

Inspector General

Texas Health and Human Services



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OIG

Quarterly Report

Quarter 3, Fiscal Year 2021

Table of Contents

I. Executive Summary.....	1
II. Quarter Results.....	2
III. Trends.....	3
IV. Policy Recommendations.....	7
V. Agency Highlights.....	8
Completed Reports.....	12
Stakeholder Outreach.....	15
Trainings and Conferences.....	17
VI. Program Integrity Spotlight.....	18
VII. Division Performance	20

I. Executive Summary

I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the third quarterly report for fiscal year 2021, summarizing the excellent work this office has performed during this period.

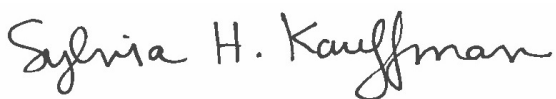
The Office of Inspector General recovered just under \$135 million this quarter. In addition, we identified nearly \$90 million in potential future recoveries and achieved \$31 million in cost avoidance by deterring potentially questionable spending before it could occur.

With the COVID-19 pandemic reaching the one-year mark during the quarter, the OIG continued its work to identify fraud, waste and abuse issues related to the expansion of services during the health crisis. Our Benefits Program Integrity division continued to process referrals due to the rising number of beneficiaries and assigned specific investigative staff to work those cases (read more on page 4). With the increase in the use of telemedicine, the OIG is working with providers, managed care organizations and other HHS agencies to help identify risks and collaboratively develop solutions. You can read more about that work in our Program Integrity Spotlight section on page 18. The OIG has also resumed most of its required on-site activities, following proper protocols to keep both staff and those whom we interact with safe.

During the 87th Texas Legislature, OIG staff worked closely with legislators and other state officials on bills that had an impact on the agency and offered our information when requested. You can read more about our outreach efforts on page 15. I am proud that this agency has a positive relationship with lawmakers and our stakeholders, which is a result of the culture of professionalism we cultivate at the OIG.

The OIG team follows its core values – Accountability, Integrity, Collaboration and Excellence – in performing our work on behalf of Texas taxpayers. I am honored to work with this outstanding team.

Respectfully,

A handwritten signature in black ink that reads "Sylvia H. Kauffman". The signature is fluid and cursive, with the first name "Sylvia" being the most prominent.

Sylvia Hernandez Kauffman
Inspector General

II. Quarter 3 Results

Dollars recovered

Audit and Inspections	
Audit collections	\$77,897
Investigations and Reviews	
Provider overpayments	\$15,658,460
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	\$17,168,011
Voluntary repayments by beneficiaries	\$22,972
Acute care provider overpayments	\$3,034,804
Hospital overpayments	\$3,304,194
Nursing facility overpayments	\$689,131
Recovery Audit Contractor recoveries	\$2,517,199
WIC collections	\$38
Provider underpayments	\$[6,184]
Total division recoveries	\$42,388,625
Third Party Recoveries	
TPR recoveries	\$92,307,191
Peace Officers	
EBT trafficking retailer overpayments	\$191,701
Total dollars recovered	\$134,965,414

Dollars identified for recovery

Audit and Inspections	
Provider overpayments	\$154,917
Investigations and Reviews	
MCO identified overpayments	\$9,227,978
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	\$14,560,218
Acute care provider overpayments	\$3,262,867
Hospital overpayments	\$1,794,057
Nursing facility overpayments	\$707,974
Recovery Audit Contractor identified	\$10,460,319
WIC vendor monitoring	\$15
Total identified recoveries	\$40,013,428
Third Party Recoveries	
TPR identified recoveries	\$49,165,900
Peace Officers	
EBT trafficking	\$414,003
Total dollars identified for recovery	\$89,748,248

Cost avoidance

Investigations and Reviews	
Medicaid provider exclusions	\$355,291
Client disqualifications	\$1,502,809
WIC vendor monitoring	\$0
Pharmacy Lock-In	\$973,638
Third Party Recoveries	
Front-end claims denials	\$27,995,290
Peace Officers	
EBT recipient avoidance	\$474,404
Total cost avoidance	\$31,301,432

Liquidated damages

LDs collected	\$20,400
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How we measure results

An investigation, audit, inspection or review that is performed, managed or coordinated by the OIG can result in:

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

Dollars identified for recovery: This is a measure of the total potential overpayments resulting from activities of the Office of Inspector General. These potential overpayments have not actually been collected at this point (and notice not necessarily sent to providers, contractors and/or managed care organizations). These potential overpayments are estimates prior to further analysis or additional information submitted by the subject of the potential recovery.

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

Liquidated damages: The OIG recommends that HHS assess liquidated damages when managed care organizations (MCOs) and dental maintenance organizations (DMOs) are found to be non-compliant with program integrity requirements in their contracts. Liquidated damages are not intended to be a penalty but are intended to be reasonable estimates of HHS's projected financial loss and damage resulting from an MCO's nonperformance.

III. Trends

Provider Investigations

Investigations & Reviews (I&R) continues to receive complaints and managed care organization (MCO) referrals related to personal care attendants. For the quarter, 37.8 percent of preliminary complaints are for attendants billing for services not rendered, falsifying documentation and billing for attendant care while the client is an inpatient at a hospital or nursing facility. The OIG continues to investigate attendant care cases and recommend administrative action based on findings.

A sample of case results for Provider Investigations settled by Litigation for this quarter includes:

- **PCR testing settlement.** The OIG settled a case in May with a pediatric office in Rio Grande City. The provider had been excessively ordering expensive polymerase chain reaction (PCR) testing for clients presenting with standard symptoms, who were otherwise healthy. These tests substantially exceeded the recipients' needs, and a \$74,500 penalty was assessed.
- **OIG reaches settlement with Austin DME supplier.** The OIG settled a case in April against one of the largest durable medical equipment suppliers in the state. The investigation found evidence supporting one or more alleged program violations consistent with missing a doctor's authorization. The provider agreed to a settlement of \$103,845.
- **Private duty nursing settlements.** As part of an OIG initiative, investigators identified providers who were billing over the daily allowable amount for private duty nursing and, in some instances, submitting duplicate claims. Three separate full-scale investigations related to one home health agency with locations in Dallas, Fort Worth and Tyler reached settlements in April to repay a total of \$130,950.

Provider Investigations

Referral sources for cases

MCO/DMO	32%
Government agency	30%
Public	22%
Provider	9%
Anonymous	6%
OIG initiated	1%

Types of preliminary investigations opened

Attendants	38%
Physician (individual/group/clinic)	17%
Home health agency	11%
Dental	7%
Nursing facility	4%
Therapy (counseling)	4%
Durable medical equipment	3%
Pharmacy	3%
Therapy (physical/occupational/social)	2%
Rehabilitation center	2%
Adult day care	2%
Hospital	1%
Federally qualified health center	1%

10 other categories at less than 1%

Types of full investigations opened

Physician (individual/group/clinic)	25%
Home health agency	16%
Attendants	13%
Nursing facility	13%
Dental	6%
Pharmacy	6%
Adult day care	3%
Assisted living	3%
Durable medical equipment	3%
Hospital	3%
Managed care organization	3%
Parent/guardian/recipient	3%
Therapy (physical/occupational/social)	3%

- **OIG settles case with South Texas DME provider.** The OIG entered into a settlement agreement in May with a durable medical equipment supplier from Mission. The investigation found that between 2014 and 2018, the provider billed for items without a proper doctor authorization and billed for supplies that were not supported by inventory records and never provided to clients. The provider agreed to a settlement of \$349,963.

Benefits Program Integrity

The Benefits Program Integrity (BPI) division completed 5,539 investigations involving some form of benefit recipient overpayment or fraud allegation. Ninety percent of all investigations completed involved unreported income or an issue with the reported household composition. Household composition cases usually deal with an unreported household member who has income or could also include a reported household member who does not actually live in the same residence. Both instances cause the household to receive more benefits than they are eligible for. BPI referred 8 investigations for prosecution and 181 for an administrative disqualification hearing.

Update to increased caseload

During the second quarter, BPI reported a significant increase in fraud, waste and abuse (FWA) referrals due to more individuals applying for and receiving benefits during the COVID-19 pandemic. BPI allocated specific personnel to these cases and set weekly completion goals to adjust to the increased volume. During the span of the project between January and April 2021, OIG staff completed 1,787 investigations identifying \$2,164,511 in overpayments.

A targeted team of BPI investigators across several regions of the state continue to work the cases.

Sample cases worked by BPI this quarter include:

- **Inaccurate income and household composition.** In March, BPI resolved a case in Hale County regarding a client who excluded her husband and his income from benefit applications. Between 2014 and 2018, the

client made multiple false statements to HHS. Investigators gathered evidence that included government and school records, employment and payroll information, social media content, and witness statements to prove the husband was part of the household and gainfully employed. The household received \$32,502 in excess SNAP benefits. The case was presented to the Hale County district attorney for criminal prosecution. The subject pleaded guilty, received 10 years' deferred adjudication probation, and was ordered to pay \$32,502 in restitution.

- **Fraud hotline tip.** BPI received a referral from the OIG Fraud Hotline alleging an individual residing in Mexico was receiving Texas benefits. BPI investigators discovered multiple individuals were using the same El Paso County address and phone number to receive benefits. An investigator interviewed the current resident of the Texas address, who admitted to allowing Mexico residents to use her address for benefits. As a result of the investigation, two households were administratively disqualified from the SNAP program for 12 months and ordered to repay benefits that had been inappropriately received. One household was ordered to pay \$30,074, and the other was ordered to pay \$25,067 for the fraudulently received benefits.
- **Falsifying benefits application.** BPI investigated a client in Harris County who concealed her spouse's income when obtaining benefits. The investigation revealed that the client had not reported a joint checking account shared with her husband, which included deposits of his employment earnings. The client requested both an Administrative Disqualification Hearing and a Fair Hearing, where she and her attorney contested BPI's fraud finding and associated overpayment. BPI's findings were upheld in April. The client was disqualified from SNAP for 12 months and ordered to repay \$34,565.

Electronic Benefits Transfer

This quarter the Electronic Benefits Transfer (EBT) Trafficking Unit completed 64 investigations and presented another 32 investigations for either administrative disqualification hearings (30) or prosecution (2). During the quarter the EBT Trafficking Unit identified for recovery \$414,003 and collected \$191,701.

Trends identified by the unit include:

- **Group home cases.** During this quarter, EBT Trafficking has experienced a slight increase in reports of group homes or boarding homes misusing residents' SNAP benefits. Complainants report the homes are requiring residents to either apply for SNAP or, if already a SNAP recipient, to provide their cards and benefits to the facility. Additionally, reports state these homes are misusing the recipients' benefits to purchase supplies for the homes after a recipient's departure.
- **Selling benefits.** EBT Trafficking continues to experience reports of recipients selling their benefits to small restaurants and business owners, who use the benefits to purchase inventory for their stores. Analysis of transaction histories for the reported recipients indicate large purchases, consistent with inventory for stores and restaurants, at major retailers under the business owners' accounts.

Sample cases worked by EBT this quarter include:

- **Restaurant owner convicted in SNAP crime.** In 2018, EBT Trafficking in Houston detected irregularities at a large discount retailer in Beaumont. After an investigation, a search warrant was obtained and executed on a restaurant in Beaumont. Members of EBT Trafficking from across the state coordinated with multiple agencies to search the restaurant, arrested a primary offender, and obtained signed statements from several other offenders and witnesses. The Jefferson County district attorney charged 62 recipients. The majority pleaded guilty and received a

sentence. The restaurant owner was convicted in May and sentenced to 27 years in prison. He was accused of purchasing SNAP benefits from the recipients at a discounted rate and using the benefits to make purchases for his restaurant at the large retailer.

- **Vendor stealing EBT benefits.** In April, members of EBT Trafficking Unit were joined by members of the Houston Police Department in executing a search warrant at a convenience store in Houston. The store was under investigation because the owner was recording EBT card numbers and observing PIN numbers entered by recipients during normal purchases. After the recipients left the store, the owner manually entered the EBT card numbers and PINs, accessing the SNAP benefits. The owner conducted the same act with an EBT card presented during an undercover transaction. The store owner removed between \$30 to \$40 per transaction from several accounts for over a year, fraudulently obtaining over \$28,880 in SNAP benefits. The search warrant secured the owner's 2020 business records, a surveillance digital video recorder and a cell phone. This case will be referred to the Harris County district attorney for prosecution.

Internal Affairs

Internal Affairs (IA) worked 35 active investigations and closed 42 investigations in the third quarter. IA processed 113 referrals this quarter and investigated 34 of those referrals. The remaining were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers, Department of Family and Protective Services (DFPS), Office of Consumer Relations, and HHS Complaint and Incident Intake.

Trend identified by IA:

- **DFPS cases.** The majority of IA's open cases involve DFPS. Many of the cases relate to allegations of falsifying documents. This may be the result of DFPS management establishing quality assurance processes

to identify misconduct by employees and reporting these cases to IA, as well as a greater number of clients alleging caseworker misconduct.

Sample cases concluded by IA this quarter:

- **Unprofessional conduct.** IA investigated an allegation that a Texas Works Advisor (TWA) posted a message on Facebook threatening to suspend a recipient's Supplemental Nutrition Assistance Program (SNAP) benefits. When interviewed, the TWA admitted to the Facebook post, as the SNAP recipient had made derogatory remarks about the TWA's daughter. The TWA subsequently removed the post, and there was no evidence that the TWA had adjusted or modified the recipient's SNAP benefits. The TWA was terminated.
- **Tampering with a government record.** IA investigated allegations that a Child Protective Services investigator had put her supervisor's electronic signature on a home study for a client without the supervisor's approval and was subsequently fired for her conduct. Through interviews and record reviews, IA concluded that investigator had forged her supervisor's signature. The case was referred to the Harris County District Attorney's Office.
- **Falsification of travel records.** IA investigated allegations that a Family-Based Safety Services (FBSS) specialist falsified records and was overpaid for travel expenses. A review of the specialist's records revealed the employee had made several false travel reports, including traveling to facilities that were no longer open or were not connected to their assigned cases, resulting in an overpayment of \$1,026. It was also determined that the employee did not work case files to completion, follow up with providers, or update case narratives and contact information. The employee resigned after their supervisor began inquiring about the false travel records. This case was referred to the Harris County district attorney for

Open IA cases by type

Falsifying information/documents	56%
Computer misuse	9%
Law enforcement assist	9%
Unprofessional conduct	6%
Other	20%

prosecution.

- **Tampering with a government record.** IA received the final adjudication notice from the Lubbock County District Attorney's Office for a previously investigated case involving a CPS investigator who documented investigative actions, assessments, contacts and interviews that did not occur. The CPS investigator pleaded guilty to tampering with a government record and was sentenced to 90 days in jail, ordered to serve 50 hours of community service and pay \$845 in fines and court costs, and placed on community supervision for 12 months.

State Center Investigations Team

The OIG's State Center Investigations Team (SCIT) opened 145 investigations and completed 139 investigations in the third quarter of fiscal year 2021, with an average completion time of 19 days. This compares to 152 opened investigations and 187 completed investigations in the third quarter of fiscal year 2020.

A recent SCIT case involved a false report at the Mexia State Supported Living Center. An employee was accused of intentionally making a false report. The case was referred to the Limestone County district attorney for prosecution. The court accepted a guilty plea of making a false report. The OIG received the notice of the court decision in the third quarter. As part of the plea agreement, the individual received 60 hours of community service with court costs and fines imposed.

IV. Policy Recommendations

Pharmacy benefit transactions

Determine if the MCO used the appropriate method of classifying pharmacy benefit transactions on its Financial Statistical Reports, including discount guarantee payments, per-claim credits, and rebates, in coordination with HHSC Financial Reporting and Audit Coordination.

OIG recommends solution after provider enrollment error

OIG Provider Enrollment Integrity Screenings (PEIS) program integrity staff identified an issue where providers with certain revalidation denials had their enrollment periods incorrectly extended. The denials were based on either an OIG recommendation or an outstanding HHSC

Accounts Receivable issue. However, their extensions were granted along with all other providers when revalidations were delayed during the COVID-19 pandemic.

When OIG PEIS discovered the error, the state's Medicaid claim administrator TMHP identified 20 providers who had received the revalidation denials but continued to bill the state and MCOs. The OIG coordinated with HHSC Operations Management and Financial Reporting and Audit Coordination to provide direction to TMHP to correct the enrollment period dates for the impacted providers and ensure all other revalidation denials issued during the remainder of the pandemic are accurately disenrolled.

V. Agency Highlights

Data-led initiative leads to hospital infusion settlements

The OIG continues to settle cases involving hospital outpatient facilities that bill, or were paid separately, for injections/infusions when the same services were already covered by another billing code paid on the same date of service. Injections and infusions are included in an emergency room service charge and are not reimbursed separately. The cases are part of a data-led initiative involving the OIG's Fraud, Waste and Abuse Research and Analytics team, Litigation, and Investigations and Reviews. The following cases were settled this quarter:

- In April, a settlement was reached with a Fort Worth hospital. The provider had been improperly reimbursed for administering injections and infusions in the outpatient emergency department. The case centered on billing from 2013 to 2019. The provider worked collaboratively with OIG Litigation to resolve these issues and agreed to a settlement of \$7,956,904.
- The OIG settled a case in May with a Dallas hospital that was improperly reimbursed for the administration of injections and infusions in the outpatient emergency department. The provider worked with the OIG to resolve the issues and agreed to a settlement of \$10,155,285 for billing from 2013 to April 2021.
- The OIG settled a case in May against a Plano hospital for injection and infusion billing from 2013 to April 2021. The provider had been improperly reimbursed for the administration of injections and infusions in the outpatient emergency department. The provider worked collaboratively with OIG Litigation to resolve these issues and reached a settlement of \$1,211,913.
- An outpatient hospital in Mesquite was

Quarter 3 performance

Audit reports issued	6
Audits in progress	19
Inspections reports issued	1
Inspections in progress	6
Total investigations opened	6,316
Total investigations completed	6,229
Client investigations completed	5,539
EBT retailer investigations completed	64
Internal Affairs investigations completed	35
State center investigations completed	139
Medicaid provider investigations completed	
Preliminary	415
Full-scale	37
PI cases transferred to full-scale investigation	31
PI cases referred to Medicaid Fraud Control Unit	112
Hospital claims reviewed	4,731
Nursing facility reviews completed	66
Medicaid and CHIP provider enrollment screenings performed	25,989
Medicaid providers excluded	68
Fraud hotline calls answered	5,699

improperly reimbursed for administering injections and infusions in the outpatient emergency department. The billing issues took place between 2012 and 2019. The provider collaborated with OIG Litigation to resolve these issues and in May agreed to a settlement of \$130,783.

OIG works with Texas Medical Board and resolves case with Dallas provider

The OIG settled a case in May against a Dallas family medicine practice. OIG investigators discovered instances of upcoding and a family

medicine doctor acting as a pain management doctor. Investigators submitted their findings to the Texas Medical Board, who took corrective action against the provider via an agreed order which, among other things, required completion of continuing education courses, four cycles of monitoring, and restricted the provider's authority to prescribe Schedule II controlled substances. The provider agreed to a settlement for the upcoded claims and a penalty for the standard of care issue for a total of \$10,433.

OIG reaches settlement with Houston ambulance transport company

The OIG settled a case in April that was transferred from the Texas Medicaid Fraud Control Unit, a division of the Office of Attorney General. The Houston area ambulance transport company billed for services not actually rendered and provided ambulance services that were not needed to seniors. The provider agreed to a settlement of \$23,825.

Case resolved with Houston dental provider

The OIG settled a case in April with a Houston dental provider. The provider's most common errors were upcoding services, providing medically unnecessary services and inadequate or missing x-rays. The provider worked collaboratively with the OIG regarding the documentation issues and took the initiative to improve its billing practices and internal policies. To resolve the case, the provider agreed to a settlement of \$20,000.

OIG reaches settlement with Dallas home health care provider

The OIG settled a case in May against a home health care provider in Dallas. The provider had billed and been paid for more than the maximum allowable amount of 96 units of private duty nursing for one client on one date of service. The OIG also determined that in some of the instances the provider submitted double bills for the same services by applying a different modifier code during billing that could change the payment rate.

The provider worked collaboratively with OIG Litigation to resolve these issues and agreed to a settlement of \$300,386.

Settlement reached with Hidalgo County DME supplier

In May, the OIG settled a case that was transferred from the Texas Medicaid Fraud Control Unit. The case involved a Hidalgo County durable medical equipment supplier. An inventory analysis revealed that the provider did not purchase sufficient supplies to justify their claims submitted to Medicaid. The provider worked collaboratively with OIG Litigation to resolve these issues and agreed to a settlement of \$120,000.

Dental marketer excluded in North Texas

An individual was identified as a marketer for multiple Medicaid dental providers in the Dallas and Fort Worth area. OIG investigators found evidence that the individual offered improper transportation and non-allowable cash inducements to Medicaid clients to receive dental services. In April, the individual was excluded from participating in Medicaid for 25 years.

Daily Activity and Health Services Fraud Detection Operation

OIG data analytics continues to play a proactive role in detecting potential FWA. The Investigations and Reviews Division advanced work on a Fraud Detection Operation (FDO) executed in May. Through a collaborative effort with Fraud, Waste Abuse Research and Analytics, the FDO team selected three Daily Activity and Health Services (DAHS) providers and one home health provider billing as a DAHS that were identified as outliers among their peers for inclusion in the FDO. Outlier status is not an automatic indicator of wrongdoing; it simply flags providers who may warrant a closer look due to unusual billing patterns.

Monitoring for FWA related to the COVID-19 pandemic

The OIG's Fraud, Waste and Abuse Research and

Analytics team (FWARA) is actively conducting data research to identify specific billing schemes and provider behavior changes during the COVID pandemic. FWARA has continued to participate in multiple information-sharing sessions with federal and state partners to leverage nationwide research and analysis of these schemes.

The sessions and research have led to the identification of numerous COVID topics that OIG will focus on as FWARA continues to design and develop new algorithms to detect potential FWA within Medicaid. During the next quarter, OIG will investigate allegations related to COVID schemes impacting laboratory services and therapies delivered via telehealth.

OIG completes initial COVID-19 FWA initiative stakeholder meetings

The emergence of COVID-19 presents new challenges for health care systems. The federal government and the State of Texas implemented policy and programmatic flexibilities to minimize negative impacts to client services. Though these flexibilities have been implemented to ensure safety and access to care, policy and program changes coupled with changes in service delivery may also create new program integrity issues and considerations. The OIG kicked-off the COVID-19 FWA Initiative with Medicaid stakeholders in February and completed the initial meetings in April. Stakeholders provided insight related to issues such as utilization of telehealth/telemedicine, COVID-related laboratory testing, and evolution of policy and clinical guidance throughout the public health emergency across services and settings. The OIG will continue to engage Medicaid stakeholders in future meetings where key takeaways and next steps for the COVID-19 FWA initiative will be discussed.

OIG implements critical project to coordinate prevention efforts

Over the course of the last fiscal year, the OIG has initiated efforts to coordinate and promote prevention-related activities across the office and within the HHS system. Through this work, each

OIG division contributes with the identification of opportunities for prevention activities and potential topics for future efforts. Prevention-focused work routinely initiated within the OIG includes activities such as provider and client education, public fraud advisories, policy recommendations and stakeholder collaborations. The OIG takes a proactive approach to detect program integrity issues and trends and coordinates efforts to mitigate those issues with stakeholders across the system. This results in prevention successes including cost avoidance, efficient operations and improved health and safety.

WIC sees results with vendor education

The OIG's Women Infant and Children (WIC) Vendor Monitoring Unit (VMU) has seen a significant reduction in certain violations, due in part to their prevention efforts. The unit reports fewer Least Expensive Brand violations throughout Traditional Women Infant and Children (TWIC) vendors, who derive less than 50 percent of their annual food sales revenue from WIC products. Grocers must label their least expensive brand "WIC Approved." The decrease in this violation type has allowed WIC VMU to reduce the number of visits to ensure compliance from five or more per store to as few as two.

The reduction corresponds with WIC VMU's operational modifications and communication efforts using educational letters and compliance buys to ensure vendor adherence to WIC regulations. During this quarter, the team transmitted 279 education letters to WIC vendors. This is an important tool for the WIC VMU as the letters provide valuable and necessary information for WIC vendors regarding how each vendor interprets the WIC regulations. The increase in utilizing these letters has proven successful in their impact on compliance buys, on-site store reviews and inventory reviews.

Through the application of vendor inventory reviews and using technology, WIC VMU has also experienced a reduction in the number of

cases where significant claims and redemption errors have been identified. Technology use in the inventory review efforts reduced the amount of time to receive the data and has increased the ability to identify transactional violations. These activities in advanced monitoring have significantly reduced the number of cases where high-dollar amounts of fraud are identified.

WIC compliance activities

WIC VMU developed and initiated a restart of field operations during this quarter. The team conducted compliance buys, on-site store reviews and inventory reviews, resulting in a total increase in productivity to levels that reach near pre-COVID-19 activity.

During a series of covert compliance buy activities in Schertz, WIC VMU identified a vendor who violated WIC policy. In this case, the vendor used WIC-allowable food scan codes from WIC food items to provide an unauthorized food item with a different product code. The WIC vendor was cited and charged back for the infraction.

A series of covert compliance buy activities at five WIC vendor locations in North Texas focused on ineligible purchases. WIC VMU attempted to purchase alcoholic beverages to test vendor compliance. The vendor correctly refused the transactions in all instances.

While conducting an inventory review, the WIC VMU identified a major statewide WIC vendor that was not providing accurate information during an initial request for inventory data. To facilitate the inventory reviews of this vendor, the WIC VMU took the proactive step of conducting a video meeting with the vendor's compliance officers to outline exact details needed, allowing for expedited results. This approach created a more effective working relationship with the vendor.

OIG audit confirms positive progress

The OIG conducted a follow-up audit on two audits completed in 2019 regarding services to members in the Medically Dependent Children Program (MDCP):

- “Audit of Selected Services to STAR Kids Members in the Medically Dependent Children Program: Cook Children’s Health Plan” (August 30, 2019)
- “Audit of Selected Services to STAR Health Members in the Medically Dependent Children Program: Superior HealthPlan” (August 30, 2019)

Both audits observed STAR Kids Screening and Assessment Instruments (SK-SAIs) SK-SAIs were not always complete or aligned with medical records reviewed, and the OIG recommended creating or expanding review processes to identify and correct incomplete or inaccurate assessments.

Managed care organization (MCO) service coordinators use the SK-SAI to perform an annual comprehensive assessment of a member’s physical and functional needs. Through the assessment process, service coordinators should identify member needs and preferences, which are used to design the member’s service plan. The member and the member’s authorized representative must be present for the assessment. The SK-SAI is used to determine both MDCP eligibility and an annual cost limit for MDCP services for that member.

To follow up on whether SK-SAIs were being completed timely and thoroughly, the OIG conducted an audit of to determine whether, for newly enrolled members in MDCP, (a) the SK-SAI data entered in the Texas Medicaid and Healthcare Partnership (TMHP) online portal agrees with the information submitted by the MCO and (b) evidence shows the assessments were completed timely. The OIG concluded that SK-SAIs for members newly enrolled in MDCP are being completed correctly and timely, and no recommendations were warranted. That report, “Audit of STAR Kids Screening and Assessment Instrument New Enrollment Timeliness,” was published on the OIG website in April 2021.

New contract review process for audit topics

Beginning this fiscal year, the OIG developed a

process to identify potentially high-risk contracts to be audited within the given fiscal year. The contracts review team conducted a review of 120 unique contracts executed by HHS, Department of State Health Services, and Department of Family and Protective Services. OIG staff evaluated the potential and magnitude of program integrity risks and vulnerabilities of each contract and is working to prioritize selected contracts for future OIG audit topics beginning in fiscal year 2022.

Implementing projects to help MCOs improve benefits coordination

OIG Third Party Recoveries (TPR), in collaboration with HHS Medicaid CHIP Services and the Texas Medicaid and Healthcare Partnership (TMHP), continues efforts to strengthen and improve Third Party Liability (TPL) activities performed by MCOs. The OIG and TMHP initiated several key projects in this fiscal year to assist the MCOs in coordinating benefits to ensure Medicaid is the payer of last resort. Additionally, these projects will assist in reducing obstacles that Medicaid beneficiaries may encounter while attempting to receive services.

To ensure MCOs receive accurate and up-to-date other insurance (OI) records to maximize cost avoidance and cost recovery efforts, TMHP began providing MCOs information daily instead of weekly. Along with the daily OI file, the MCOs

receive a monthly OI reconciliation file. This project was implemented in March. Additionally, OIG TPR, in coordination with TMHP, updated the MCO referral file that MCOs use to report OI to TMHP that is not included on, or differs from, the daily OI file. The updated file, effective July 1 and posted in the HHS Uniform Managed Care Manual in May, includes additional information to assist the MCOs in submitting a file that TMHP can process timelier. TMHP continues to monitor and assist MCOs in support of these improvements to the TPL process.

NFUR team improves processes

The OIG Nursing Facility Utilization Review (NFUR) team continues to work on processes that promote collaboration, accountability and excellence for the agency's nursing facility stakeholders. NFUR is working on enhancements to the recovery process with MCOs. This effort includes multiple OIG divisions and STAR+PLUS MCOs. In April, NFUR, the Fraud, Waste and Abuse Research and Analytics team, and staff from the OIG's Policy and Strategy teams held a teleconference with the STAR+PLUS MCOs. The meeting addressed the Resource Utilization Group recovery process and will be followed with further discussions of this process and next steps for improvement.

Completed Reports

Audit

Audit of STAR Kids Screening and Assessment Instrument New Enrollment Timeliness. The OIG conducted an audit of select long-term care (LTC) eligibility processes at the Texas Medicaid and Healthcare Partnership (TMHP) for new members enrolling in the Medically Dependent Children Program. TMHP is the claims administrator for Texas Medicaid under contract with HHSC. The audit objectives were to determine whether, for newly enrolled members in Medically Dependent Children Program, (a) the STAR Kids Screening and Assessment Instrument (SK-SAI) data entered

in the TMHP LTC Online Portal agrees with the information submitted by the managed care organization (MCO) and (b) evidence in the TMHP LTC Online Portal and the Health and Human Service Enterprise Administrative Report Tracking (HEART) system supports the completion of SK-SAIs by MCOs within 30 days of receiving initial authorization from HHSC Program Support Unit. The audit scope covered the period from September 1, 2019 to March 31, 2020.

For newly enrolled members in MDCP during the period from September 1, 2019 to March 31, 2020, (a) the SK-SAI data entered into the TMHP

LTC Online Portal agrees with the information submitted by the MCO, and (b) evidence in the TMHP LTC Online Portal and the HEART system supports the completion of SK-SAIs by MCOs within 30 days of receiving initial authorization from the HHSC Program Support Unit. Evidence reviewed in the TMHP LTC Online Portal and the HEART system supports the completion of SK-SAIs by MCOs within the required timelines. As a result of the OIG's conclusions, there are no recommendations to TMHP.

Driscoll Health Plan: A Texas Medicaid and CHIP Managed Care Organization. The OIG conducted an audit of the Driscoll Health Plan (Driscoll) Administrative Expenses Financial Statistical Report (FSR) process for fiscal year 2019. Driscoll was selected for audit based on risks identified through an OIG analysis of its FSR.

The FSR process is a reporting mechanism used by managed care organizations (MCOs) to provide financial information, including administrative operations expenses, related to the Medicaid programs in which the MCO participates. MCOs are required to submit quarterly and annual FSRs for each program and every service area for which the MCO provides coverage, and a separate FSR to report administrative expenses.

The audit objective was to determine whether Driscoll accurately reported selected administrative expenses to HHSC. The audit scope was Driscoll's 334-day 2019 Administrative Expenses FSR and related internal controls over the preparation of the Administrative Expenses FSR.

Driscoll reported unallowable and unsupported costs on its 2019 Administrative Expenses FSR, and it misclassified other costs. These errors occurred because Driscoll did not establish an effective system of internal controls over the preparation of its Administrative Expenses FSR.

Specifically:

- Driscoll's 2019 Administrative Expenses FSR included (a) \$606,183 in unallowable and unsupported expenses and (b) \$288,243 in

allowable expenses reported to incorrect Administrative Expenses FSR line items.

- Driscoll did not conduct a true-up of its affiliate third-party administrator costs as required. As a result, the OIG could not determine whether the budgeted amount of \$2,839,425 reported as a corporate allocation on the 2019 Administrative Expenses FSR accurately represented the affiliate third-party administrator's actual expense.

In addition, Driscoll did not have documented policies and procedures to prepare the Administrative Expenses FSR, including a secondary review process, to help ensure the 2019 Administrative Expenses FSR submitted to HHSC was accurate, reported only allowable expenses, and was supported by documentation.

The OIG offered recommendations to Driscoll, which, if implemented, will address unallowable and unsupported expenses reported on Driscoll's Administrative Expenses FSR for 2019 and other years.

Summary of Results: Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Selected Managed Care Organizations.

The OIG completed a summary of five recent audits of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by the five Texas managed care organizations (MCOs) that participate in the STAR+PLUS program.

The OIG conducted these audits as a follow-up to complaints of nursing facility payments from MCOs being delayed by more than 90 days and of unprocessed nursing facility utilization review resource utilization group (RUG) rate retroactive adjustments. These five audits focused on (a) clean claim payments made more than 90 days after the received date, (b) retroactive adjusted claim payments made more than 30 days after receipt of the SAS notice, and (c) unprocessed nursing facility utilization review RUG rate retroactive adjustments. The scope of the audits included clean claims received during fiscal year 2018, including run-out of retroactive adjustments through April 13, 2019.

The populations for the five MCO audits were outlier claims initially paid past the 90-day requirement. For these audits, outlier claims are considered nursing facility claims for the same member and service dates with more than 90 days between (a) the date the claim was first received and (b) the date the final payment is made. Based on self-reported information, the audited MCOs paid most clean claims timely. Although the MCOs adjudicated most clean claims within required timelines, in all five audits, MCOs did not always (a) make payment adjustments timely or (b) make retroactive utilization review adjustments timely or at all.

The OIG tested a statistically valid sample of 30 adjusted claims identified as outliers for each MCO. That testing identified high error rates, indicating that the five MCOs did not process adjustments within required timeframes. Specifically, within our samples, payments associated with adjustments that were not processed timely resulted in delayed payments to nursing facilities ranging between 31 days and 671 days. Significant delays in payments to nursing facilities could impact the nursing facilities' ability to operate and provide quality care to residents. The OIG recommended that the MCOs ensure their processes effectively identify and process all retroactive claims adjustments within 30 days of an HHSC SAS notice. All five MCOs indicated that, before the reports were issued, they had already strengthened their processes to ensure adjustments are processed within 30 days.

In addition, MCOs did not consistently process retroactive OIG nursing facility utilization review RUG rate adjustments as required. As of January 2020, the MCOs had not processed expected outstanding adjustments. Specifically, they had not processed \$363,259 in adjustments expected to increase payments to nursing facilities and \$2,563,294 in adjustments that were expected to reduce prior payments, and therefore, would result in overpayments that were due back to HHSC. When combined, those changes resulted in a net estimated overpayment amount of \$2.2 million. The MCOs asserted that, among other

things, reasons for not having processed the adjustments included experiencing difficulties with the update file format and confusion determining which update file is current. In October 2020, TMHP changed the location of some files the MCOs use to distribute and submit SAS record changes.

As of May 28, 2021, all the MCOs had made significant progress toward processing outstanding adjustments and improving their processes to ensure adjustments are processed timely.

Managed Care Organization Reimbursements to Pharmacy Benefit Managers: Superior HealthPlan, Inc. and Superior HealthPlan

Network. The OIG conducted an audit of Superior HealthPlan, Inc. and Superior HealthPlan Network (Superior). The audit focused on reimbursements for Medicaid and Children's Health Insurance Program (CHIP) pharmacy expenses under the Uniform Managed Care Contract (UMCC).

HHSC requires each MCO, including Superior, to subcontract with a pharmacy benefit manager (PBM) to process prescription claims and administer its prescription drug program. The state also requires MCOs to base their reimbursements to their PBMs on the actual amounts paid to pharmacies for dispensing fees and ingredient costs. This does not prohibit the MCO from paying the PBM reasonable administrative and transactional costs. These requirements prohibit the practice known as spread pricing. Spread pricing exists when the amount the MCO pays to the PBM for prescription claims costs differs from the amount the PBM pays to the pharmacy.

The audit objective was to determine whether Superior had controls in place to ensure its payments to its subcontracted PBM were based on actual amounts paid to pharmacies for dispensing and ingredient costs; were accurately reported to the state in its FSRs and encounter data; and complied with other applicable requirements related to spread pricing. The audit scope covered Medicaid and CHIP pharmacy benefit services provided by Superior and its

subcontracted PBM during fiscal year 2019.

Superior accurately reimbursed its PBM for the actual amounts paid to pharmacies for dispensing fees and ingredient costs, and Superior accurately reported those reimbursements on its 2019 FSRs and in its encounter data. For 2019, Superior reported prescription paid claims expense of \$881,811,438 on its 334-day FSRs. However, it did not report other payments that affect its reported cost of those prescriptions as required, which overstated pharmacy-related expenses on its FSRs. In addition, Superior incorrectly classified other reported expenses on its FSRs. Specifically, on its 2019 FSRs, Superior:

- Did not report the fiscal year 2019 portion of \$2,074,063 in discount guarantee payments it received. Discount guarantee payments are calculated payments that offset portions of Superior's reported cost of prescriptions in excess of contractually determined market rates. This error can increase HHSC's calculated capitated pharmacy premiums and can decrease profit-sharing experience rebates that MCOs may pay to the state.
- Incorrectly classified \$10,108,911 in payments for per-claim credits and rebates as recoveries from third-party insurers. These include per-claim credits that Superior receives for certain claims processed by its PBM and manufacturer rebates that Superior receives for certain home health supplies.

Overstating and incorrectly classifying expenses on FSRs affect HHSC's ability to understand the components of the MCOs' income and expenses. The OIG offered recommendations to Superior,

which, if implemented, will (a) ensure that Superior reports on its FSRs all pharmacy-related payments that affect the cost of prescriptions and (b) enable Superior and HHSC to determine the true net cost of Superior's prescription expenses for 2019.

Inspections

Inspection of Telemonitoring Services:

Prior Authorizations. The OIG completed an inspection to determine whether fee-for-service telemonitoring provider services were consistent with selected state requirements including Texas Administrative Code policy and procedures. The OIG requested prior authorization documentation for 90 unique Texas Medicaid members from Texas Medicaid and Healthcare Partnership (TMHP) to determine whether the documentation was completed with all required information and signatures. Additionally, the inspection team reviewed the telemonitoring claim information to test whether (a) the prior authorization number and diagnosis on the claim matched the approved prior authorization documentation, (b) the claim date was during the approved prior authorization time frame, and (c) the correct procedure codes were used for both the physician and telemonitoring provider.

A review of TMHP's claims data and prior authorization documentation indicated that fee-for-service telemonitoring services (a) contained required information and appropriate procedure codes and (b) matched the information on the prior authorization.

Stakeholder Outreach

Legislative session

In May, the Texas Senate unanimously confirmed the reappointment of Sylvia Hernandez Kauffman as the Inspector General for Texas Health and Human Services. Kauffman was appointed to this position in January 2018 by Texas Gov. Greg Abbott. During her tenure, the OIG has

established more robust internal controls, accountability in case-processing, and significantly increased monetary recoveries.

OIG Government Relations discussed budget and legislative issues with the following lawmakers and/or their staff:

- Governor Greg Abbott

- House Speaker Dade Phelan
- House Committee on Human Services
- Sen. Cesar Blanco
- Sen. Bob Hall
- Sen. Brandon Creighton
- Sen. Ina Minjarez
- Sen. Drew Springer
- Sen. Sarah Eckhardt
- Sen. Dawn Buckingham
- Rep. Carol Alvarado
- Sen. Joan Huffman
- Sen. Angela Paxton
- Rep. Chris Paddie
- Rep. Stephanie Klick
- Rep. Candy Noble
- Rep. Gene Wu
- Rep. Andrew Murr
- Rep. Ann Johnson
- Rep. John Raney
- Rep. Ina Minjarez
- Rep. Armando Martinez

OIG meets with MCO leadership teams

The OIG held a Texas Fraud Prevention Partnership MCO Leadership Meeting in May. This meeting included discussion of the OIG's COVID-19 Fraud, Waste and Abuse initiative and a recent Fraud Detection Operation on Behavioral Health. OIG leadership also gave an update on utilization reviews, recent audits and the results of the 87th Legislature.

Texas Fraud Prevention Partnership update

In May, the OIG held a Texas Fraud Prevention Partnership Special Investigation Unit one-on-one meeting with Amerigroup to discuss their pending investigations, referrals and current efforts related

to ongoing fraud, waste and abuse schemes. Staff from the Attorney General Medicaid Fraud Control Unit also participated in the meeting and discussed telehealth fraud schemes involving therapy providers.

OIG publishes educational article for providers

The OIG Communications team collaborated with OIG Chief Dental Officer Dr. Janice Reardon, DDS and Provider Investigations to produce an article for the Texas Dental Association's TDA Today. The piece outlined the most common violations observed in OIG dental investigations and gave examples of recent settlements involving provider billing discrepancies. Ongoing OIG prevention efforts strive to help providers minimize billing mistakes that waste taxpayer dollars.

Medical Services meets with stakeholders

Medical Services continued to educate and inform stakeholders by holding virtual quarterly stakeholder meetings in March for NFUR and in April for Hospital Utilization Review (HUR). NFUR discussion included updates on onsite reviews, communication processes, Minimum Data Set extensions, Section O review items, IV infusions of vitamins, and quality control monitoring. HUR discussion included trending diagnosis-related group changes, status of managed care utilization reviews, fee-for-service utilization reviews, and quality control.

Lock-In Program meets with managed care organizations

The Lock-In Program held webinars throughout the quarter for managed care organizations. Topics included reviewing lock-in policies and procedures, automatic and continued lock-in reviews, daily enrollment files, monthly reports and MCO annual surveys.

Conferences and Presentations

- In May, a member of the OIG dental staff presented “Management, Record Keeping and Medicaid Solicitation” to a class of dental hygiene students at Austin Community College. The presentation covered information on fraud, waste and abuse in healthcare and the OIG’s duty to protect the health, safety and well-being of Texans by ensuring the integrity of the HHS System.
- In April, the State Centers Investigative Team and EBT Trafficking Peace Officers conducted their bi-annual peace officer training in San Antonio. The training consisted of CPR/First Aid/AED certification, de-escalations techniques, high profile case reviews, and firearms training and tactics. The training also addressed the intense issue of police relations amid an often-volatile social climate.
- FWARA began a training initiative for team members during the third quarter. This initiative involves advanced training on data coding, mining and visualization software, statistical research methodologies, and data structures. All staff within the division have begun a series of trainings to build upon current skills and to learn new data analytics techniques and tools. The training is part of the OIG’s effort to enhance the use of sophisticated data analytics to detect and deter FWA.
- Investigations and Reviews and Chief Counsel divisions held training for investigators. The training, created as a foundation for conducting provider investigation interviews, included new and experienced investigators. Information presented included how to prepare for, conduct and document interviews of clients, providers and their staff, and associated individuals identified in investigations. Legal staff provided guidance and insight on interacting with a provider’s attorney during an investigation.
- Investigations and Reviews (I&R) Program

Training summary

Trainings conducted this quarter

73

-
- Integrity Development and Support (PIDS) collaborated with HHS Medicaid & CHIP Services Contract Administration & Provider Monitoring team to provide training for I&R Provider Investigations. The training delivered an overview and provided an understanding of Medicaid waiver programs client eligibility, interest lists, covered services, funding, geographic coverage areas, billing for services, common errors and citations, sanctions, the monitoring process and recoupments.
- PIDS provided training to Provider Investigations on the OIG’s statutory authority to conduct investigations and areas of program violations associated with statutes, rules, policies and contracts. The training included where to locate the materials needed to identify program violations, both under fee-for-service and managed care delivery systems, and how to apply these resources for thorough analyses and conclusions.
 - Medical Services provided virtual staff education for Nursing Facility Utilization Review and Hospital Utilization Review. Training topics included medical records review and issues in managed care. The Lock-In Program also held virtual training for managed care organizations throughout the quarter; training topics included referral processes and the use of 90-day and 24-month lock-in criteria.
 - The BPI San Antonio Field Investigative unit provided an OIG overview and referral training to a group of HHS Access and Eligibility Services Quality Assurance supervisors and staff. The training was part of a regional outreach initiative to increase FWA prevention and improve joint program integrity collaboration.

VI. Program Integrity Spotlight

Billing for telemedicine during COVID-19

COVID-19 prompted an increased use of telemedicine to connect physicians with their patients. Adopted waivers and changes eased technology restrictions and expanded the number of Medicaid services available by telehealth. The significant shift in service delivery and demand due to the pandemic gave rise to new program integrity issues for the OIG to explore, especially in services where telehealth was not previously used.

Working with providers, managed care organizations and other HHS agencies helps the OIG identify risks and collaboratively develop solutions. The areas of potential risk associated with COVID-19 presented here are a result of OIG analysis, stakeholder input, Healthcare Fraud Prevention Partnership information sessions, and collaboration with the National Health Care Anti-Fraud Association.

MCO reimbursement

Provider reimbursement for telemedicine and telehealth averaged less than \$800,000 per month in 2019. Reimbursements jumped to \$9 million for March 2020 and \$43 million for April 2020; reimbursements averaged more than \$37 million monthly throughout 2020 (see chart on page 19).

Medicaid and CHIP Services provided the following guidelines to MCOs to determine if telemedicine services should be reimbursed:

- Medical necessity.
- Clinical effectiveness.
- The telemedicine service provided is cost-effective.
- The telemedicine service is provided in accordance with the law and contract requirements applicable to the provision of the same health care service provided in person.

Definitions

Using terminology set by state law, Texas Medicaid “telemedicine” services are delivered by a physician, advanced practice registered nurse, or physician assistant acting under the direction and supervision of a physician.

“Telehealth” generally refers to a health service other than telemedicine delivered by a licensed or certified health professional, such as registered nurses, occupational therapists, home health agencies, or licensed professional counselors.

- The use of telemedicine promotes and supports patient-centered medical homes.

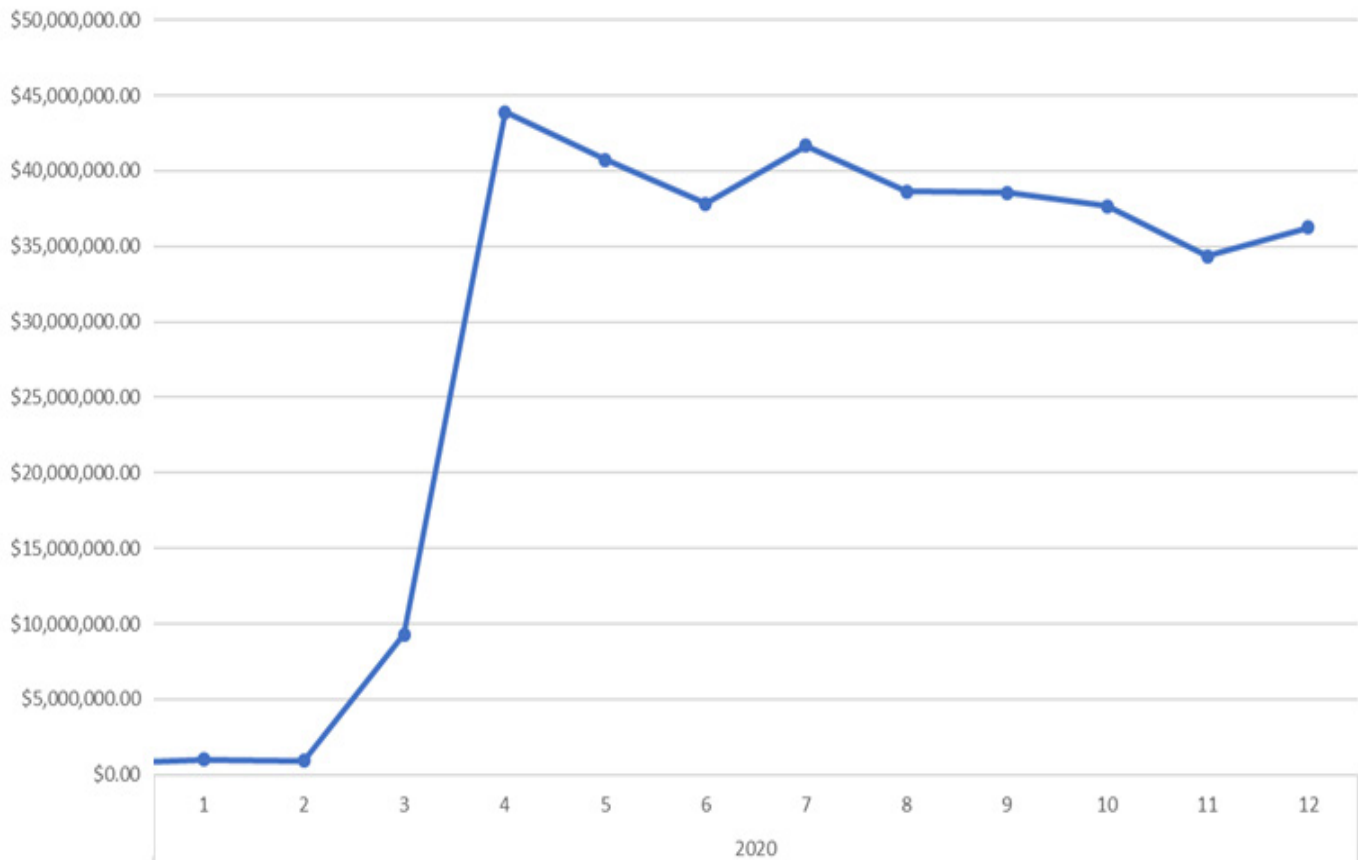
Potential risk indicators

Multiple services within a brief time. While an increase in overall telemedicine services was expected with the pandemic, certain billing patterns may indicate wasteful errors or possible suspicious activity. One issue of interest is billing for multiple telemedicine or telehealth services on the same client in a short period of time, such as one month or even one day. In general, it is not uncommon to see multiple services, such as counseling or therapy sessions, provided via telehealth more than once a month. However, multiple visits in one month via telemedicine to the same provider may be unusual if they did not occur with that frequency prior to the pandemic.

Examples of behavior indicating potentially improper billing:

- Physicians calling patients as a “follow-up” within the same week as a telemedicine visit and billing an evaluation and management (E&M) code.
- Physicians performing telemedicine visits, then an in-person visit, with a modifier 25

Services via Telecommunication Paid by Month



(separately identifiable service) for the same diagnosis.

- Physicians calling patients they had not recently seen and who had not requested an appointment to “check up” on them and billing an E&M code.

Impossible hours. Providers billing impossible hours occurred prior to the pandemic for behavioral health or therapy services. However, telemedicine services are also vulnerable to overbilling. Using timed procedure codes, providers are flagged in excess of 24 billed hours in a day. There are situations in which telehealth services are billed more than 24 hours by a single provider, due to services being rendered by assistants. If this is the case, it is taken into consideration.

Telephone-only services. Telemedicine provided

via telephone—only introduces a new facet in terms of E&M. The Texas Medical Board and HHS issued guidance regarding billing for telephone calls. E&M services cannot be billed if the physician determines an in-person or video telemedicine visit is required within 24 hours or the next available appointment time, as the services rendered via telephone will be considered part of the office/video visit. If a call follows an office visit within seven days for the same diagnosis, the telephone call is considered part of the previous visit and cannot be billed separately.

COVID-19’s evolving impact on health care delivery necessitates an ongoing exploration of current and emerging program integrity. This includes analyzing encounter data and revising algorithms to detect possible improper payments based on COVID-19 schemes.

VII. Division Performance

Strategy

The Strategy Division includes three teams: Fraud, Waste and Abuse Research and Analytics; Policy and Strategic Initiatives; and the Results Management Team.

Fraud, Waste and Abuse Research and Analytics (FWARA) implements tools and innovative data analytic techniques that streamline OIG operations and increase the identification of fraud, waste and abuse. FWARA assesses trends and patterns regarding behavior of providers, clients and retailers participating in Texas Health and Human Services (HHS) programs. FWARA consists of five units:

- Fraud Analytics
- Data Research
- Data Intelligence
- Statistical Analysis
- Data Operations

Policy and Strategic Initiatives serves as the policy

FWARA performance

Data requests received	175
Data requests completed	167
Algorithms executed	80
New algorithms developed	1

research team and liaison between HHS and the OIG. The unit conducts analysis of program policies and coordinates and ensures timely and effective communications with a variety of stakeholders. This unit also leads cross-functional priority projects across the OIG.

The **Results Management Team** collaborates with divisions across the OIG to identify opportunities for operational efficiencies and effectiveness with a focus on continuing to evolve the OIG's work in managed care.

Chief Counsel

The Office of Chief Counsel Division provides legal counsel and conducts employee fraud waste and abuse investigations. It is comprised of the following units:

General Law provides legal support for audits, investigations, inspections and reviews. Furthermore, General Law supports OIG operations, including researching termination/exclusion issues, reviewing federal share obligations, analyzing extrapolation processes, contracting and assisting with rule and statute changes affecting the agency.

Litigation handles the appeal of investigations and audits that determined providers received Medicaid funds to which they were not entitled.

Internal Affairs investigates employee misconduct in the provision of health and human services, including

Internal Affairs performance

Investigations opened	34
Investigations completed	35

State Centers Investigations Team performance

Cases opened	145
Cases completed	139

contract fraud within the HHS system.

The **State Centers Investigations Team** conducts criminal investigations of allegations of abuse, neglect and exploitation at state supported living centers and state hospitals.

Audit and Inspections

Audit conducts risk-based audits related to the accuracy of medical provider payments; the performance of HHS agency contractors; and programs, functions, processes and systems within the HHS system. Protocols of provider audits are periodically published on the Resources page on the OIG's website.

Inspections conducts inspections of HHS programs, systems and functions.

Inspections reports issued

- Inspection of Telemonitoring Services: Prior Authorizations

Inspections in progress

- Overlapping Long-Term Care Claims During Hospital Stays
 - Local Mental Health Authorities
 - Mental Health Targeted Case Management and Rehabilitative Services in Managed Care
 - Delivery Supplemental Payments
 - Supplemental Nutrition Assistance Program
-

Audit performance

Overpayments recovered	\$77,897
Overpayments identified	\$154,917
Audit reports issued by contractors	1

Audit reports issued

- Audit of STAR Kids Screening and Assessment Instrument New Enrollment Timeliness
 - FSR Driscoll
 - NF Outlier Claims Summary
 - Managed Care Organization Reimbursements to Pharmacy Benefit Managers: Superior HealthPlan, Inc. and Superior HealthPlan Network
-

Audits in progress

- IT Security and Business Continuity and Disaster Recovery Plans
 - Performance of Selected Contractors Supporting the Texas Integrated Eligibility Redesign System (TIERS)
 - Selected Durable Medical Equipment Providers
 - Selected Pharmacy Providers
 - Selected HHSC Grant Recipients
 - HHS Human Resources Vendor Contract
 - Selected DFPS Contracts
 - Emergency Ambulance Providers
 - Co-Therapy Billing Guidelines
 - Fee-for-Service Payments for Services Covered by MCOs
 - Selected MCO Special Investigation Units
-

Investigations and Reviews

The Investigations and Reviews Division includes these units:

Provider Investigations (PI) investigates and reviews allegations of fraud, waste and abuse involving Medicaid providers who may be subject to a range of administrative enforcement actions including but not limited to education, prepayment review of claims, penalties, required repayment of Medicaid overpayments and/or exclusion from the Medicaid program. Some referrals come through the OIG Fraud Hotline and via online complaints through the OIG's Waste, Abuse and Fraud Electronic Referral System. Referrals are also received from managed care organizations throughout the state. When criminal Medicaid fraud is suspected, PI refers the matter to the Attorney General's Medicaid Fraud Control Unit. The OIG collaborates with MFCU on joint investigations by sharing resources and information that will lead to successful administrative disposition or criminal prosecution.

Benefits Program Integrity investigates allegations of overpayments to health and human services program clients enrolled in the Supplemental Nutrition Assistance Program (SNAP); Temporary Assistance for Needy Families (TANF) program; Medicaid; Children's Health Insurance Program (CHIP); and the Women, Infants, and Children (WIC) program.

Medical Services conducts claims and medical record reviews on a variety of health and human services, including acute care utilization, hospital utilization, nursing facility utilization, and pharmacy lock-in. Medical Services also provides clinical consultation to the Benefits Program Integrity and Provider Investigations units, as well as the Audit and Inspections Division, on dental, medical, nursing and pharmacy services.

Program Integrity Development and Support (PIDS) provides support and process improvements to other division units. Responsibilities include developing projects to improve investigative outcomes, reporting statistics, acting as the Managed Care Organization Special Investigative Unit liaison, planning and conducting Investigative Initiatives and Fraud Detection Operations and acting as the lead on open records requests.

Provider Enrollment Integrity Screenings (PEIS) unit is responsible for conducting certain federal and state

Provider Investigations performance

Preliminary investigations opened	460
Preliminary investigations completed	415
Full-scale investigations completed	37
Cases transferred to full-scale investigation	31
Cases referred to AG's Medicaid Fraud Control Unit	112
Open/active full-scale cases at end of quarter	85

Medical Services performance

Acute care provider recoveries	\$3,034,804
Acute care services identified overpayments	\$3,262,867
Hospital and nursing home UR recoveries	\$3,987,141
Hospital UR claims reviewed	4,731
Nursing facility reviews completed	66
Average number of Lock-in Program clients	2,937

Benefits Program Integrity performance

Overpayments recovered	\$17,168,011
Cases completed	5,539
Cases opened	5,598
Cases referred for prosecution	4
Cases referred for Administrative Disqualification Hearings	181

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	7,723
Individual screenings processed	25,989

EBT Trafficking Unit performance

Overpayments recovered	\$191,701
Cases opened	48
Cases completed	64

Peace Officers performance

EBT recipient avoidance	\$474,404
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required screening activities for providers seeking to enroll in Medicaid, CHIP and other state health care programs. The screenings and reviews conducted by PEIS promote compliance with federal provider enrollment program integrity requirements; increase accountability for the appropriate use of taxpayer resources by helping to prevent fraud, waste and abuse; and protect the health and safety of Texans.

The **Electronic Benefits Transfer (EBT)** and **Women, Infants and Children (WIC)** Investigation teams include commissioned peace officers and non-commissioned

Operations

The Operations Division is comprised of six core functions.

OIG Purchasing and Contract Management helps to ensure compliance with HHSC purchasing and contracting laws, rules, and policies by coordinating with HHSC procurement and contracting team and OIG divisions throughout the procurement and contracting lifecycle and processing of invoices prior to submission to Accounts Payable.

The **Fraud Hotline** receives allegations of fraud, waste and abuse, screens them and refers them for further investigation or action as appropriate.

Finance and Budget oversees the OIG budget, tracks recoveries, reports Legislative Budget Board performance measures and works closely with HHSC Central Budget on the agency’s LAR/Exceptional Items.

Program Support and Training promotes OIG training services and internal OIG operational policy development.

Third Party Recoveries works to ensure that Medicaid is the payer of last resort, which requires that Medicaid recipients use all other resources available to them (e.g., private health insurance, automobile insurance)

External Relations

The External Relations Division focuses on engaging and ensuring a timely response to OIG critical stakeholders.

Communications manages press relations, maintains the OIG website and social media platforms, publishes the agency’s external facing reports and work products, and facilitates communication between the Inspector General and various stakeholders.

Government Relations serves as the primary point of contact for the executive and legislative branches

personnel. The **Cooperative Disability Investigations** team investigates statements and activities that raise suspicion of disability fraud. These teams conduct administrative and criminal investigations related to those benefit programs.

Investigations and Reviews also oversees the Recovery Audit Contractor, which is a vendor contracted with the state to identify and recover Medicaid overpayments using data analytics and clinical reviews of medical records.

Fraud Hotline performance

Fraud Hotline calls answered	5,699
Fraud Hotline referrals within OIG	
Benefit recipients	1,486
Medicaid provider	129
HHS employee/contractor	48
EBT retailer	28
State Supported Living Center/State Hospital	2

Third Party Recoveries performance

Dollars recovered	\$92,307,191
Identified recoveries	\$49,165,900
Cost avoidance	\$27,995,290

to pay for all or part of their medical care before billing Medicaid. TPR also operates the Medicaid Estate Recovery Program.

The **Ombudsman** provides an independent and neutral process for OIG employees to address concerns and work towards resolution.

External Relations performance

Website page views	208,151
Communications materials produced	95

of government and state policy makers. Government Relations also analyzes legislation to understand the impact to OIG operations.

Office of Chief of Staff leads OIG-wide initiatives and special projects.



Texas Health and Human Services Office of Inspector General

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To report fraud, waste or abuse

OIG Fraud Hotline: 800-436-6184 **Online:** oig.hhsc.texas.gov/report-fraud

Website: ReportTexasFraud.com

OIG on LinkedIn: [hhsc-office-of-inspector-general](https://www.linkedin.com/company/hhsc-office-of-inspector-general)

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This report meets the requirements for information related to the expansion of managed care as required by House Bill 1, 86th Legislature, Rider 112, Office of Inspector General Report and Government Code §531.102 (t)