics expertise to identify the flow of kickbacks between the primary and secondary suspects and to analyze person-to-person transactions in mobile payment platforms frequently used to transfer funds.

OIG completes new annual MCO overpayment recoveries report
Under a new Centers for Medicare & Medicaid Services (CMS) rule, MCOs submitted their first annual overpayment recoveries reports to the OIG in December. In their reports, MCOs must submit total recoveries for each Medicaid program they administer, indicating whether the recoupments were monetary recoveries or claim adjustments/offsets. The OIG subsequently provided a summary of the reports — indicating approximately $741 million in combined MCO recoveries — to HHS, which will include the information in a larger report submitted to CMS.

OIG collaborates on new Uniform Managed Care Manual compliance guidelines
A new federal rule requires MCOs and dental maintenance organizations (DMOs) to report overpayment recoveries and identified recoveries monthly. In regular meetings, the OIG has shared its progress on developing the necessary reporting process and received feedback from MCOs and DMOs on report specifications and the method of submission. The OIG is now amending the Uniform Managed Care Manual to include the new monthly reporting requirements. The revisions will be shared with stakeholders during a formal review process. The OIG will continue meeting with MCOs and DMOs through the end of this fiscal year to implement the new reporting requirements and will monitor implementation into FY 2026 to ensure compliance with the intent of the federal prompt reporting rule.

OIG coordinates with the Unified Program Integrity Contractor
The OIG is coordinating with the Unified Program Integrity Contractor (UPIC) on a federal CMS initiative. Through UPIC, CMS is engaging 10 Texas MCOs to review their compliance plans, paid claims to certain types of network providers, denied claims and prior authorizations, provider network adequacy and preventative services for certain types of enrollees. The OIG is working with UPIC to deconflict any potential or ongoing OIG investigations or audits involving the MCOs selected to participate in the federal initiative.

Modern tools boost Fraud Analytics team's efficiency and advance processes
Fraud Analytics is taking major steps to modernize its processes and tools. By leveraging secure cloud-based technologies, the team is enhancing its ability to efficiently process large and complex datasets. In addition, the team is implementing the Agile methodology and adopting version controls to improve prioritization, transparency, reproducibility and streamlined development of fraud, waste and abuse detection algorithms and models.

Fraud Analytics and Data Operations

131	Data requests received
124	Data requests completed
38	Algorithms executed
6	Algorithms developed

Desk review process ensures provider accessibility
Prior to each nursing facility desk review, staff conduct a virtual entrance meeting with the provider to explain the process and what will be required. In January, the OIG transitioned to using prerecorded videos in place of these virtual meetings. An OIG desk review coordinator will oversee communication for upcoming desk reviews, help the facilities access entrance recordings via SharePoint and answer any questions from facility staff. Nursing facility administrators can access these recordings any time for training or review, making them an informational resource for nursing facilities during their review. The transition has also increased efficiency for both the OIG and nursing facilities.

Acute Care Surveillance collaborates on case generation projects
In the second quarter of FY 2025, the Acute Care Surveillance team worked with Fraud Analytics and Data Operations staff on two projects. The first assessed whether providers appropriately delivered and documented applied behavior analysis services. The second identified high-risk providers using algorithms to find similarities between current providers and those previously excluded from participating in Medicaid. As a result of these collaborations, the OIG is taking a closer look at 11 providers to determine if errors or wrongdoing occurred. Four cases were initiated from the applied behavior analysis project and seven from the high-risk provider project.

AUDIT REPORTS COMPLETED

UnitedHealthcare Dental's Financial Statistical Reports
The OIG conducted an audit of UnitedHealthcare Dental's process for preparing and submitting expenses on its financial statistical reports (FSRs). HHS paid dental management organizations $1.53 billion for providing Texas Children's Medicaid and CHIP dental services in FY 2023, a 3% increase from FY 2022. The audit objective was to determine whether UnitedHealthcare Dental reported expenses on its FSRs in accordance with applicable requirements and designed and implemented effective internal controls over the preparation of its FSRs. The audit scope covered administrative, quality improvement and pre-implementation expenses from October 29, 2019, through August 31, 2022.

UnitedHealthcare Dental had a process for preparing and reviewing FSRs; however, UnitedHealthcare Dental's internal controls were not always effective and allowed for reporting errors. It also did not have an effective process for reporting expenses accurately and in accordance with requirements on its FSRs for FY 2021 and FY 2022, and its pre-implementation expense report. As a result, UnitedHealthcare Dental overstated expenses by $799,351.

Additionally, UnitedHealthcare Dental did not establish fair market value for reported affiliate expenses of $9,717 and incorrectly categorized $9,002,010 in expenses within those reports.

The OIG offered UnitedHealthcare Dental recommendations which, if implemented, will improve its FSR reporting.

Audit Performance

$3,548,002 Overpayments recovered

$1,065 Overpayments identified

Audits Issued (3)

UnitedHealthcare Dental's Financial Statistical Reports (1/23/2025)

Follow-Up Assessment on a Previously Published Audit Report: Managed Care Claims Submitted by Cook Children's Home Health (2/11/2025)

Wellpoint Texas Special Investigative Unit (2/28/2025)

Audits In Progress (22)

- Selected MCO Special Investigation Unit
- Centers for Independent Living
- Texas Integrated Eligibility Redesign System (TIERS)
- Substance Use Disorder Treatment Facility
- Selected DSHS Contract
- Selected Long Term Care Facilities
- Selected DFPS Contract
- Selected Local Mental Health Authorities
- Allergy Immunotherapy Provider
- Projects for Assistance in Transition from Homelessness Grantee
- Comprehensive Rehabilitation Services Provider
- Non-Emergency Transportation Provider
- Consumer-Directed Services
- Pediatric Hospice Provider
- Prescribed Pediatric Extended Care Center

Follow-Up Assessment on a Previously Published Audit Report: Managed Care Claims Submitted by Cook Children's Home Health

The OIG conducted a follow-up assessment of the previously published audit report titled "Managed Care Claims Submitted by Cook Children's Home Health and Paid by Cook Children's Health Plan: A Texas Medicaid Durable Medical Equipment and Supplies Provider" to determine the resolution status of audit issues identified in the previous report, which was published in 2021.

Cook Children's Home Health did not fully resolve some reported audit issues. Cook Children's Home Health incorrectly submitted claims and received reimbursement for durable medical equipment and supplies for 7 of 19 clients (36.8%) tested. As a result, the OIG reissued two recommendations from the previous audit, revised as appropriate to address the results of this assessment. Additionally, Cook Children's Home Health should repay $1,065 to the State of Texas for overpayments identified during this assessment.

Wellpoint Texas Special Investigative Unit

MCOs must have a special investigative unit (SIU) to investigate potential fraud, waste or abuse by clients and health care service providers. The Texas Medicaid and CHIP programs cost approximately $33.6 billion per year. Estimates of health care fraud range from 3% to 10% of all health care expenditures. Texas MCOs reported total recoveries of $6.7 million and $4.2 million in FYs 2022 and 2023, respectively. Across FYs 2022 and 2023, HHS paid Wellpoint Texas (Wellpoint) $14.9 billion in capitation payments to provide Medicaid and CHIP services to approximately one million Texas clients per month for all programs and service areas.

The OIG audit evaluated the effectiveness of Wellpoint's SIU performance in preventing, detecting and investigating fraud, waste and abuse and reporting reliable information on SIU activities, results and recoveries to the OIG. The audit scope covered SIU activities in FY 2022 and FY 2023.

Wellpoint's SIU did not consistently comply with certain state and contractual requirements related to preventing, detecting and investigating fraud, waste and abuse and reporting reliable information on SIU activities, results and recoveries to the OIG. While Wellpoint had processes in place to complete fraud, waste and abuse investigations, these resources and processes were not effective and resulted in recoveries of only $102,799. Wellpoint paid medical claims of $12.8 billion for the audit period.

While Wellpoint proactively mined data for indicators of Medicaid fraud, waste and abuse, had dedicated staff and performed investigations, it did not:

- Conduct CHIP-specific data mining or investigations.
- Complete investigations, maintain supporting documents or meet timeliness requirements.
- Accurately document or report its fraud, waste and abuse investigations. Wellpoint's SIU documented a total of 418 investigations with $16.6 million of identified overpayments in its case management system in 2022 and 2023. However, Wellpoint reported to the OIG 413 investigations with a total identified overpayments of $5.9 million in the same period.
- Ensure the required fraud, waste and abuse training was tailored to individuals based on their specific job functions.

The OIG offered recommendations to Wellpoint which, if implemented, will improve the effectiveness of its SIU.

INSPECTION REPORTS COMPLETED

Case-by-Case Services: Texas Children's Health Plan

Case-by-case services are additional health-related services not covered by the state plan that an MCO may offer individual clients. MCOs have the flexibility to provide case-by-case services without obtaining approval from HHS. MCOs may not include case-by-case services in the reporting of Medicaid medical expenses that HHS uses to calculate capitation payments. MCOs are financially responsible for the case-by-case services they provide.

Inspections Issued (1)

Case-by-Case Services: Texas Children's Health Plan (2/27/2025)

Inspections In Progress (6)

MCO Provider Claims Appeals

Nursing Facility Abuse, Neglect, Exploitation and Misappropriation

Nursing Facility Transfers to Emergency Rooms

The OIG initiated this inspection series because of the potential for MCOs to misclassify encounters in their HHS financial reports. OIG's inspection found that Texas Children's Health Plan (TCHP) misclassified encounter data for non-covered services on its FSRs submitted to HHS. None of the 478 tested encounters related to non-covered services were coded with the correct financial arrangement code to classify them as case-by-case services. TCHP confirmed with inspectors that it included the non-covered services as covered medical expenses, thereby overstating the total medical expenses by $132,664 on its 2022 FSR. However, TCHP documented the reason for providing non-covered Medicaid services, as required, in all 20 patient records tested.

The OIG recommended that TCHP implement controls to correctly classify the non-covered services they provide as case-by-case services, report case-by-case services on its FSRs correctly and consult with HHS Financial Reporting and Audit Coordination to determine how best to correct the misreported medical expenses.

CLIENT ACCOUNTABILITY

TRENDS

The Benefits Program Integrity (BPI) Unit investigates allegations of overpayments to health and human services program clients. This quarter the unit completed 4,200 investigations involving benefit recipient overpayments or fraud allegations.

Concerns involving a client's household composition made up 63% of all completed BPI investigations, with an additional 18% involving unreported income. Household composition cases usually involve an unreported household member who has reportable income or a reported household member who does not live in the same residence. Both instances may cause clients in the household to receive benefits in excess of what is allowed. This quarter, BPI referred 11 investigations for prosecution and 207 investigations for administrative disqualification.

Benefits Program Integrity Performance

$5,672,302
Overpayments recovered

4,874
Cases opened

4,200
Cases completed

11
Cases referred for prosecution

207
Cases referred for administrative disqualification

CASE HIGHLIGHTS

Hidalgo County woman pleads guilty to third-degree felony theft for SNAP and Medicaid fraud
As a result of an OIG investigation, a Hidalgo County woman was charged with theft of property over $20,000 but less than $100,000, a third-degree felony. The woman applied to receive Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits, but OIG investigators found evidence that she failed to report all required household members and their income. Eligibility is tied to household income. Therefore, applicants are legally required to provide truthful information regarding income, financial resources and household composition. In total, the defendant obtained more than $76,000 in SNAP and Medicaid benefits she was not entitled to. After pleading guilty, her sentence of confinement was suspended and she was placed on six years of community supervision. She was ordered to pay full restitution of $76,578. In accordance with federal regulations, she was also disqualified from receiving SNAP benefits for 12 months.

Atascosa County SNAP client falsifies application, leading to SNAP repayment
In a recent OIG investigation, an Atascosa County woman admitted to falsifying applications to obtain SNAP benefits she was not entitled to. The client failed to report her husband was living in the home and receiving income. The OIG investigation uncovered evidence proving the client intentionally falsified statements and applications to exclude her husband as a household member. Through the deception, she fraudulently obtained more than $53,000 in SNAP benefits from 2020 to 2024. The investigation was scheduled for an administrative disqualification hearing, but before the hearing could be conducted, and when presented with the evidence, the woman waived her right to a hearing and voluntarily agreed to be disqualified from the SNAP program for 12 months. She also agreed to repay the full overpayment over the next 36 months per federal regulations.

Juarez, Mexico woman falsifies Texas residency to obtain SNAP benefits
In a recent proceeding, an HHS hearing officer determined that a United States citizen committed an intentional program violation by failing to report on her SNAP application that she moved from Texas to Juarez, Mexico. The client listed an El Paso address on several applications for assistance from 2019 to 2022. The OIG investigation uncovered evidence proving the client was residing in Mexico and, therefore, was not eligible for Texas SNAP benefits. As a result of the falsified applications, she fraudulently obtained more than $21,000 in benefits. The subject was ordered to repay the entire amount and disqualified from SNAP for 12 months per federal policy.

RETAILER MONITORING

TRENDS

Electronic Benefits Trafficking Unit
The Electronic Benefits Transfer (EBT) Trafficking Unit is comprised of commissioned law enforcement officers and non-commissioned investigators who conduct criminal investigations into EBT misuse by retailers. This quarter, the EBT Trafficking Unit completed 122 investigations and presented 70 investigations for either administrative disqualification hearings (65) or prosecution (5).

Electronic Benefits Transfer Trafficking Unit Performance

$141,130	Overpayments recovered
116	Cases opened
122	Cases completed

The most common occurrence across cases involves clients selling their SNAP benefits to a small store or food truck in exchange for cash. A retailer typically gives cash to the EBT cardholder at a discounted rate in exchange for their benefits. Then, the retailer uses the full amount of the benefits to buy inventory for their business.

In addition, the EBT Trafficking Unit continues to investigate allegations of HHS employees using information from benefit recipient accounts to steal benefits.

WIC Vendor Monitoring Unit
The Women, Infants, and Children (WIC) Vendor Monitoring Unit (VMU) uses a variety of tools to monitor and ensure the compliance of retailers participating in the WIC program. This quarter, WIC VMU conducted 106 compliance buys across the state. A compliance buy is a covert in-store inspection. An OIG inspector poses as a WIC client and uses a WIC (EBT) food card to make purchases to ensure vendors are following WIC rules. Investigators cited violations during five of the compliance buys.

WIC Vendor Monitoring Unit Performance

106	Compliance buys
1	Inventory reviews
44	On-site store inspections

The team also began work on 49 inventory reviews for WIC-contracted vendors across the state. An inventory review is a comparison of a vendor's paid claims and purchase invoices for WIC food items. The inventory review determines if the vendor had a sufficient inventory of WIC food items to justify submitted claims. One review was completed this quarter, while the remaining will continue to be completed in future quarters.

The WIC VMU also conducted 44 on-site store inspections. The inspection is an overt in-store assessment during which the OIG works with the respective WIC vendor to identify any deficiencies that may or may not exist with the sale of authorized WIC products.

CASE HIGHLIGHTS

Owner of retail store faces administrative action after crediting SNAP accounts
An OIG analysis of high-dollar transactions at a retail store in Zapata suggested that the retailer was allowing customers to settle credit accounts using their SNAP benefits, which is a violation of SNAP rules. In interviews with EBT Trafficking Unit investigators, clients with high-dollar transactions admitted to obtaining credit at the store and paying off their balances using SNAP benefits. The retail owner was also interviewed and acknowledged providing credit accounts, stating that she was unaware the activity violated program rules. OIG referred the case to the U.S. Department of Agriculture's Food and Nutrition Service (USDA-FNS) for potential administrative action against the retailer. Several similar cases in San Antonio, El Paso and Mission were also investigated and referred to USDA-FNS in the second quarter of FY 2025.

HHS OVERSIGHT

Internal Affairs Performance

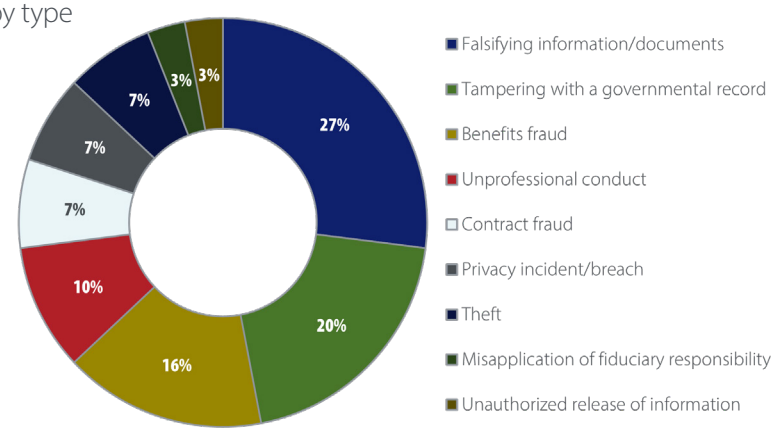
120	Cases opened
48	Cases completed

State Center Investigations Team Performance

171	Cases opened
200	Cases completed

Internal Affairs Completed Cases

by type



TRENDS

Internal Affairs

Internal Affairs (IA) processed 129 referrals this quarter. IA opened 120 investigations and closed 48 investigations in the same period. The remaining referrals were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers, the Department of Family and Protective Services (DFPS) Office of Internal Affairs and HHS Complaint and Incident Intake.

Approximately 16% of Internal Affairs' open cases involved Child Protective Services client or supervisor allegations of DFPS employees falsifying documents. Many referrals also came from outside entities not involved with a state agency or HHS.

State Center Investigations Team

The OIG State Center Investigations Team (SCIT) is comprised of commissioned peace officers who investigate allegations of abuse and other wrongdoing at state hospitals and state supported living centers. This quarter, SCIT opened 171 investigations and completed 200 with an average completion time of 19 days. This compares to 213 opened investigations and 242 completed investigations in the prior quarter. In the same quarter of FY 2024, SCIT opened 209 investigations and completed 187 investigations.

CASE HIGHLIGHTS

HHS employees falsify benefits applications

IA investigated two cases this quarter where HHS employees allegedly falsified information on their own benefits applications. In the first case, the employee failed to report all required household members. Witness statements, document reviews and the employee's admission confirmed the violation. In the second case, the HHS employee failed to report required household income on their state benefits application. Witness statements and document reviews confirmed the violation. In both cases, the employee signed agreements to repay the money and OIG's findings were provided to the employees' program areas to determine appropriate disciplinary action.

Sentence handed down in Brenham SCIT case

After a SCIT investigation confirmed allegations of abuse at the Brenham State Supported Living Center, the case was turned over to the Washington County District Attorney's Office for criminal prosecution. The defendant was subsequently found guilty of injury to a child, elderly or disabled individual. On January 30, the perpetrator was sentenced to three years of deferred adjudication, ordered to complete 100 hours of community service and pay court costs and fines.

SCIT investigation confirms abuse allegations at Mexia facility
In the second quarter of FY 2025, SCIT officers investigated alleged injury to a disabled individual at the Mexia State Supported Living Center. The SCIT investigator conducted interviews and reviewed video of the incident, confirming the allegation. The case is being referred to the Limestone County District Attorney for criminal prosecution.

POLICY RECOMMENDATIONS

Policy updates recommended for certain Texas Health Steps services
As a result of multiple investigations, the OIG identified numerous providers who billed for Texas Health Steps medical checkups on the same day as hearing tests even though a hearing test is included in the medical checkup reimbursement. The OIG recommended that HHS include in its audiometry policy the Texas Health Steps policy prohibiting unbundling and separate billing for hearing tests.

In another investigation, the OIG found inconsistencies in the provider types billing for certain Texas Health Steps oral evaluation and fluoride varnish (OEFV) services. The OIG recommended that HHS update its policy guidance to specify which provider types can complete certain OEFV components and which components can be delegated to other clinical staff. As a result of the OIG's recommendations, HHS is updating the policy, which is scheduled to take effect in April.

HHS updates food thickener billing policy
In the fourth quarter of FY 2024, the OIG recommended that HHS update its food thickener policy to specify the unit of measurement and whether the unit of measurement is a pre-mix or post-mix amount. These recommendations followed an investigation in which the OIG found inconsistencies in how providers billed for food thickener. As a result of the OIG's recommendations, HHS updated the policy to specify that food thickener is reimbursed per unit, and 1 unit equals 1 ounce.

RULES

New inspections rule addresses recovery of overpayments
The OIG may now recover overpayments identified in inspections as the result of a new rule that went into effect on December 26, 2024. Before the adoption of Texas Administrative Code, Title 1, Section 371.1721, the OIG Inspections team did not have explicit authority to recover overpayments based on its work and were required to refer overpayments to other OIG divisions to pursue recovery. The rule addresses the recovery of overpayments, specifies procedures for notifying providers of overpayments, details steps for providers to contest findings and outlines recovery methods. The OIG Inspections team updated its procedures to include using business records affidavits and assisting the OIG Chief Counsel Division with evidence collection.

Texas Government Code reorganization
In 2023, the Texas Legislature passed HB 4611 to renumber and reorganize Chapter 531 of the Texas Government Code. The OIG's portion of Chapter 531 will become Chapter 544 on April 1, 2025. The OIG proposed amendments to Texas Administrative Code, Title 1, Chapter 371, to update statutory citations and references within the administrative code to accurately reflect these upcoming changes. The proposed amendments will become effective April 1, 2025. The agency has published a crosswalk on its website to help stakeholders locate updated statutory references.

Medicaid Estate Recovery Program
The OIG is proposing amendments to Texas Administrative Code, Title 1, Chapter 373 concerning the Medicaid Estate Recovery Program (MERP). The rule will clarify MERP eligibility and rule requirements to ensure proper recovery of Medicaid long-term care costs, update outdated terminology and citations, adjust financial thresholds based on inflation and eliminate ambiguous language. The proposed rule amendments are currently undergoing review and are expected to post in the Texas Register for the 31-day public comment period in the third quarter of FY 2025.

STAKEHOLDER ENGAGEMENT

Fraud Hotline Performance

7,868 Fraud Hotline contacts handled

1,411 Fraud Hotline referrals to OIG units

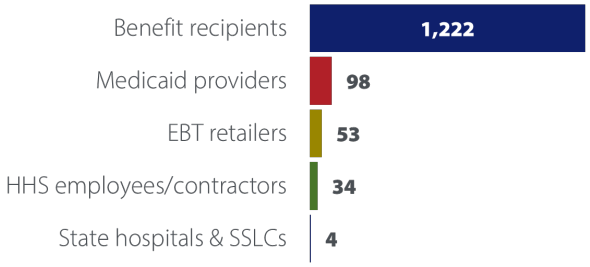
External Relations Performance

24,503 Digital subscribers and followers

74,520 OIG web page views

STAKEHOLDER OUTREACH

Fraud Hotline Referrals by Type



Texas Fraud Prevention Partnership leadership meeting

On February 21, the OIG held a Texas Fraud Prevention Partnership meeting with OIG leadership and executive leadership from MCOs to discuss current initiatives and combined efforts to prevent, detect and investigate fraud, waste and abuse. Participants discussed the CMS Managed Care Oversight Initiative, new reporting requirements for MCOs resulting from CMS prompt-payment final rules, fraud trends, MCO referrals and 89th Texas Legislative Session initiatives. The OIG also updated attendees on recent agency activities, including audits, inspections, data integrity and surveillance utilization reviews.

Texas Fraud Prevention Partnership special investigative unit meeting

A February 26 Texas Fraud Prevention Partnership meeting included the OIG, MCO and DMO special investigative unit staff, and the Texas Office of Attorney General's Medicaid Fraud Control Unit. In the meeting, Cook Children's Health Plan discussed a scheme involving private duty nursing services. Also, the OIG provided an overview of the Unified Program Integrity Contractor, which conducts fraud, waste and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed across the country, including in Texas.

OIG leadership team meets with University of Texas Medical Branch in Galveston

OIG leaders outside "Old Red," UTMB's original medical school, built in 1890.

On January 17, 2025, Inspector General Winter and executive staff visited the University of Texas Medical Branch in Galveston. The team met with UTMB health leaders who briefed the OIG on the storied history of UTMB, the community it serves and its future for growth and adaption to serve a growing population of Texans. UTMB also provided a tour of its facilities including the hospital's labor and delivery wing, the high-risk and maternal ICU and NICU, and the medical school. These immersive learning opportunities allow agency leaders to engage with health care partners who serve the most vulnerable Texans.

OIG continues collaboration with HHS Behavioral Health Services

The OIG team assigned to audit Texas local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) meets regularly with HHS's Behavioral Health Services (BHS) team to collaborate on the work being performed. BHS provides input on rule interpretations, LMHA and LBHA performance expectations, and common practices at these entities. The audit team shares information about audit results and recommends potential rule or policy changes that could help LMHAs and LBHAs meet BHS expectations. Discussions have included LMHA and LBHA staff qualifications, Texas Resilience and Recovery Utilization Management Guidelines, and performance measurement. The ongoing collaboration allows auditors to make informed conclusions about audit testing results.

Nursing Facility Utilization Review stakeholder meeting
The OIG Surveillance Utilization Review (SUR) team conducted a quarterly nursing facility stakeholder meeting for in-person and virtual audiences at the North Austin Complex on February 10. This was the first hybrid stakeholder meeting since 2019. SUR staff met with nursing facility representatives and provided updates on the desk review process, common findings in reviews and the status of its work plan. Quarterly meetings allow stakeholders to meet with SUR staff to discuss current issues and improve collaboration and engagement.

CONFERENCES, PRESENTATIONS AND TRAININGS

HHS Office of Chief Counsel receives OIG training
In February, OIG Program Support and Training conducted fraud, waste and abuse training for more than 100 HHS Legal Services Division staff as part of their ongoing speaker series. The training provided an overview of the OIG and its areas of responsibility, defined fraud, waste and abuse using case examples, and outlined reporting mechanisms. These presentations increase awareness of the role all HHS staff have in preventing fraud, waste and abuse and build collaborative relationships between OIG and HHS divisions.

Training Overview

43 Trainings conducted this quarter

Targeted Queries team strengthens expertise through training
The Targeted Queries (TQ) team held three training sessions this quarter. The trainings included a refresher on initiating retrospective payment reviews, best practices for effectively deconflicting reviews with other OIG activities to avoid duplication, and documenting case records for accurate tracking. These trainings reinforce the OIG's commitment to maintaining high-quality TQ review processes.

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This report meets the requirements for information related to the expansion of managed care as required by Senate Bill 1, 87th Legislature, Rider 102, Office of Inspector General Report and Government Code Section 531.102 (U)