Inspector General

Texas Health and Human Services

20D0695

OIG Quarterly Report

Quarter 1, Fiscal Year 2021

Table of Contents

I. Executive Summary

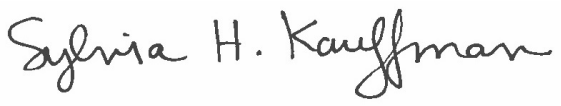
I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the first quarterly report for fiscal year 2021, summarizing the excellent work this office has performed during this period.

The Office of Inspector General recovered just over $95 million this quarter. In addition, we identified nearly $81 million in potential future recoveries and achieved nearly $41 million in cost avoidance by deterring potentially questionable spending before it occurs. This advances the excellent work of the OIG team following a record-setting year for recoveries achieved in fiscal year 2020.

Since the COVID-19 pandemic continues to negatively affect Texans, the OIG team is accomplishing its mission by teleworking. While we have successfully adapted our work to this environment, we have developed procedures to carefully return to conducting on-site visits to nursing homes and SNAP retailers with safety – of our staff and those whom we visit – as the top priority. We remain flexible with providers and managed care organizations by adjusting reporting deadlines to allow them to focus on patient care. We maintain a COVID-19 dedicated page on our website to keep stakeholders advised of any developments.

As we head toward the new calendar year and the start of the 87th session of the Texas Legislature, the OIG team will follow its core values – Accountability, Integrity, Collaboration and Excellence – in performing our work on behalf of Texas taxpayers. We will continue to adapt and change as needed and work with our state and federal partners to fulfill our responsibilities. I am honored to work with this outstanding team.

Respectfully,



Sylvia Hernandez Kauffman
Inspector General

II. Quarter 1 Results

Dollars recovered

Audit and Inspections	
Audit collections	$237,495
Investigations and Reviews	
Provider overpayments	$9,444,500
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$4,613,724
Voluntary repayments by beneficiaries	$16,636
Acute care provider overpayments	$2,687,750
Hospital overpayments	$4,902,501
Nursing facility overpayments	$535,118
Recovery Audit Contractor recoveries	$11,968,485
WIC collections	$0
Provider underpayments	$[18,649]
Total division recoveries	**$34,150,065**
Third Party Recoveries	
TPR recoveries	$60,856,579
Peace Officers	
EBT trafficking retailer overpayments	$112,226
Total dollars recovered	**$95,356,365**

Dollars identified for recovery

Audit and Inspections	
Provider overpayments	$11,735
Investigations and Reviews	
MCO identified overpayments	$27,222,057
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$11,387,699
Acute care provider overpayments	$2,752,995
Hospital overpayments	$8,404,861
Nursing facility overpayments	$71,494
Recovery Audit Contractor identified	$14,124,423
WIC vendor monitoring	$0
Total identified recoveries	**$63,963,529**
Third Party Recoveries	
TPR identified recoveries	$15,874,388
Peace Officers	
EBT trafficking	$907,656
Total dollars identified for recovery	**$80,757,308**

Cost avoidance

Investigations and Reviews	
Medicaid provider exclusions	$10,659,870
Client disqualifications	$1,583,603
WIC vendor monitoring	$158,067
Pharmacy Lock-In	$865,137
Third Party Recoveries	
Front-end claims denials	$27,324,432
Peace Officers	
Disability determination services	$239,784
Total cost avoidance	**$40,830,893**

Liquidated damages

LDs collected	$0

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 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 and Reviews (I&R) continues to proactively monitor data to detect 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 services. During the quarter, two full-scale investigations were initiated based on the data. In October, two of these investigations initiated during fiscal year 2020 were finalized and transferred to Litigation for further action. The OIG continues to investigate injection/infusion cases and recommend administrative action based on findings.

Pharmacy Invoice Initiative

I&R's Provider Field Investigations continues to pursue cases resulting from a pharmacy invoice initiative. The initiative is a data-driven proactive approach which detects pharmacies with unusual billing patterns. As a reflection of the work accomplished through the initiative, seven full-scale investigations involving pharmacy invoices were complete and referred to OIG Litigation for further action this quarter.

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

- **North Texas dental settlement.** I&R Provider Field Investigations initiated two cases against a dental provider with locations in Irving and Farmers Branch. Investigators found multiple instances where the provider billed for services not provided, billed a more expensive service code instead of the appropriate lower-cost service code, and lacked inadequate documentation for services during May 2016 through August 2018. In October, the dental provider agreed to repay $100,000.
- **Houston area durable medical equipment settlement.** In October, the OIG settled a case against a durable medical equipment provider in Webster. Based on information

Provider Investigations

Referral sources for cases

Government agency	32%
MCO/DMO	27%
Public	20%
Provider	12%
Anonymous	6%
OIG initiated	3%

Types of preliminary investigations

Attendants	48%
Physician (individual/group/clinic)	15%
Home health agency	11%
Hospital	6%
Nursing facility	4%
Dental	3%
Durable medical equipment	3%
Pharmacy	3%
Therapy (counseling)	2%
Adult day care	1%
Medical transportation	1%
Assisted living	1%

6 other categories at less than 1%

Types of full investigations

Home health agency	20%
Hospital	20%
Physician (individual/group/clinic)	17%
Assisted living	9%
Attendants	9%
Therapy (counseling)	9%
Managed care organization	6%
Nursing facility	6%
Adult day care	3%
Pharmacy	3%

obtained during the investigation, the provider did not have appropriate documentation to support payments for claims with dates of service during February 2018. To resolve these allegations, the provider agreed to a settlement of $79,209.

- **Pharr pharmacy settlement.** The OIG executed a settlement agreement in October with a pharmacy in Pharr for unsupported billed services and a lack of appropriate authorization from the prescribing physician during June 2015 through May 2019. Through a collaborative effort, the provider agreed to repay $80,000 as settlement.

Benefits Program Integrity

The Benefits Program Integrity (BPI) division completed 4,254 investigations involving some form of client overpayment or fraud allegation. Eighty-four percent of all investigations completed involved unreported income or an issue with the reported household composition. Household composition cases usually include 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 benefits that exceed the allowed amount. BPI completed 135 investigations where fraud was determined. BPI referred 2 investigations for prosecution and 133 for an administrative disqualification hearing. Ninety-one percent of fraud investigations completed involved either unreported income or an issue with the reported household composition.

A sample of cases worked by BPI this quarter include:

- **Failing to report income.** In September, BPI resolved a case in Jones County where a client failed to report her son's father and his income as part of her benefits applications for Supplemental Nutrition Assistance Program (SNAP), Medicaid and Temporary Assistance for Needy Families (TANF). BPI investigators interviewed multiple witnesses and utilized Texas Department of Public Safety records, Texas Department of Motor Vehicle records and employment verifications to substantiate that the client failed to report the father's living status and his income from September 2016 through September 2019. Based on available corroborating evidence, the case was presented to the Jones County District Attorney; the client was found guilty of securing the execution of a document by deception. The client was sentenced to two years in jail, which was suspended in exchange for three years of community supervision, disqualification from the SNAP program for 12 months, and payment of the full restitution of $30,297.
- **Falsifying SNAP application.** BPI investigated a client in Bexar County who concealed information and falsified applications for SNAP benefits. From January 2015 to August 2019, the client claimed her household consisted of only herself and her five children. The investigation proved the father of the client's children was living in the household as well and had additional reportable income. In October, the client signed a Waiver of Disqualification Hearing, agreed to pay $51,615 in restitution and was disqualified from SNAP for 12 months.
- **Defendant sentenced to prison.** BPI collaborated with the Social Security Administration to resolve a Smith County case where a client failed to report several owned properties on Medicaid and Supplemental Security Income applications for her child. As a result, the client was overissued $214,585 in Medicaid benefits from November 2007 to December 2013. This case was filed jointly with the Social Security Administration in federal court, and the client was charged with securing the execution of a document by deception. In September, BPI received the final disposition. The client plead guilty and was sentenced to 12 months in federal prison. The individual will also receive one year of supervised release upon completion of the prison term and was ordered to pay the Social

Security Administration $49,798 in restitution and a total of $214,585 in restitution for the overissuance of Medicaid benefits.

Electronic Benefits Transfer

This quarter the EBT Trafficking Unit completed 18 retailer investigations and presented another 79 investigations for either administrative disqualification hearings (75) or prosecution (4). During the quarter the EBT Trafficking Unit identified for recovery $907,656 and collected $112,226.

Trends identified by the unit include:

Mobile vendors. The EBT Trafficking Unit continues to see complaints in cases involving mobile vendors in the Houston area and their abuse of SNAP benefits. To date, the unit is investigating approximately 36 complaints against two mobile vendors. The mobile vendors create a credit account for a recipient by acquiring the recipient's SNAP benefits information and personal pin numbers. Possession of this information is a violation by the mobile vendor, and it is a violation for the recipient to provide the data. EBT Trafficking interviewed 14 recipients and obtained recorded statements from the potential victims of mobile vendor fraud.

Law enforcement collaboration. EBT Trafficking Unit continues to receive requests for assistance by law enforcement agencies throughout the state. These requests range from assisting in locating fugitives with arrest warrants or persons involved in criminal activity and requests for investigative assistance with cases that have an element that involves SNAP trafficking.

A sample of a case worked by EBT this quarter include:

EBT trafficking trial approaches. The EBT Trafficking Unit completed an investigation that resulted in criminal charges against 63 defendants for EBT trafficking and the identification of more than $71,000 in fraudulently used SNAP benefits. To date, 13 of the 63 defendants have plead guilty to felony EBT trafficking for exchanging their benefits for cash. The primary defendant's trial is scheduled to start in December. The investigation disclosed that a restaurant owner was purchasing benefits from SNAP recipients at fifty cents on the dollar and then using the SNAP card with the full benefits to purchase inventory for his restaurant. The Jefferson County District Attorney offered the restaurant owner a 20-year prison sentence as a plea agreement, but he has not accepted the offer as of this date.

Open IA cases by type

Unprofessional conduct	28%
Falsifying information/documents	22%
Benefits fraud	13%
Computer misuse	10%
Contract fraud	3%
Theft	3%
Travel fraud	3%
Other	18%

Internal Affairs

Internal Affairs (IA) worked 58 active investigations in the first quarter, and 25 investigations were closed during the quarter. IA processed 65 referrals this quarter and investigated 17 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:

- **Increase in cases related to falsification of records.** IA has seen an increase in closed cases related to alleged falsification of casework records by DFPS employees. This could be attributed to more referrals being made by DFPS for review by IA.

Sample of cases concluded by IA this quarter:

- **Falsifying records.** IA received criminal allegations that a DFPS CPS Family Based Safety Services specialist had falsified travel logs and casework documentation regarding

family contacts for an assigned CPS case. The specialist admitted to falsification of information and resigned in lieu of termination. IA referred the case to the Hale County District Attorney for prosecutorial review.

- **Theft allegation:** IA received allegations that a maintenance specialist at a state supported living center (SSLC) had stolen materials from the SSLC's maintenance shop to build a piece of furniture at the SSLC during work hours that he later sold. After gathering information from witnesses and other sources, it was determined that the maintenance specialist, with the permission of his supervisor had used discarded materials and used his personal time prior to his work shift to build the furniture. Based on the information, it was determined that the evidence did not support that a criminal violation had occurred.
- **Falsifying records.** IA investigated allegations that a DFPS Child Protective Investigations (CPI) investigator falsified casework documentation, including investigative contacts, interview narratives and safety assessments in the course of her investigations. The CPI investigator admitted to falsifying government records by documenting interviews that did not occur and making safety determinations without following the required investigative steps. The CPI investigator resigned her position, and the matter has been referred to the Williamson County District Attorney for prosecutorial review.

State Centers Investigations Team

The OIG's State Centers Investigations Team (SCIT) opened 140 investigations and completed 149 investigations in the first quarter, with an average completion time of 21 days. This compares to 195 opened investigations and 209 completed investigations in the first quarter of fiscal year 2020.

A recent SCIT case involved an assault at the Denton State Supported Living Center. An employee was accused of striking a client in the head and ribs. Subsequent interviews by the SCIT investigator confirmed the allegation. The case was referred to the Denton County District Attorney for prosecution. The court accepted a guilty plea to assault, a class A misdemeanor. As part of the plea agreement, the accused received 12 months of community supervision with court costs and fines imposed.

IV. Agency Highlights

OIG resolves a case against a Central Texas pharmacy

The OIG settled a case in August against a pharmacy in Temple. The quantity for particular pharmaceuticals that were billed did not correspond to the amount that was ordered. The provider resolved a significant number of the discrepancies through submitting documentation of vendor invoices; however, not all of these discrepancies were resolved. The provider agreed that it did not have the vendor invoice documentation to resolve the remaining issues and agreed to repay $54,454.

Settlement reached with North Texas dental practices

The OIG obtained a joint settlement in November with two dental practices, located in Lancaster and Fort Worth, both owned and operated by the same two dentists. A review of client files discovered instances of inappropriate billing, services not rendered, upcoded services, missing or inadequate documentation, medically unnecessary services and failure to meet the professional standard of care. The provider agreed to pay $90,000 to resolve the overpayment caused by the identified violations.

OIG settles case against Garland dentist

In November, the OIG settled a case against a dentist in Garland. The dentist submitted inappropriate billing claims to Medicaid, including claims for services not rendered and upcoded services. The dentist worked collaboratively with the OIG to resolve some of the concerns and agreed to pay $12,068 to resolve the overpayment.

OIG resolves case against Houston home health agency

The OIG settled a case in September against a home health agency located in Houston. This case was referred to the OIG from the Texas Office of Attorney General – Medicaid Fraud Control Unit. The provider employed a personal care attendant who was misusing the electronic visit verification system and logging hours that they could not have worked. The provider fully cooperated and responded by identifying all hours that could be related to the personal care attendant's acts. The provider offered to pay $18,609 to resolve the identified hours.

Quarter 1 performance

Audit reports issued	4
Audits in progress	18
Inspections reports issued	1
Inspections in progress	6
Total investigations opened	6,799
Total investigations completed	5,015
Client investigations completed	4,254
EBT retailer investigations completed	97
Internal Affairs investigations completed	25
State center investigations completed	149
Medicaid provider investigations completed	
Preliminary	433
Full-scale	57
PI cases transferred to full-scale investigation	35
PI cases referred to Medicaid Fraud Control Unit	114
Hospital claims reviewed	5,756
Nursing facility reviews completed	3
Medicaid and CHIP provider enrollment screenings performed	22,135
Medicaid providers excluded	38
Fraud hotline calls answered	5,516

OIG resolves a case against San Antonio home health agency

The OIG settled a case in October against a San Antonio home health care provider. The provider was found to have employed a personal care attendant to provide personal attendant services to a patient. However, it was discovered that the employee, by self-admission, did not provide any attendant services to the patient but did submit time sheets and receive compensation. The provider worked collaboratively with the OIG and took the initiative to improve its policy and practices on conducting proper and routine home visits and communication with clients. To resolve the case, the provider agreed to a settlement of $76,697.

OIG settles case against McAllen home health agency

The OIG settled a case in September against a home health agency located in McAllen. The provider offers telehealth services but was unable to provide adequate documentation for a number of claims to support that they took the clients' vital readings and forwarded them to the appropriate party. The provider collaborated with the OIG to implement new record keeping procedures. The provider agreed to pay $12,731 to resolve the unsupported claims.

OIG settles case against Brownsville urgent care

The OIG finalized a settlement of a case in November against a pediatric acute/urgent care provider in Brownsville. A review of records for "after-hours" claims submitted by the provider exhibited a high error rate. The provider billed for services rendered during its posted, routine office hours, for which "after-hours" billing is not applicable per the MCO's policy. The provider cooperated with the OIG to provide information and resolved the concerns identified. Provider has agreed to pay $21,734 to resolve the overpayment.

OIG resolves a case against telemedicine provider

The OIG settled a case November against a provider of telemedicine in McAllen. The provider was found to have issues with its documentation related to billing and having up-to-date preauthorization forms. The provider also billed and was paid during the time when its Texas Provider Identifier was inactive. The provider agreed to settlement terms resulting in recoupment of the full value of the lack of documentation and inadequate documentation claims. The provider agreed to pay the OIG $39,741.

OIG refers case to Texas Medical Board

An OIG nurse analyst and provider field investigator reviewed the medical records in 2019 of a family medicine physician in Garland. The provider appeared as an outlier in a data review of prescribers. As a result of the medical records review, a referral was made to the Texas Medical Board that resulted in a quality of care disciplinary action for the physician this quarter. The board found that the physician failed to obtain or document adequate patient history or assessment for 15 patients that he treated for chronic pain, failed to appropriately monitor patients' use of controlled substances and failed to document adequate medical rationale for the pain medications he prescribed.

Nursing Facility onsite reviews resumed in November

In response to the COVID-19 pandemic, the Nursing Facility Utilization Review unit halted all onsite nursing facility reviews beginning in March but continued with desk reviews. In October, OIG nurses received personal protective equipment and virtual training on COVID-19 safety procedures, including prevention measures, social distancing, travel guidance and testing protocols during annual training. As a result, nursing facility onsite reviews have resumed as of November.

Data analytics enhances new detection method

OIG initiated the development of new detection methods that will use existing and new data sets to display trends in utilization in the Medicaid program. The new methods will highlight trends within specific categories of service. For example, OIG users will be able to access content that will display increases in services by provider type, regional location, and even by managed care plan. The goal is to provide insightful information in an easy-to-use format for data intelligence, clinical review and investigative purposes. The OIG continues to find new methods to utilize data analytics to help prevent fraud, waste and abuse from happening in the first place.

OIG receives grant to fight SNAP fraud

The OIG's data-driven fraud detection efforts are getting a half-million dollar boost from the federal government. In September, the U.S. Department of Agriculture (USDA) awarded the OIG $500,000 to create an automated data analytics model for the Supplemental Nutrition Assistance Program (SNAP).

With the ultimate goal of protecting taxpayer dollars and continuing to build public confidence in the SNAP program, the funds are part of $5 million in grants the USDA awarded to nine states. The grants are intended to fund new and expanded strategies for reducing recipient fraud and payment errors.

The OIG's fraud detection model will analyze SNAP recipient and vendor data from the eligibility, enrollment and usage data systems across HHS, integrating it in one place. By evaluating SNAP data across all HHS programs, the OIG can better concentrate investigative efforts on recipients and vendors identified as likely engaging in fraud.

Investigations initiated based on the model are expected to produce additional restitutions, recoveries and disqualifications of individuals and vendors through either prosecutions or administrative proceedings.

The USDA also awarded HHS's Access and Eligibility Services' Integrity Support Services $21,650 for software to determine a client's location when submitting an application.

EBT Trafficking Unit developing client training

The goal of the client training is to prevent EBT recipients from becoming victims of disreputable mobile vendors. Investigators have discovered mobile vendors taking advantage of SNAP recipients who are out of benefits and yet still need food. The mobile vendor obtains the recipient's account information and personal pin number for the account, extending credit to the recipients (both of which are program violations). The vendor then charges an inflated amount for the products and accesses the account to withdraw the benefits when the recipient's account is replenished. Some vendors will withdraw funds without delivering any food.

The training will make SNAP recipients aware that most legitimate big box stores accept EBT cards and offer a variety of products and services, such as ordering by phone and free curb-side pickup or delivery. With this training, the investigators aim to help benefit recipients better protect themselves from becoming a victim of EBT fraud by disreputable mobile vendor operations.

BPI improves efficiency

The BPI Intake Team is showing an eight percent increase in the number of referrals received the first two months of fiscal year 2021. During this period, the number of investigations created by BPI Intake increased 39 percent from 1,545 in fiscal year 2020 to 3,965 in fiscal year 2021. Since the consolidation of BPI Intake – which included new quality control measures, standardized performance measures and specializing certain tasks – the amount of time BPI Intake takes to screen a referral has decreased from approximately 60 days to an average of five days.

OIG Audit completes series on nursing facility STAR+PLUS claims and adjustments

OIG completed its series of audits of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by five managed care organizations (MCOs): Amerigroup, Cigna HealthSpring, Molina Healthcare of Texas, Superior HealthPlan, and United Healthcare Community Plan. The audit was a follow-up to complaints of MCO payments to nursing facilities being delayed by more than 90 days and unprocessed retroactive adjustments related to nursing facility utilization review resource utilization group (RUG) rates. The audit objectives were to determine whether the MCOs accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

The five MCOs audited adjudicated and paid the vast majority of clean claims timely in 2018, with payment within 10 days for an average of 97% to 99.99% of the claims. However, this series of audits examined the outlier claims, which were those with more than 90 days between the date the claim was first received and the date of the final payment. Of this subset of outlier claims, all five MCOs had issues completing claim payment adjustments timely. Claim payment adjustments occur when the MCO makes a change to the claim in response to new information from (a) HHS, (b) the nursing facility or (c) the MCO's quality review results.

Once a clean claim has been adjudicated, MCOs are required to automatically identify and process any HHS retroactive payment adjustments transmitted from HHS. Retroactive changes are typically made to member eligibility; the member's applied income, RUG or service level; provider contracts; provider hold; provider rate or nursing facility service authorizations. The MCO has 30 days to review the change and process the HHS retroactive payment adjustment.

The amount of unprocessed net rate adjustments ranged from $207,942 to $758,289 and totaled $2,118,917. Other types of adjustments not timely processed resulted in payments to nursing facilities totaling $58,661 being delayed between 31 and 617 days. Further review indicates the MCOs are making progress toward processing outstanding adjustments.

The OIG offered recommendations to the MCOs, which, if implemented, will result in their complying with their contractual requirements to automatically identify and process all retroactive adjustments within 30 days. For instances of noncompliance identified in these audit report, the Medicaid and CHIP Services may consider tailored contractual remedies to compel the MCOs to meet contractual requirements related to their nursing facility claims function. In addition, the audit findings may be subject to OIG administrative enforcement measures, including administrative penalties.

OIG continues to enhance internal training during the pandemic

OIG Program Support and Training assisted staff across the organization to maintain the flow of communication due to the increased utilization of virtual work environments. Training adapted existing courses to be delivered via virtual platforms to meet staff needs. These include employee and manager orientation programs. In addition, new courses on leadership, OIG values and communication were created to continue staff development.

To promote the safety of OIG staff voluntarily returning to the office, Recovery Coordination and Program Support collaborated with Program Support and Training to create a COVID-19 Return to Office video. All staff returning to the office are required to watch the 21-minute training video, which is a compilation of the Centers for Disease Control and Texas Department of State Health Services videos, in addition to some HHS/OIG guidelines and requirements to promote staff safety and social distancing while at the office.

Completed Reports

Audit

Homeward Bound Inc.: Substance Use Disorder Treatment Provider. OIG conducted an audit of Homeward Bound, Inc. (Homeward Bound), a substance use disorder treatment facility under contract with Health and Human Services Commission (HHSC). Homeward Bound was paid a total amount of $1,655,548 by HHSC in 2019 for services evaluated in this audit. The objective was to determine whether client eligibility determinations, treatment stays, discharge events and corresponding paid claims to Homeward Bound's Dallas facilities for detoxification, intensive residential and HIV residential services were processed in accordance with rules, guidelines and applicable requirements.

Homeward Bound ensured that clients met requirements to be eligible for its substance use disorder programs, including verifying that clients met financial requirements, and also conducted initial screenings and assessments, developed treatment plans for clients and maintained records to support its claims. However, Homeward Bound should strengthen controls related to its HIV and residential detox programs because it did not meet certain requirements related to treatment plan execution and discharge planning and follow-up. Specifically, (a) for 19 of 57 (33 percent) clients in detoxification, Homeward Bound could not provide support that required individual counseling sessions were provided or attempted for clients each day; (b) for all 20 clients tested that required co-infection counseling, Homeward Bound did not provide the two hours of counseling each month as required; and (c) for a sample of 113 individual episodes of care: follow-up to referrals were not documented for 35 (31 percent), follow-up was not documented or was not completed within the required timeframe for 52 (46 percent), and discharge summaries were not documented or were not completed within the required timeframe for 19 (17 percent).

Providing and documenting discharge and referral follow up services aid clients in successful long-term sobriety and mitigates the risk of clients relapsing, resulting in further services and increased program cost. OIG Audit offered recommendations to Homeward Bound, which, if implemented, will correct deficiencies in compliance with Texas Administrative Code and contractual requirements.

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Superior HealthPlan. The OIG conducted an audit of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by Superior HealthPlan, Inc. (Superior), a managed care organization (MCO). The audit was a follow-up to complaints of MCO payments to nursing facilities being delayed by more than 90 days and unprocessed retroactive adjustments related to nursing facility utilization review resource utilization group (RUG) rates. Superior was one of five MCOs audited to address this concern. The audit objective was to determine whether Superior accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

Superior adjudicated an average of over 99.99% of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated timeframe as required by its Uniform Managed Care Contract. However, Superior did not always (a) process RUG rate adjustments as required or (b) process other types of adjustments timely. Specifically, Superior did not process $207,941 in net RUG rate adjustments, and for 22 (73 percent) of 30 other types of adjustments tested, Superior did not process the adjustments totaling $1,266 timely, which caused delays in payments to nursing facilities that ranged from 31 to 661 days.

OIG offered recommendations to Superior, which, if implemented, will result in Superior complying with its contractual requirements to automatically identify and process all retroactive adjustments within 30 days.

Fee-for-Service Claims Submitted by Maverick Medical Supply: A Texas Medicaid Durable Medical Equipment and Supplies Provider. The OIG completed an audit of Aveanna Healthcare Medical Solutions Maverick Medical Supply (Maverick), a durable medical equipment (DME) and supplies provider. The audit evaluated whether there was valid support for the authorization and delivery of fee-for-service DME and supplies associated with Medicaid claims submitted by and paid to Maverick as required by applicable state laws, rules and guidelines.

Of 1,858 claims tested, 1,750 (94 percent) were completed as required by laws, rules and guidelines. Additionally, Maverick s obtained Title XIX forms as required for 99.9 percent of clients tested. However, Maverick did not always meet authorization requirements for DME and supplies, and Maverick did not always maintain the appropriate proof of delivery documentation for Medicaid fee-for-service claims. As a result, Maverick did not meet Texas requirements for DME and supplies for a total of 108 claims, for which Texas Medicaid made payments of $11,735 in error. The total amount due to the State of Texas is $11,735.

OIG offered recommendations to Maverick, which, if implemented, will correct deficiencies in compliance with state laws, rules and guidelines.

Inspections

Processes for Hiring and Training Direct Support Professionals: Austin State Supported Living Center. OIG conducted an inspection to review the processes used by Austin State Supported Living Center (SSLC) for hiring and training employees. The objectives were to determine whether Austin SSLC with the support of Texas Health and Human Services Commission Human Resources (HHSC-HR) (a) hired direct support professionals consistent with Texas Administrative Code (TAC) requirements for criminal history checks and registry clearance and (b) trained direct support professionals consistent with TAC requirements for new employees and direct support professionals.

TAC requires that SSLCs complete due diligence checks, which include criminal background checks and registry clearance of an applicant prior to the applicant's first day of employment. OIG Inspections concluded that HHSC-HR usually documented the results of the due diligence checks prior to the first day of employment of direct support professionals, and Austin SSLC usually documented the completed training of direct support professionals. However, there were two instances in which HHSC-HR did not comply with due diligence check requirements outlined in TAC and two instances in which Austin SSLC did not document completed training to comply with TAC training requirements. Policies and procedures for background checks and training should be improved to help ensure direct support professionals meet all TAC requirements for due diligence checks and training.

Stakeholder Outreach

OIG collaborates with MCOs on fraud prevention

The OIG began holding one-on-one meetings with executive leadership from individual MCOs and DMOs in October. The OIG will meet with all MCOs and DMOs over the first and second quarter of fiscal year 2021.

Meetings include discussions regarding the operations of an organization's compliance program; Special Investigative Unit organizational structure and resources; and challenges and best practices in identifying fraud, waste and abuse, among other topics. The goal of these meetings is to share information between the OIG and MCO/DMOs, promote collaboration around program integrity, and support the evaluation of areas for future improvements and coordination.

Third Party Recoveries engages MCOs to help improve coordination of benefits

OIG Third Party Recoveries (TPR), in collaboration with Medicaid and CHIP Services Department, began implementation of a focused education and training plan to strengthen and improve Third Party Liability (TPL) activities performed by MCOs. The OIG continues to meet one-on-one with MCOs, MCO stakeholder groups, and providers to discuss improvements to the TPL process that will assist in coordinating benefits to ensure Medicaid is the payer of last resort. Improvements have been initiated to enhance the process in which MCOs submit other insurance (OI) information to the state, which is anticipated to increase accuracy and provide more timely OI data. A computer-based training has also been developed to further educate and assist the MCOs with TPL activities.

Remote audits include outreach, education

Helping vendors avoid potential violations is at the heart of the OIG's Women, Infants and Children (WIC) Vendor Monitoring Unit's (VMU) evolving outreach efforts. Multiple notifications ahead of and after an audit assist vendors in providing the required documentation to support WIC vendor claims for reimbursement. With the current temporary move to entirely electronic communication, WIC VMU engages vendors to provide a thorough understanding of how to prepare for a contemporary, remote audit of store inventory. OIG outreach includes educating vendors and their suppliers with the proper interpretation of WIC policies and procedures.

OIG publishes educational article for providers

OIG Chief Dental Officer Dr. Janice Reardon collaborated with OIG Communications Team on the article "Medicaid Providers Penalized for Illegal Dental Solicitation," featured in the Texas Dental Association Today November 2020 newsletter. The article outlined the outcomes in a variety of cases related to dental solicitation and educated providers about how to avoid illegally soliciting patients. Sanctions against providers who solicit patients can include exclusion from the Medicaid and CHIP programs, disciplinary action from the Texas State Board of Dental Examiners, and monetary penalties.

Medical Services meets with stakeholders

Medical Services continued to educate and inform stakeholders by holding virtual quarterly stakeholder meetings for the Nursing Facility Utilization Review (NFUR) in September and for the Hospital Utilization Review (HUR) unit in October. Both units provided an overview of the quality control process and quality assurance. NFUR discussion included Long Term Care Medicaid Information (LTCMI) mismatches and Minimum Data Set items, registered nurses temporary licenses on LTCMI issues and resuming NFUR onsite reviews in November. HUR discussion included reviews in managed care, review of fiscal year 2020 HUR results and diagnosis-related

group education, digital scanning updates and announcement of a new HUR quality nurse.

OIG provides education for Access and Eligibility Services

In September, the OIG San Antonio office of beneficiary investigations provided an OIG overview and referral training to 10 Access and Eligibility Services (AES) supervisors and program managers as part of an OIG regional outreach initiative. This training provided education on the roles and responsibilities of the OIG beneficiary investigations team, the referral documentation required by OIG for investigative processes, and how AES eligibility workers should properly submit referrals to the OIG.

Conferences and Presentations

- Inspector General Kauffman gave a presentation in October to the Texas Association of Health Plans. The virtual presentation focused on the OIG's efforts and coordination with managed care plans to ensure program integrity. The inspector general also discussed how the agency is leveraging data and technology to fight FWA.
- In October, the State Centers Investigative Team underwent its biannual peace officer training. The training consisted of defensive tactics, baton certification and firearms training.
- In September, OIG Chief Dental Officer Dr. Janice Reardon and OIG Senior Dental Analyst Sherry Jenkins attended the Texas Dental Association quarterly meeting. The meeting was held through a virtual platform. The OIG presented updates on illegal dental solicitation to the other attendees that included HHS and the three dental maintenance organizations: MCNA Dental, DentaQuest, and United Health.
- Strategy staff have attended national conferences, including the National Association for Medicaid Program Integrity conference in September, which included targeted sessions on fraud, waste and abuse issues stemming from the pandemic.
- In October, Mindy Schroeder, Nurse Trainer for Acute Care Surveillance presented medical coding training to the Texas Medical Auditor Association. She maintains certifications in Certified Professional Coder, Certified Professional Medical Auditor and InterQual Certified Instructor and shared her expertise and experience with the attendees and answered basic questions regarding medical coding.
- Medical Services continued to educate staff by holding virtual trainings for the Acute Care Surveillance, Hospital Utilization Review and Nursing Facility Utilization Review units. The topics ranged from medical records review to issues in managed care.

Training summary

Trainings conducted this quarter	37

V. Program Integrity Spotlight

Data analytics informs future OIG COVID-related work

COVID-19's taxing impact on the health care industry has the potential to create opportunities for errors in and exploitation of the Texas Medicaid system. With a mission to prevent, detect and deter fraud, waste and abuse (FWA), the OIG's response to the pandemic has focused on how to assess program integrity within the evolving crisis. The OIG does this by maximizing existing resources and expertise while collaborating with other health care and fraud prevention professionals.

Data identifies trends

The OIG's Policy and Strategic Initiatives team and Fraud, Waste and Abuse Research and Analytics team are working together to identify emerging trends and potential FWA schemes in health care related to COVID-19. They are reviewing published reports and identifying focal points for data analysis related to program integrity. OIG staff are currently using data analytics to:

- Monitor the use of COVID-related procedure codes and modifiers.
- Monitor previously established concerning behavior and any changes in occurrence during the COVID time period (e.g., the delivery of prohibited non-essential/elective services during Texas' initial "shelter in place").
- Analyze potential program impacts related to the shift from face-to-face health care to telehealth visits.

Data analysis, ongoing OIG investigations and nationwide collaborations have revealed a variety of COVID-related issues that may warrant additional review. These are potential topics for further OIG work:

COVID time period billing

Managed care organizations (MCOs), the OIG, federal contractors and state Medicaid programs areas are seeing COVID-19 "spike-billing" (an increase in billing during the lockdown period), back-billing (billing after a lockdown but with dates of service during the lockdown) and unsuspected billing where the patterns neither changed or increased in response to the pandemic. The OIG and our MCO partners are running data reviews to search for such billings.

Telehealth services

With the onset of COVID, Centers for Medicare and Medicaid Services increased the number of Medicaid services available by telehealth and indicated these temporary flexibilities may become permanent. Easing restrictions on the use of telehealth technology potentially presents bad actors in the telehealth space with opportunities to engage in schemes that were not possible one year ago.

PCR testing

One of the ways COVID-19 is identified is through a polymerase chain reaction (PCR) test. In addition to identifying COVID, PCR panels can detect several respiratory and gastrointestinal pathogens. While using a PCR panel to test for multiple possible conditions or pathogens, the expanded use of this test may not always be medically necessary. The OIG has identified instances where providers have ordered a PCR panel test for conditions or pathogens beyond COVID-19 when not medically necessary based on medical records review.

CLIA certification

Clinical Laboratory Improvement Amendments of 1988 (CLIA) certifications are required to perform different lab tests. CLIA certification is important because it verifies that laboratories meet federal performance, quality and safety standards to properly diagnose, prevent and treat diseases. The OIG has previously identified labs that did not have the proper CLIA certification for the tests being performed and may review this issue for PCR testing.

Additional monitoring activities

The OIG is monitoring national COVID-19 related fraud schemes through a variety of federal sources:

- National Health Care Anti-Fraud Association
- National Association of Medicaid Program Integrity
- Healthcare Fraud Prevention Partnership
- Federal OIG
- Centers for Medicare and Medicaid Services (CMS).

The OIG also participates in the CMS Program FWA Integrity Technical Assistance Group calls to monitor other states' identified fraud schemes. Additional trends are identified by working with Medicaid and CHIP Services and the Center for Analytics and Decision Support.

MCO collaboration

The OIG continues to partner with MCOs and their Special Investigative Units to share information related to potential COVID-19 related FWA trends or schemes. Early on, one MCO shared a concern related to flexibilities with telehealth policies and therapies which allowed the OIG and Medicaid and CHIP Services to address policy gaps. During a series of one-on-one meetings with the OIG, some MCOs have shared information regarding their monitoring efforts for COVID-19 related FWA issues; they have pledged to send any concerning trends or cases through the OIG referral process.

The OIG has adjusted to the changing environment throughout the pandemic and worked with providers at every step. The OIG remains committed to collaborating with providers to identify COVID-19 related schemes and prevent FWA from happening in the first place. The OIG will continue to adapt to events, anticipate their results and take action to support health care delivery in Texas.

VI. 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 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.

FWARA performance

Data requests received	234
Data requests completed	292
Algorithms executed	49
New algorithms developed	7

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 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.

Internal Affairs performance

Investigations opened	20
Investigations completed	25

State Centers Investigations Team performance

Cases opened	139
Cases completed	149

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

- Processes for Hiring and Training Direct Support Professionals: Austin State Supported Living Center

Inspections in progress

- Child and Adolescent Needs and Strengths (CANS 2.0) Assessments in Community-Based Care
- Telemonitoring
- Documentation of Reductions to Authorized Levels of Care in Local Mental Health Authorities
- Overlapping Long-Term Care Claims During Hospital Stays
- Mental Health Targeted Case Management and Rehabilitative Services in Managed Care
- State Supported Living Centers' Background Checks and Training Processes

Audit performance

Overpayments recovered	$237,495
Overpayments identified	$11,735
Audit reports issued by contractors	1

Audit reports issued

- Homeward Bound Inc.: Substance Use Disorder Treatment Provider
- Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Superior HealthPlan
- Fee-for-Service Claims Submitted by Maverick Medical Supply: A Texas Medicaid Durable Medical Equipment and Supplies Provider

Audits in progress

- IT Security and Business Continuity and Disaster Recovery Plans
- Managed Care Pharmacy Benefit Managers' Compliance
- Substance Use Disorder Contracts
- Performance of Selected Contractors Supporting the Texas Integrated Eligibility Redesign System (TIERS)
- Selected MCO Financial Data
- Selected HHSC Grant Recipients
- Third Party Administrator
- Fee-for-Service Payments for Services Covered by MCOs
- STAR Kids Medical Necessity Determination Processes
- Selected MCO Special Investigation Units
- Durable Medical Equipment Claims
- MCO Clean Claims for Nursing Facility Providers

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	486
Preliminary investigations completed	433
Full-scale investigations completed	57
Cases transferred to full-scale investigation	35
Cases referred to AG's Medicaid Fraud Control Unit	114
Open/active full-scale cases at end of quarter	97

Medical Services performance

Acute care provider recoveries	$2,687,750
Acute care services identified overpayments	$2,752,995
Hospital and nursing home UR recoveries	$5,437,619
Hospital UR claims reviewed	5,756
Nursing facility reviews completed	3
Average number of Lock-in Program clients	2,610

Benefits Program Integrity performance

Overpayments recovered	$4,613,724
Cases completed	4,254
Cases opened	5,993
Cases referred for prosecution	0
Cases referred for Administrative Disqualification Hearings	192

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	7,455
Individual screenings processed	22,135

EBT Trafficking Unit performance

Overpayments recovered	$112,226
Cases opened	126
Cases completed	97

Peace Officers performance

Cost avoidance	$239,784

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 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.

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 payor of last resort and operates the Medicaid Estate Recovery Program.

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

Fraud Hotline performance

Fraud Hotline calls answered	5,516
Fraud Hotline referrals within OIG	
Benefit recipients	1,012
Medicaid provider	110
HHS employee/contractor	41
EBT retailer	26
State Supported Living Center/State Hospital	2

Third Party Recoveries performance

Dollars recovered	$60,856,579
Identified recoveries	$15,874,388
Cost avoidance	$27,324,432

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 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.

External Relations performance

Website page views	188,088
Communications materials produced	90

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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

OIG on Twitter: @TexasOIG

OIG on Facebook: TxOIG

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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)