Inspector General

Texas Health and Human Services

20D0695

OIG Quarterly Report

Quarter 2, 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 second quarterly report for fiscal year 2021, summarizing the excellent work this office has performed during this period.

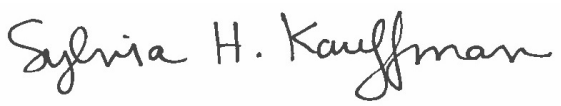
The Office of Inspector General recovered nearly $74 million this quarter. In addition, we identified nearly $77 million in potential future recoveries and achieved $39 million in cost avoidance by deterring potentially questionable spending before it could occur.

The OIG team continues to do outstanding work on behalf of Texas taxpayers. Many of the staff continue to telework, but the OIG has resumed some outside compliance activities, including on-site visits to nursing homes and Supplemental Nutrition Assistance Program (SNAP) vendors. These are done following all current COVID-19 requirements and recommendations to ensure the safety of both our staff and those whom we visit. We will continue to follow these guidelines as we increase the number of on-site visits. Safety will be the highest priority in all our decision making.

We are also working closely with legislators and other state officials during the current 87th Texas Legislature session. OIG staff has and will continue to meet with lawmakers and stakeholders on bills that will impact the agency and offer our information when requested. 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,



Sylvia Hernandez Kauffman
Inspector General

II. Quarter 2 Results

Dollars recovered

Audit and Inspections	
Audit collections	$2,134,389
Investigations and Reviews	
Provider overpayments	$1,919,083
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$4,705,026
Voluntary repayments by beneficiaries	$16,063
Acute care provider overpayments	$414,638
Hospital overpayments	$4,551,870
Nursing facility overpayments	$63,534
Recovery Audit Contractor recoveries	$3,630,406
WIC collections	$0
Provider underpayments	$[2,171]
Total division recoveries	**$15,298,449**
Third Party Recoveries	
TPR recoveries	$56,435,081
Peace Officers	
EBT trafficking retailer overpayments	$99,248
Total dollars recovered	**$73,967,167**

Dollars identified for recovery

Audit and Inspections	
Provider overpayments	$793,007
Investigations and Reviews	
MCO identified overpayments	$6,801,645
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$10,564,689
Acute care provider overpayments	$464,686
Hospital overpayments	$3,765,056
Nursing facility overpayments	$773,280
Recovery Audit Contractor identified	$10,255,300
WIC vendor monitoring	$0
Total identified recoveries	**$32,624,656**
Third Party Recoveries	
TPR identified recoveries	$42,767,743
Peace Officers	
EBT trafficking	$432,897
Total dollars identified for recovery	**$76,618,303**

Cost avoidance

Investigations and Reviews	
Medicaid provider exclusions	$3,193,470
Client disqualifications	$3,311,934
WIC vendor monitoring	$0
Pharmacy Lock-In	$973,859
Third Party Recoveries	
Front-end claims denials	$31,543,988
Peace Officers	
EBT recipient avoidance	$145,608
Total cost avoidance	**$39,168,859**

Liquidated damages

LDs collected	$21,450

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 and Reviews (I&R) continues to receive complaints and managed care organization (MCO) referrals related to personal care attendants. Complainants report 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. During the quarter, two personal care attendants were excluded from Medicaid.

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

- **Beaumont hospital settlement.** The OIG settled a case in January against a Beaumont hospital. The provider had been improperly reimbursed for administering injections and infusions in the outpatient emergency department; injections and infusions are already included in an emergency room service charge and not reimbursed separately. The claims included dates of service ranging from January 2015 through April 2019. The provider worked collaboratively with OIG Litigation to resolve the issues, and the OIG agreed to a settlement of $425,391.
- **Houston durable medical equipment settlement.** In December the OIG settled a case against a durable medical equipment (DME) provider in Houston. Based on information obtained during the investigation, the DME provider did not have appropriate documentation to support payments for claims with dates of service between January 2016 through June 2017. To resolve these allegations, the provider agreed to a settlement of $85,349.
- **Home health provider self-reports nursing violations.** A Home health provider with locations across Texas filed a self-report involving five of its agencies. The provider's compliance department received reports in

Provider Investigations

Referral sources for cases

Government agency	31%
MCO/DMO	27%
Public	16%
Provider	12%
Anonymous	9%
OIG initiated	5%

Types of preliminary investigations opened

Attendants	44%
Physician (individual/group/clinic)	18%
Home health agency	11%
Dental	10%
Nursing facility	3%
Pharmacy	3%
Hospital	2%
Rehabilitation center	2%
Adult day care	1%
Durable medical equipment	1%
Therapy (counseling)	1%

8 other categories at less than 1%

Types of full investigations opened

Dental	26%
Physician (individual/group/clinic)	26%
Attendants	8%
Nursing facility	8%
Adult day care	5%
Durable medical equipment	5%
Hospital	5%
Pharmacy	5%
Rehabilitation center	5%
Assisted living	3%
Home health agency	2%
Therapy (physical/occupational/social)	2%

2020 that some of its nurses had provided care to patients in the nurses' homes instead of in the patients' homes. The provider's investigation substantiated eleven cases where that behavior occurred. The provider terminated 10 registered nurses based on their investigation. The provider also self-reported that all services were provided as documented, and no evidence indicated any patient was harmed or that any of the patients' primary caregivers objected to care being provided in the nurses' homes. The provider agreed to pay a penalty of $28,214.

Benefits Program Integrity

The Benefits Program Integrity (BPI) division completed 3,989 investigations involving some form of benefit recipient overpayment or fraud allegation. Ninety-one 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 completed 153 investigations where fraud was determined. BPI referred 5 investigations for prosecution and 148 for an administrative disqualification hearing. Ninety-five percent of fraud investigations completed involved either unreported income or an issue with the reported household composition.

Increase in cases

Due to the increased volume of benefits applications and recipients resulting from the pandemic, BPI is reporting a significant increase in fraud, waste and abuse (FWA) referrals through the fiscal year. To address the additional volume of investigations, a targeted team of BPI investigators across several regions of the state were called upon to assist. BPI implemented stringent case assignment and tracking protocols. BPI also adjusted duties to help prioritize investigators' workloads. In the first month of this project, the team identified more than $650,000 in overpayment claims.

A sample of cases worked by BPI this quarter include:

- **Inaccurate income and household composition.** In December 2020, BPI resolved a case in Taylor County where a client failed to report her children's father and his associated income as part of her benefits applications for the Supplemental Nutrition Assistance Program (SNAP) and Medicaid. The BPI investigation obtained witness statements, driver license information, social media posts, school records, marriage records, Department of Motor Vehicle records and payroll information proving the husband and his income should have been reported on the applications. As a result, the client received $27,025 in excessive SNAP and $11,941 in excessive Medicaid benefits. The case was presented to the Taylor County District Attorney, and the client was charged with a second-degree felony of securing execution of a document by deception. The client pled guilty, and as part of a plea bargain, the client was sentenced to ten years' deferred adjudication probation and was ordered to pay $20,000 in restitution.
- **Falsifying benefits application.** BPI investigated a client in Hidalgo County who concealed her household income and falsified applications for SNAP benefits. The client alleged that her husband and two sons were all receiving Retirement, Survivors and Disability benefits from the Social Security Administration and reported no other source of income for the household. During the investigation, the client admitted she failed to report her income from cleaning houses and babysitting and waived her right to an administrative hearing to contest the findings. In February, the client was disqualified from SNAP for 12 months and ordered to pay $28,392.
- **Fraudulently receiving SNAP benefits.** BPI received a referral from HHS Access and

Eligibility Services alleging a client in Hidalgo County was self-employed and failed to report her actual income on applications for SNAP benefits. During an interview, the client admitted to the BPI investigator that she was using her SNAP benefits to purchase ingredients for her independent food business and supporting her household with the profits she made. Since the client was fraudulently receiving SNAP benefits, and misusing those benefits as a source of income, BPI referred the case for an administrative disqualification hearing. In January the client signed a Waiver of Disqualification Hearing, agreed to pay $8,850 and was disqualified from the SNAP program for 12 months.

Electronic Benefits Transfer

This quarter the Electronic Benefits Transfer (EBT) Trafficking Unit completed 62 investigations and presented another 36 investigations for either administrative disqualification hearings (34) or prosecution (2). During the quarter the EBT Trafficking Unit identified for recovery $432,897 and collected $99,248.

Trends identified by the unit include:

- **Mobile vendors.** EBT Trafficking continues to receive complaints in cases involving mobile vendors in the Houston area who accept Supplemental Nutrition Assistance Program (SNAP) benefits and their unauthorized deductions from recipients' accounts. This quarter EBT Trafficking received 57 complaints on two mobile vendors owned by a married couple. Research of the transaction history shows that the majority of the transactions are manual transactions, and the transactions are conducted between 11 p.m. and 1 a.m. – outside of normal business hours – on the day the recipients' allocations are deposited into their accounts. The investigation is ongoing.
- **Law enforcement collaboration.** EBT Trafficking continues to collaborate with law enforcement agencies throughout the state. These requests range from assisting in locating fugitives with arrest warrants, persons involved in criminal activity and request for investigative assistance with cases that have an element that involves SNAP trafficking.

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

- **Houston taco truck.** EBT Trafficking investigated allegations involving owners of multiple food trucks in the Houston area. They are accused of using SNAP benefits to purchase items at a major retailer for their business. Interviews of recipients involved in the scheme revealed the owners were purchasing SNAP benefits at a rate of 50 cents per dollar of benefits. Other recipients stated they would shop at the retail store and sell the items to the restaurant owners. The owners admitted purchasing the SNAP benefits from multiple recipients and using the benefits to buy items for their food trucks. The total amount of fraud is $24,961. This case has been referred to the Harris County District Attorney.
- **Restaurant investigation.** EBT Trafficking received an allegation that a recipient was conducting high-dollar purchases at a major retail store in Fort Worth. Working jointly with the retailer, investigators determined that the recipients' SNAP benefits and card were used to make purchases on the account belonging to a local restaurant owner. A transaction review showed products purchased were used as inventory for the restaurant. Surveillance of the restaurant owner revealed he was using the recipients' EBT cards and delivering the purchases to his restaurant. During interviews the restaurant owner and SNAP recipients admitted to the fraudulent activity. The fraud amount in this case is $61,078. The investigation was referred to the Tarrant County District Attorney's Office, where the cases are currently pending disposition.

Internal Affairs

Internal Affairs (IA) worked 30 active investigations in the second quarter, and 27 investigations were closed during the quarter. IA processed 92 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 include:

- **Falsification of government records cases.** IA continues to work cases related to falsification and tampering with government records, mostly alleged against DFPS employees. This could be attributed to more referrals being made by DFPS for review by IA, in addition to cases referred by DFPS clients.

Sample of cases concluded by IA this quarter:

- **Tampering with government records.** IA received information that a former Family-Based Safety Services (FBSS) specialist falsified travel vouchers over a four-month period. A review of the FBSS specialist's records revealed the employee had made several false reports regarding travel, including traveling to facilities that were no longer open or that were not connected to the cases the employees was assigned, resulting in an overpayment of $1,026. It was also determined that the employee did not work case files to completion, conduct follow-up communication with providers or update case narratives and contact information. This case was referred to the Harris County District Attorney for prosecution.
- **Privacy breach.** IA investigated an allegation that an Electronic Benefit Transfer (EBT) coordinator inappropriately accessed the information of an EBT client. A review of the EBT coordinator's Texas Integrated Eligibility Redesign System access revealed that the employee had viewed the client's account information without a business need. The EBT coordinator admitted to the unprofessional conduct and was terminated because of the investigation's findings.

Open IA cases by type

Falsifying information/documents	24%
Unprofessional conduct	22%
Computer misuse	8%
Perjury	8%
Theft	5%
Law enforcement assist	5%
Tampering with a government record	5%
Benefit fraud	5%
Other	18%

- **Falsification of documents.** IA received allegations that a state hospital psychiatric nurse assistant (PNA) submitted false documentation to qualify for federal and state benefits regarding COVID-19 related leave. The IA investigation determined the PNA had posted on Facebook an outside catering business during the summer of 2020, which was the same time the PNA had filed for COVID-19 leave. The employee was terminated, and the estimated financial loss to the state due to absence from work was $3,201. The case was sent to the Cherokee County District Attorney's Office, but they declined to prosecute.

State Center Investigations Team

The OIG's State Center Investigations Team (SCIT) opened 110 investigations and completed 125 investigations in the second quarter of fiscal year 2021, with an average completion time of 24 days. This compares to 170 opened investigations and 185 completed investigations in the second quarter of fiscal year 2020.

A recent SCIT case involved an employee at the San Antonio State Supported Living Center who was accused of assaulting and injuring a client. Subsequent interviews and video review by the SCIT investigator confirmed the allegation. The case was referred to the Bexar County District Attorney for prosecution.

IV. Policy Recommendations

Fair market value reporting

The OIG completed an audit of reporting and compliance of affiliate third-party administrator services for a dental maintenance organization, including a review of its fair market value exception documentation. While there were no audit findings for the audited entity, the OIG identified some areas of risk that HHS Medicaid and CHIP Services and HHS Financial Reporting and Audit Coordination should address to strengthen contractual requirements related to fair market value reporting. As a result of those contractual issues, fair market value exceptions may not reflect the current market and may decrease experience rebates owed by managed care organizations. The OIG recommended that HHS take action to strengthen its contractual requirements.

V. Agency Highlights

Hospice executive sentenced to prison for health care fraud

The owner of a Texas chain of hospice companies was sentenced in December 2020 to 20 years in federal prison for his role in a $150 million health care scheme. The individual from San Antonio was found guilty of conspiracy to commit health care fraud, conspiracy to commit money laundering, conspiracy to obstruct justice, conspiracy to pay and receive kickbacks, and six counts of health care fraud. His sentence from a federal judge also includes paying $120 million in restitution.

Investigators said the defendants enrolled patients at group homes and nursing homes by falsely telling them they had less than six months to live and sending chaplains to lie to them and discuss last rites. However, the patients did not have terminal illnesses with the six-month prognosis that hospice care requires.

This case was investigated by the Rio Grande Valley Health Care Fraud Task Force, which includes the OIG, the FBI and the Texas Attorney General Medicaid Fraud Control Unit.

OIG resolves a case against two North Texas hospitals

The OIG settled cases in January with two outpatient hospital facilities in Dallas and Plano. The providers billed for critical care codes for emergency room visits, when an evaluation and management code should have been used, causing providers to be reimbursed more than allowable for emergency room services. The providers worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to settlements for $6,511,720 and $1,046,429, respectively.

OIG settles case with Southeast Texas dental provider

The OIG settled a case in January against a Beaumont dental provider. The provider's most common error was upcoding preventive resins to composite resins, according to 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 $28,211.

OIG settles case with a Valley telemonitoring provider

The OIG settled a case in January against a McAllen telemonitoring entity. The provider's most common errors were for readings that were

Quarter 2 performance

Audit reports issued	7
Audits in progress	19
Inspections reports issued	2
Inspections in progress	4
Total investigations opened	5,821
Total investigations completed	4,608
Client investigations completed	3,989
EBT retailer investigations completed	62
Internal Affairs investigations completed	27
State center investigations completed	125
Medicaid provider investigations completed	
Preliminary	361
Full-scale	44
PI cases transferred to full-scale investigation	38
PI cases referred to Medicaid Fraud Control Unit	122
Hospital claims reviewed	2,092
Nursing facility reviews completed	38
Medicaid and CHIP provider enrollment screenings performed	19,918
Medicaid providers excluded	36
Fraud hotline calls answered	4,815

not taken on dates that services were billed and pre-authorization forms that were incorrect. 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 $41,771.

Settlement reached with Plano dentist

The OIG settled a case in December against a dentist in Plano. Between February 2015 and January 2019, the dentist billed for services that were not rendered, unnecessary or didn't meet the standard of care, and billed for services that differed from clinical notes. The provider agreed to a settlement of $91,324.

OIG settles cases with Valley home health provider

OIG Provider Investigations and Reviews initiated a case against a home health provider with locations in Pharr and McAllen. The investigation included claims for services between September 2016 through March 2018. Investigators found the provider neglected to keep daily home monitoring records, including blood glucose or blood pressure readings, altered pre-authorization forms and failed to keep proper billing records for services. In January, the provider agreed to pay $39,771 as a settlement.

Behavioral health fraud detection operation

OIG data analytics continues to play a proactive role in detecting potential FWA. This quarter the Investigations and Reviews (I&R) Division further advanced the findings of a Fraud Detection Operation (FDO) initiated in November 2020. Through a collaborative effort with OIG Fraud, Waste and Abuse Research and Analytics, the FDO team selected four behavioral health providers identified as outliers among their peers. Preliminary reviews of client and business records and extensive research was conducted on four providers located in San Antonio, Houston, Victoria and Brownsville. Findings included instances of no client record or other documentation to support services rendered and clients reporting shorter sessions than providers billed, which results in a higher reimbursement rate to the provider.

Monitoring the use of vitamin infusions

The OIG continues to see cases with the use of vitamin infusions in long-term care facilities. The practice involves outside entities giving facility residents intravenous fluids containing vitamins and other medications. The OIG has concerns about this practice in several areas, among them quality of patient care, adherence to Medicaid requirements and a practice known as upcoding in which a facility gets a higher payment by providing or billing for unnecessary care.

The OIG is working with long-term care provider organizations to raise awareness of the issue and prevent future occurrences. The OIG Provider Investigations unit is reviewing cases and initiating investigations when evidence indicates potential wrongdoing, as well as referring cases to HHS Long-Term Care Regulatory.

Vitamin infusions can be appropriate care for nursing home residents when determined to be medically necessary and in alignment with care plans coordinated by facility staff and attending physicians. Facilities must ensure that the administration of the infusions is appropriate and, along with medical necessity, well documented.

OIG launches COVID-19 FWA stakeholder initiative

The emergence of COVID-19 presents new challenges for health care systems and an increased reliance on health and human services programs. The federal government and the State of Texas have 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 in February by conducting meetings with Medicaid stakeholders. The OIG seeks to work in partnership with stakeholders to identify areas of greatest risk to the state resulting from COVID-19 changes in service delivery and develop strategies, including retrospective reviews and prevention activities, to mitigate these risks.

Data analytics helps to identify FWA related to the COVID-19 pandemic

The OIG's Fraud, Waste and Abuse Research and Analytics (FWARA) team 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. These sessions and research have led to the identification of numerous COVID topics the OIG will explore this fiscal year as FWARA designs and develops new algorithms to detect potential FWA within Medicaid. During the next quarter, the OIG will investigate allegations related to COVID schemes impacting laboratory services and telecommunications (telehealth and telemedicine).

OIG seeks to expand data analytics capabilities

The OIG is working to procure external professional services in the field of healthcare data analytics, data science and statistical analysis to assist the office with this ongoing work. The effort is designed to enhance the agency's ability to examine large volumes of highly structured healthcare data and identify trends, patterns and other indicators of potential FWA in government healthcare programs. This procurement will mark the next step in the OIG broadening its scope from descriptive-based analytics to predictive and prescriptive analytics. Using analytical tools across the continuum of analysis will allow the OIG to quickly react to identified historical concerns and identify emerging concerns.

TFPP meeting focuses on current FWA trends

The OIG continues to advance the work of the Texas Fraud Prevention Partnership (TFPP), which encourages all Texas Medicaid and CHIP managed care organizations to collaborate with the OIG to strengthen the Medicaid and CHIP programs in Texas.

The agenda for the January meeting included discussion of the COVID-19 pandemic and assessing related FWA trends; updates related to third-party liability and value-based purchasing considerations; and updates on ongoing and upcoming OIG audits and medical services reviews.

The OIG's chief of Audit and Inspections presented the results of three recent audit series that addressed the following issues:

- MCOs that contract with Navitus, a pharmacy benefits manager, to administer the drug formulary, preferred drug list, and prior authorization processes
- Outlier processing of nursing facility claims
- Information Technology audits, including security controls and business continuity/ disaster recovery planning

During the second quarter, the OIG held TFPP special investigative unit meetings with Community Health Choice, Cooks Children's and Texas Children's Health Plan to discuss their pending investigations, referrals and current FWA schemes. Texas Attorney General Medicaid Fraud Control Unit staff also participated in the meetings and discussed pending referrals and requests for information.

A meeting in February included an HHS presentation about their new Electronic Visit Verification system and the Non-Emergency Transportation program soon to be carved into managed care. The OIG discussed monthly reporting and reported on COVID FWA schemes involving adult day cares and dental providers, and a fraud scheme involving IV vitamin infusions in nursing facilities.

BPI implements quality assurance process

Benefits Program Integrity (BPI) implemented a new Quality Assurance (QA) process. The initial team of reviewers are evaluating a sample of BPI investigations each month, in addition to their regular workload. BPI is already reaping the rewards of the team's efforts and finding multiple opportunities to strengthen policies, develop training, and design new tools and resources for investigators. The division will include other BPI staff as reviewers in the future to further strengthen the QA process. Initial results indicate that BPI investigators continue producing quality work products and making sound decisions. The QA process is also showcasing the complexity of completing these investigations and has highlighted the incredible level of detail and knowledge that BPI staff must possess to effectively perform their jobs. With this new QA process in place, BPI hopes to discover methods to strengthen investigations.

Third Party Recoveries enhances efficiencies with MCOs

OIG Third Party Recoveries (TPR), in collaboration with HHS and Texas Medicaid and Healthcare Partnership (TMHP), continues to strengthen and improve Third Party Liability (TPL) activities performed by MCOs. During the first two quarters of fiscal year 2021, OIG and TMHP initiated several key projects to help MCOs coordinate benefits to ensure Medicaid is the payer of last resort.

To ensure MCOs receive accurate and up-to-date other insurance (OI) records to maximize cost avoidance and cost recovery efforts, TMHP will provide MCOs daily information instead of weekly. TPR is updating the referral file MCOs used to report OI to TMHP. TPR and TMHP conducted trainings and provided technical assistance to help MCOs better understand the referral process and information needed for a referral.

OIG completes audit series on substance use disorder treatment providers

The OIG completed an initial series of audits on HHSC-contracted substance use disorder treatment providers Homeward Bound and Cenikor Foundation. The OIG initiated the audits in response to a referral from HHS Regulatory Services. The audit objectives were to determine whether treatment services were provided in accordance with requirements and supported payment received.

HHSC-contracted substance use disorder facilities provide substance use rehabilitation services to Texas residents who meet eligibility requirements. Clients must meet residency, financial and medical eligibility to receive services under the block grant. Substance use disorder facilities provide services directly to clients, coordinate referrals for clients with third-party providers, and monitor client status after discharge from substance use disorder programs.

Homeward Bound ensured that clients met requirements to be eligible for its substance use disorder programs, including verifying that clients met financial requirements. Homeward Bound 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 treatment plan execution and discharge planning and follow-up.

Cenikor did not consistently comply with core contractual requirements for providing adult substance use disorder program services in region seven (Central Texas), including those related to delivery of required medical and clinical services, consent for treatment, and follow-up activities. In addition, Cenikor did not (a) consistently place clients in service types consistent with and supported by the client's assessment and consent form or (b) ensure all direct care and clinical staff met Texas Administrative Code and contractual requirements related to qualifications, training and education, and supervision. Based on the

results of this audit, the OIG will further examine the delivery of medical and clinical services under HHS contracts for substance use disorder treatment.

Completed Reports

Audit

Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Molina Healthcare of Texas. The OIG conducted an audit of State of Texas Access Reform PLUS (STAR+PLUS) nursing facility claims paid by Molina Healthcare of Texas (Molina), 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. Molina was one of five MCOs audited to address this concern. The audit objective was to determine whether Molina accurately and timely adjudicated qualified nursing facility provider clean claims in compliance with selected criteria.

Molina adjudicated an average of 99.8 percent of clean claims within 10 days in calendar year 2018 and met the clean claim adjudicated time frame as required by its Uniform Managed Care Contract. However, Molina did not always (a) process RUG rate adjustments as required or (b) process other types of adjustments timely. Specifically, Molina did not process $315,023 in net RUG rate adjustments, and for 13 of 30 (43 percent) other types of adjustments tested, Molina did not process the adjustments totaling $16,540 timely, which caused delays in payments to nursing facilities that ranged from 31 to 622 days.

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

Summary of Results: Pharmacy Benefits Manager Navitus Health Solutions LLC. The OIG completed a summary of the results and conclusions of three audits of MCOs with the same pharmacy benefits manager (PBM), Navitus Health Solutions (Navitus), performed in 2020: Community First Health Plans (Community First), Parkland Community Health Plan (Parkland) and Community Health Choice. The objective of the audits was to determine whether the MCOs and their subcontracted PBM, Navitus, administered the formulary, preferred drug list, and prior authorizations in accordance with the UMCC, STAR Kids contract, UMCM and selected applicable state rules and statutes.

Across the three audits, OIG observed that, in general, that Navitus:

- Adhered to Medicaid and CHIP formularies for 97.2 percent of the formulary items.
- Adhered to Medicaid preferred drug lists for 98.8 percent of the preferred drug list items.
- Did not always process prior authorizations and reject claims correctly.

Results at the eight MCOs subcontracted with Navitus as their PBM would be expected to be consistent with these results. The OIG offered recommendations to the audited MCOs, which, if implemented, will ensure Navitus:

- Adds all VDP-approved formulary items.
- Correctly reflects all current VDP-approved formulary items in the Medicaid and CHIP formularies.
- Add all approved preferred drug list line items with the appropriate designated preferred or non-preferred status.
- Correctly reflects all current drug codes in the Medicaid preferred drug list.
- Follows adjudication requirements for preferred drug list drug codes.
- Complies with the VDP clinical criteria requirements for drug codes that require additional clinical reviews on subsequent doses.
- Communicates rejection messages to

members correctly.

Navitus is the PBM for 11 of the 20 MCOs in Texas, providing services to nearly 40 percent of members in the state and receiving more than 25 percent of pharmacy capitation.

Security Controls Over Confidential HHS Information: Parkland Community Health Plan, Inc. The OIG completed an audit of Parkland Community Health Plan (Parkland). The objectives of the audit were to assess the design and effectiveness of selected security controls over confidential Texas Health and Human Services (HHS) System information stored and processed by Parkland, as well as business continuity and disaster recovery plans for operations relating to the processing and storage of confidential HHS System information by Parkland.

Overall, Parkland implemented controls to safeguard confidential HHS System information and developed procedures to ensure the continuation of the operations necessary to deliver services to members in the event of an emergency or disaster. Access to confidential HHS System information must be managed in accordance with HHS Information Security Controls (IS-Controls). Parkland's processes for managing certain accounts with access to confidential HHS System information in its claims management system did not meet all HHS IS-Controls requirements. The OIG offered recommendations to Parkland, which, if implemented, should ensure access to confidential HHS System information in its claims management application is managed in accordance with HHS IS-Controls requirements.

Reporting and Compliance of Affiliate Third-Party Administrator Services: MCNA Insurance Company. The OIG completed an audit of reporting and compliance of affiliate third-party administrator services for MCNA Insurance Company (MCNA Texas), a Texas Medicaid and Children's Health Insurance Program (CHIP) dental maintenance organization (DMO).

MCNA Texas's fair market value documentation met the technical requirements for fair market value reporting. In addition, MCNA Texas accurately reported payments for third-party administrator services to the Texas Health and Human Services Commission (HHS). Finally, MCNA Dental Plans (MCNA Florida) approved invoices and MCNA Texas approved payments in accordance with established processes. Based on the results of the audit, there were no recommendations to MCNA Texas.

Cenikor Foundation: Region 7 Substance Use Disorder Treatment Provider. OIG conducted an audit of Cenikor Foundation (Cenikor), a substance use disorder treatment provider under contracts with the Health and Human Services Commission (HHSC). OIG initiated the audit in response to a referral from HHSC Regulatory Services.

OIG evaluated one contract between HHSC and Cenikor for services provided at facilities in Region 7, which includes Austin, Killeen, San Marcos, Temple and Waco. HHSC paid Cenikor $3,495,797 for services to 1,405 clients under the contract during the audit scope, which included the period September 1, 2018, through February 29, 2020. The audit objective was to evaluate whether Cenikor's treatment services (a) were provided in accordance with requirements, (b) were provided by qualified staff, and (c) supported the payment received.

Cenikor did not consistently comply with core contractual requirements for providing adult substance use disorder program services in Region 7. Specifically, Cenikor did not:

- Ensure clients admitted into residential detoxification, intensive residential, supportive residential, and ambulatory detoxification received required monitoring for withdrawal management or counseling services. Cenikor did not provide evidence that it delivered all required monitoring or counseling services to the following clients tested:
  - ◊ 99 percent of clients admitted into its residential detoxification service.
  - ◊ 70 percent of clients admitted into its intensive residential service.

- ◊ 47 percent of clients admitted into its supportive residential service.
- ◊ 100 percent of clients admitted into its ambulatory detoxification service.

Cenikor should return $124,509.66 to the State of Texas for amounts paid to Cenikor for admissions where delivery of, or support for, 50 percent or more of required monitoring or counseling services was not provided.

- Provide evidence to support performance of, and compliance with, program and contractual provisions related to medical and clinical requirements, obtaining required client consent, and referral and discharge follow-up procedures.

In addition, Cenikor did not (a) consistently place clients in service types supported by the client's assessment and consent form or (b) ensure all direct care and clinical staff met TAC and contractual requirements related to qualifications, training and education, and supervision. This may result in placing clients in a costlier care setting than appropriate or providing services that do not meet clients' needs.

OIG Audit offered recommendations to Cenikor, which, if implemented, will correct deficiencies in compliance with TAC and contractual requirements.

Inspections

Child and Adolescent Needs and Strengths (CANS 2.0) Assessments in Community-Based Care. The OIG conducted an inspection to determine whether ACH Child and Family Services (ACH) provided services to children in community-based care consistent with the Texas Child and Adolescent Needs and Strengths 2.0 (CANS 2.0) assessment. The inspection objectives were to determine whether ACH (a) conducted CANS 2.0 assessments for children in community-based care as required by the Department of Family and Protective Services (DFPS), and (b) provided services to children in community-based care timely.

ACH is a community-based care contractor for DFPS to coordinate support and services for children in the Dallas-Fort Worth service delivery area. As a community-based care contractor, ACH provides a full continuum of foster care services to Texas children in DFPS conservatorship. The CPS Handbook requires ACH to provide each child in its care who is between 3- and 17-years-old a CANS 2.0 assessment within 30 days of entering DFPS conservatorship. The CANS 2.0 is a comprehensive trauma-informed assessment designed to provide all those involved in a child's care a thorough understanding of a child's behavioral health needs and to make recommendations for support and services.

ACH could not provide evidence of a CANS 2.0 assessment for 12 children included in the sample. For the remaining 228 children in the sample, ACH did not always comply with the 30-day assessment completion contract requirement. ACH should:

- Implement the tracking process in development during the inspection.
- Maintain a schedule to track CANS 2.0 assessment actual and required completion dates.
- Require CANS 2.0 assessment providers report to ACH when they competed CANS 2.0 assessment and monitor IMPACT for assessment uploads.
- Follow up with case workers for CANS 2.0 assessments that are not completed and are approaching the required completion date.

Processes for Hiring Direct Support Professionals at State Supported Living Centers. The OIG completed an inspection to review the processes used by HHSC-HR during the hiring process for direct support professionals at State Supported Living Centers (SSLCs). The inspection objective was to determine whether HHSC-HR performs pre-employment criminal history and registry clearance checks for direct support professionals at SSLCs in compliance with Texas Administrative Code and HHSC-HR policies and procedures.

The OIG concluded that HHSC-HR implemented

policies, procedures and processes to conduct and document due diligence checks required by Texas Administrative Code; however, some criminal history background and registry clearance checks were not always performed or completed timely, and HHSC-HR did not consistently document due diligence checks. Of the 363 records examined, there were four (1.1 percent) separate instances of direct support professionals beginning employment at an SSLC prior to the completion of the due diligence checks as required by Texas Administrative Code. Additionally, 95 (27.3 percent) of the 363 due diligence checks did not follow HHSC-HR policies and procedures, which require the documentation of the dates the due diligence checks were completed, the eligibility status of the applicant and the initials of the HHSC-HR or the human resources contractor service center staff member who completed and documented the due diligence check.

OIG Inspections offered recommendations to HHSC-HR, which, if implemented, will improve deficiencies in documentation and provide evidence of compliance with Texas Administrative Code and HHSC-HR requirements for due diligence checks.

Stakeholder Outreach

Legislative session

The 87th Session of the Texas Legislature is under way. Inspector General Sylvia Hernandez Kauffman testified before the Senate Finance Committee on February 25. She presented the OIG's budget and explained the agency's exceptional item requests. In March, IG Kauffman testified before the House Appropriations Article II subcommittee. IG Kauffman and OIG staff also met with State Rep. Candy Noble on proposed legislation.

OIG meets with MCO leadership teams

The OIG senior leadership team continues to meet with executive leadership from individual MCOs and DMOs. During the second quarter, meetings included discussions regarding the operations of each organization's compliance program; special investigative unit organizational structure and resources; and challenges and best practices in identifying FWA, among other topics. The goal of these meetings is to share information between the OIG and MCO/DMOs, collaborate around program integrity work, and evaluate areas for future improvements and coordination. The OIG intends to continue these leadership discussions at least annually.

OIG published educational article for Texas Dental Association article

The OIG Communications Team collaborated with OIG Chief Dental Officer Dr. Janice Reardon, DDS, Provider Investigations and FWARA to produce an article for the Texas Dental Association's TDA Today. The article educates dentists, hygienists and dental assistants about a recent dental fraud detection operation. It explained how OIG teams analyzed claims data from more than 5,500 providers to uncover questionable dental billing practices; the article gave examples of billing that can flag a provider for a closer look.

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 December and for the Hospital Utilization Review (HUR) in January. NFUR discussion included updates on onsite reviews, digital scanning, quality common errors and trends. HUR discussion included trending diagnosis-related group changes and updates on managed care utilization reviews, fee-for-service utilization reviews, quality control and digital scanning.

Conferences and Presentations

- Chief of Staff Susan Biles gave a presentation in February to the Texas Association of Home Care and Hospice. The virtual presentation focused on recent FWA trends and common violations related to the home care and hospice industry. Attendees also learned about the OIG's efforts to strengthen the HHS system and to prevent FWA from happening in the first place.
- In February, Dr. Janice Reardon, DDS and Sherry Jenkins, RDH presented dental records collection training for OIG investigators. The purpose of the training is to improve the electronic evidence collection of dental x-rays and client records to improve the efficiency of the dental expert reviewers.
- Medical Services continued to educate staff by holding virtual trainings throughout the quarter for Hospital Utilization Review and Nursing Facility Utilization Review. The topics ranged from medical records review to issues in managed care.

Training summary

Trainings conducted this quarter	28

VI. Program Integrity Spotlight

OIG reviews program integrity in value-based purchasing

Over the last decade, the federal government has prioritized the use of value-based purchasing (VBP) in the provision of health care services. VBP models tie payments for care delivery to the quality and efficiency of care provided. Federal requirements allow states flexibility to develop and implement their own requirements, measures and programs to promote value in provider reimbursement models in Medicaid and CHIP.

Texas has enacted legislation and implemented VBP programs and alternative payment model (APM) requirements to improve health care quality and outcomes while containing costs, particularly through managed care. All Medicaid and CHIP MCO contracts include policies to align financial incentives with member health outcomes.

For fiscal year 2021, MCO contracts include a target for payments tied to APMs to constitute 50 percent of all MCO-reported medical and pharmacy expenditures. Payments tied specifically to risk-based APMs are targeted at 25 percent.

Program integrity considerations

Program integrity refers to ensuring taxpayer dollars are spent appropriately on quality, necessary care and preventing fraud, waste and abuse (FWA). With the introduction of VBP and associated complex contractual arrangements, there are new program integrity considerations for both MCOs and regulators to examine.

Based on targeted research and programmatic observations, the OIG outlines two areas of operational challenge and related program integrity considerations within value-based contracting: Data Sharing and Integrity and Payment Integrity.

Data Sharing and Integrity – The impacts and program integrity considerations tied to accurate and complete data and timely sharing between providers, MCOs and the state.

Monitoring financial incentives to ensure quality and efficiency goals are achieved requires consistent review of encounter, financial and clinical data. As VBPs and APMs mature and increase in complexity, timely and accurate data is critical for monitoring and prevention of improper payments. The federal OIG recommends analyzing data systems in value-based payments for timeliness, accuracy and completeness.

Operational challenges to share and receive data between providers, MCOs and the state pose technical challenges. Interoperability between electronic health records and other data sharing programs and providers continues to be a challenge in VBP; these challenges may create data integrity issues compromising reporting and appropriate payments.

MCOs may face operational barriers with providing real-time and accurate data to providers to inform day-to-day clinical decisions. Texas managed care contracts require MCOs to share data with providers; however, there are no requirements regarding the frequency or common data elements. These challenges may also create data integrity issues that could compromise reporting and payments.

Payment Integrity – Behaviors or schemes that may result from VBPs and APMs and the potential integrity issues tied to the complexity of these models.

The relative newness of VBP and APMs requires regulators to identify methods to improve their ability to determine the appropriateness of payments and if any overpayments occurred.

Some MCO and provider VBP arrangements are directed towards achieving certain condition-based metrics, including diagnosing members

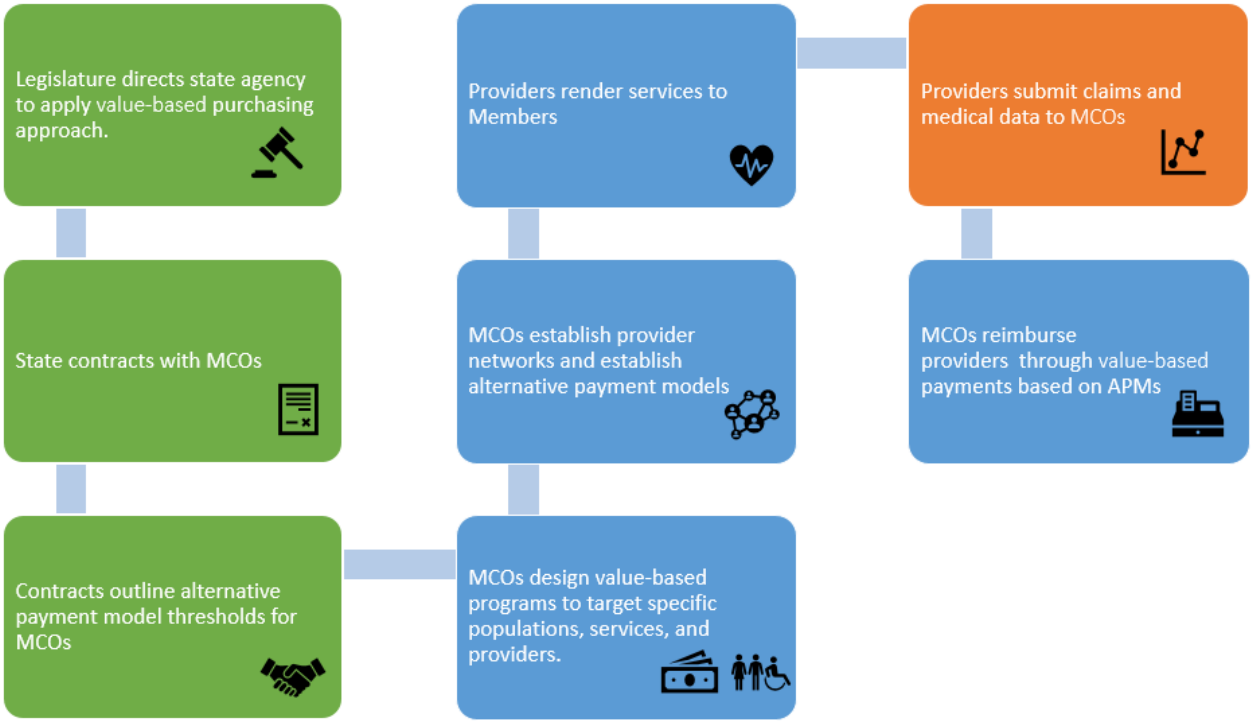
with specific chronic medical conditions (e.g., diabetes and asthma) or increasing visits (e.g., well-child). There may be an underlying incentive for providers to provide unnecessary services or provide inaccurate diagnoses to earn additional dollars, for some VBP programs. Validating condition-based payments requires clinical expertise to determine if members' diagnoses are accurate.

Identifying potential overpayments may be challenging due to bundled payments, multi-provider arrangements or differing payment structures within each MCO. To mitigate such challenges, the federal OIG has stressed evaluation of value-based payments and methodologies to ensure appropriateness and calculation accuracy.

States are exploring policies to monitor the billing practices of consolidated independent physicians as well as physician groups and health plans acquired by hospital systems. Such integration may reduce patient choice or lead to inaccurate information on subcontractor performance, which may be exacerbated by VBP models.

Process flow for APMs in Texas Medicaid and CHIP

The following figure provides a simple illustration of the process flow of APMs in Texas managed care.



OIG work in VBP

To prevent, detect and deter FWA in managed care VBP and APM arrangements, the OIG is working to address these program integrity considerations to ensure Texas Medicaid dollars are spent as intended.

As the OIG conducts audits, inspections and reviews in service of its mission, the OIG independently validates payments to determine whether the selected services complied with federal and state statutes, regulations and contract requirements. The increasing prevalence and complexity of these payment arrangements present new program integrity challenges for the OIG to consider in its VBP-related work.

Read the OIG's full report on VBP considerations on ReportTexasFraud.com.

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 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	175
Data requests completed	160
Algorithms executed	78
New algorithms developed	5

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	34
Investigations completed	27

State Centers Investigations Team performance

Cases opened	111
Cases completed	125

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

- Child and Adolescent Needs and Strengths (CANS 2.0) Assessments in Community-Based Care
- Processes for Hiring Direct Support Professionals at State Supported Living Centers

Inspections in progress

- Local Mental Health Authorities
- Overlapping Long-Term Care Claims During Hospital Stays
- Mental Health Targeted Case Management and Rehabilitative Services in Managed Care
- Telemonitoring

Audit performance

Overpayments recovered	$2,134,389
Overpayments identified	$793,007
Audit reports issued by contractors	2

Audit reports issued

- Processing of Outlier Nursing Facility STAR+PLUS Claims and Adjustments: Molina Healthcare of Texas
- Summary of Results: Pharmacy Benefits Manager Navitus Health Solutions LLC
- Security Controls Over Confidential HHS Information: Parkland Community Health Plan, Inc.
- Reporting and Compliance of Affiliate Third-Party Administrator Services: MCNA Insurance Company
- Cenikor Foundation: Region 7 Substance Use Disorder Treatment Provider

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 MCO Financial Data
- Selected Durable Medical Equipment Providers
- Selected Pharmacy Providers
- Selected HHS Grant Recipients
- HHS Human Resources Vendor Contract
- Selected DFPS Contracts
- Managed Care Pharmacy Benefit Management Provider Spread Pricing
- Emergency Ambulance Providers
- Co-Therapy Billing Guidelines
- Fee-for-Service Payments for Services Covered by MCOs
- STAR Kids Medical Necessity Determination Processes
- 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	339
Preliminary investigations completed	361
Full-scale investigations completed	44
Cases transferred to full-scale investigation	38
Cases referred to AG's Medicaid Fraud Control Unit	122
Open/active full-scale cases at end of quarter	91

Medical Services performance

Acute care provider recoveries	$414,638
Acute care services identified overpayments	$464,686
Hospital and nursing home UR recoveries	$4,613,233
Hospital UR claims reviewed	2,092
Nursing facility reviews completed	38
Average number of Lock-in Program clients	2,938

Benefits Program Integrity performance

Overpayments recovered	$4,705,026
Cases completed	3,989
Cases opened	5,268
Cases referred for prosecution	5
Cases referred for Administrative Disqualification Hearings	148

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	6,246
Individual screenings processed	19,918

EBT Trafficking Unit performance

Overpayments recovered	$99,248
Cases opened	31
Cases completed	62

Peace Officers performance

EBT recipient avoidance	$145,608

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	4,815
Fraud Hotline referrals within OIG	
Benefit recipients	1,171
Medicaid provider	78
HHS employee/contractor	45
EBT retailer	32
State Supported Living Center/State Hospital	4

Third Party Recoveries performance

Dollars recovered	$56,435,081
Identified recoveries	$42,767,743
Cost avoidance	$31,543,988

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	186,329
Communications materials produced	93

Texas Health and Human Services Office of Inspector General

Sylvia Hernandez Kauffman, Inspector General

Mailing address: P.O. Box 85200, Austin, TX 78708

Main phone number: 512-491-2000

Email: OIGCommunications@hhsc.state.tx.us

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

Produced by OIG Communications: Susan Biles, Chief of Staff; Andres Araiza, manager; Emily Hummel and Art Moore, staff

Content contributors: Analee Alderete, Collette Antoine, Mo Brantley, Jim Day, Merrie Duflot, Jim Harrison, Jill Heath, Derek Johnson, Dirk Johnson, Steve Johnson, Jen Kauffman, Nikki Kline, Andreana Ledesma, Emily McCoy, Tiesha Miller, Diane Salisbury, Jill Townsend, Chelsea Wallace, Katrina West, Stephanie Wilson

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)