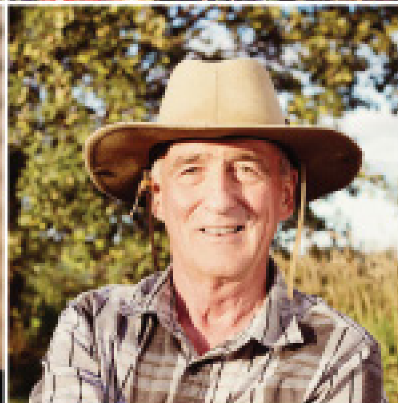
Inspector General

Texas Health and Human Services



20D0695

OIG Quarterly Report

Quarter 4, Fiscal Year 2021

Table of Contents

I. Executive Summary . . . 1

II. Fiscal Year 2021 Results . . . 2

III. Fiscal Year 2021 Highlights . . . 3

IV. Quarter Results . . . 9

V. Trends . . . 10

VI. Policy Recommendations . . . 13

VII. Agency Highlights . . . 15

- Completed Reports . . . 19
- Stakeholder Outreach . . . 28
- Trainings and Conferences . . . 28

VIII. Program Integrity Spotlight . . . 29

IX. Division Performance . . . 31

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

The Office of Inspector General (OIG) recovered nearly $120 million this quarter. For the fiscal year, net recoveries were more than $424 million. In addition, we identified nearly $754 million in potential future recoveries and achieved more than $155 million in cost avoidance.

With a mission to prevent, detect and deter fraud, waste and abuse (FWA) in Texas health and human services delivery, the OIG's response to the ongoing COVID-19 pandemic has focused on how to assess program integrity within the evolving crisis. For example, a significant shift in service delivery through the use of telemedicine gave rise to new issues for the OIG to explore, especially in areas where telehealth was not previously used. This office is committed to working collaboratively with Medicaid providers to prevent FWA from happening in the first place. The OIG's prevention strategy includes raising awareness of emerging issues in the health care environment through education and engagement with Medicaid providers, Medicaid clients and HHS staff.

The OIG continues to grow its data analytics abilities to identify trends related to the pandemic and billing and service utilization that may warrant a deeper look. Being data-driven allows the OIG to focus its work and build solid, evidence-based cases. This fiscal year, the OIG began developing new detection methods that will use existing and new data sets to display billing trends within Medicaid. The goal is to generate insightful information to continue to enhance efficiencies for fraud detection, clinical reviews and investigative purposes.

The outstanding work performed by the OIG team during the fiscal year reflects our commitment to our core values — Accountability, Integrity, Collaboration and Excellence. As we begin a new fiscal year, we remain steadfast in our dedication to our mission: ensuring that funds dedicated to providing services to those who need them are spent only for their intended purpose. I am honored to work alongside this outstanding team.

Respectfully,

Sylvia Hernandez Kauffman
Inspector General

II. Fiscal Year 2021 Results

Dollars recovered

Audit and Inspections	
Audit collections	$2,530,631

Investigations and Reviews	
Provider overpayments	$28,948,862
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$41,927,317
Voluntary repayments by beneficiaries	$101,265
Acute care provider overpayments	$8,917,553
Hospital overpayments	$14,028,286
Nursing facility overpayments	$1,382,567
Recovery Audit Contractor recoveries	$40,150,012
WIC collections	$83
Provider underpayments	$[71,903]
Total division recoveries	**$134,900,168**

Third Party Recoveries	
TPR recoveries	$285,692,876

Peace Officers	
EBT trafficking retailer overpayments	$578,096
Total dollars recovered	**$424,185,645**

Dollars identified for recovery

Audit and Inspections	
Provider overpayments	$3,103,673

Investigations and Reviews	
MCO identified overpayments	$49,357,256
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$51,834,427
Acute care provider overpayments	$9,506,844
Hospital overpayments	$16,854,150
Nursing facility overpayments	$2,764,499
Recovery Audit Contractor identified	$61,462,850
WIC vendor monitoring	$94
Provider underpayments	$[44,899]
Total identified recoveries	**$378,699,061**

Third Party Recoveries	
TPR identified recoveries	$557,541,205

Peace Officers	
EBT trafficking	$2,080,668
SCIT	$15,651
Total dollars identified for recovery	**$754,476,418**

Cost avoidance

Investigations and Reviews	
Medicaid provider exclusions	$20,855,336
Client disqualifications	$8,354,360
WIC vendor monitoring	$158,064
Pharmacy Lock-In	$4,858,425

Third Party Recoveries	
Front-end claims denials	$120,476,556

Peace Officers	
EBT recipient avoidance	$1,011,572
Total cost avoidance	**$155,714,316**

Liquidated damages

LDs collected	$59,150

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 has not necessarily been 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. Fiscal Year 2021 Highlights

OIG continues to respond to COVID-19 pandemic

COVID-19's impact on the health care industry has the potential to create opportunities for errors in and misuse 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.

Increase in FWA referrals

Due to the increased volume of benefits applications and recipients resulting from the pandemic, the agency's Benefits Program Integrity (BPI) team reported a significant increase in FWA referrals between January and April of fiscal year 2021. 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. During the span of the project, OIG staff completed 1,787 investigations identifying $2,164,511 in overpayments. The investigations during this time period were also more complex due to a number of factors, including:

- A variety of supplemental payments and amounts granted to eligible households, some of which can be counted toward an overpayment and some of which are exempt.
- Unemployment compensation adjustments.
- Differences in federal guidance that apply to each program. Since many households receive benefits in different programs, such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP), BPI investigators must account for each using completely separate criteria.
- Modified application and interview procedures, which must be accounted for when considering whether an overpayment is the result of intentional fraud versus an inadvertent error.
- Safely conducting field investigations to mitigate potential exposure to COVID-19.

Fiscal year 2021 performance

Measure	Count
Audit reports issued	38
Audits in progress	12
Inspections reports issued	9
Inspections in progress	0
Total investigations opened	24,120
Total investigations completed	21,808
Client investigations completed	18,954
EBT retailer investigations completed	289
Internal Affairs investigations completed	133
State center investigations of abuse, neglect and exploitation completed	547
Medicaid provider investigations completed	
Preliminary	1,708
Full-scale	177
PI cases transferred to full-scale investigation	161
PI cases referred to Medicaid Fraud Control Unit	506
Hospital claims reviewed	16,700
Nursing facility reviews completed	220
Medicaid and CHIP provider enrollment screenings performed	93,562
Medicaid providers excluded	201
Fraud hotline calls answered	25,134

Utilizing data analytics

As the pandemic evolves, so does the need to anticipate and address potential emerging threats to program integrity. Throughout the year, OIG teams have analyzed encounter data and revised algorithms to detect potential improper payments based on billing patterns related to COVID-19.

The OIG's fraud analytics team is actively conducting data research to identify specific billing

schemes and provider behavior changes during the COVID pandemic. The team is participating 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 during fiscal year 2022 as FWARA designs and develops new algorithms to detect potential FWA within Medicaid. The OIG has begun investigating allegations related to COVID schemes impacting laboratory services and telemedicine.

Billing for telemedicine during COVID-19

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

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

Working with providers, managed care organizations, and other HHS agencies helped the OIG identify potential improper billing patterns related to COVID-19 and collaboratively develop solutions to prevent them.

While an increase in overall telemedicine services is expected with the pandemic, certain billing patterns can indicate wasteful errors or possible suspicious activity. One issue of interest is billing for multiple telemedicine or telehealth services on the same client in a short period of time, such as on one day. Another issue is billing for impossible hours, such as for more than 24 billed hours in a day. Lastly, evaluation and management services cannot be billed separately if the physician determines an in-person or video telemedicine visit is required within 24 hours or the next available appointment time, as the services rendered via telephone will be considered part of the office/video visit.

OIG collaborates with other agencies to stop health care fraud

The OIG continues to strengthen its collaboration with law enforcement agencies across Texas to prosecute individuals who seek to defraud state health and human services.

In December, the owner of a Texas hospice company based in San Antonio was sentenced to 20 years in federal prison for his role in a $150 million health care scheme. 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.

In May, a Beaumont restaurant owner was sentenced to 27 years in prison for trafficking SNAP benefits. OIG investigators detected irregularities at a large discount retailer and launched an investigation; 62 SNAP clients were charged and accused of selling their SNAP benefits to the restaurant owner. The restaurant owner used the benefits to make $61,078 in purchases for his restaurant at the large retailer.

The OIG was part of a multi-agency investigation that led to indictments against seven people in a $110 million compound drug operation. In June, a federal grand jury in McAllen returned a 15-count indictment. A compound pharmacy owner, three marketers, a referring physician and two clinic office staff were all taken into custody. The indictment alleges three of the accused served as marketers for the pharmacy and delivered several million dollars in kickbacks for referring prescriptions for high-reimbursing

compound drugs to the pharmacy, including prescriptions that were not medically necessary or what the patients wanted. The OIG was part of the investigation that included inspectors general from the U.S. Postal Service, Department of Labor, Veterans Affairs, and U.S. Department of Health and Human Services, along with the FBI, Defense Criminal Investigative Service and the Texas Attorney General Medicaid Fraud Control Unit.

Provider enrollment screenings

The OIG Provider Enrollment Integrity Screenings (PEIS) Unit identified an issue where certain providers' enrollment was incorrectly extended during the COVID-19 pandemic after the OIG had made a denial recommendation on their enrollment application or the application was denied due to an outstanding program debt. The PEIS team worked with the Texas Medicaid claims administrator to identify the number of providers impacted and the details of incorrect payments made after a provider's enrollment should have ended. This resulted in a recoupment of $163,657 from the providers that should have been disenrolled.

OIG expands data analytics

The OIG continues to grow its use of data analytics to identify trends in billing and service utilization that may warrant a deeper look as well as prevent fraud, waste and abuse from happening in the first place. Being data-driven helps the OIG focus its work and build solid, evidence-based cases that result in the highest amount of recoveries, as required by statute (Texas Government Code §531.102).

This fiscal year, the OIG initiated the development of new detection methods that will use existing and new data sets to display trends in Medicaid utilization via dashboard. The new methods will highlight trends within specific categories of service. For example, OIG staff 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 fraud detection, clinical review and investigative purposes.

Fraud detection operations

Data analytics play a key role in the agency's fraud detection operations (FDOs), which detect the potential for waste or wrongdoing by first identifying providers with unusual billing patterns when compared to their peers. Outlier status is not an automatic indicator of wrongdoing; it simply points out providers who may warrant a closer look due to unusual billing activity.

In FY 2021, the OIG launched FDOs related to behavioral health, Daily Activity and Health Services, genetic testing, and telehealth. The initiatives are in various stages ranging from initial analysis to records requests and reviews to full-scale investigations.

The OIG reached settlements totaling $575,427 in FY 21 based on investigations conducted as part of dental FDOs from a previous year. Typical violations included solicitation of services, providing medically unnecessary services, upcoding services and not maintaining appropriate medical records to support billing. In one settlement, the agreement of $500,000 concluded four investigations involving one provider in San Antonio. An Austin provider agreed to a $65,000 settlement. Through default and recoupment payments, two additional settlements with providers were reached for $4,698 and $5,729, respectively. In fiscal year 2020, settlements totaled $359,066. FY 21 settlement dollars exceed that of all prior fiscal years since FDOs began in fiscal year 2016.

Billing for injections/infusions

A data-led initiative involving the Investigations and Reviews Division, Fraud Analytics, and Litigation led to several settlements of cases involving hospital outpatient facilities that bill, or were paid separately, for injections/infusions when the same services were already covered by another billing code paid on the same date of service. Injections and infusions are included in an emergency room service charge and are not reimbursed separately.

SNAP data analytics grant

BPI is making progress on improving its data-driven fraud detection efforts in SNAP thanks to

a federal grant. In FY 21 the U.S. Department of Agriculture awarded the OIG $500,000 to create an automated data analytics model to increase SNAP program integrity.

Grant funds will be used to hire a vendor to build a fraud detection model that will combine and analyze SNAP recipient and retailer data from across HHS eligibility, usage and investigative systems to better coordinate investigative efforts. By evaluating SNAP data across all of these systems, the OIG can better coordinate investigative efforts on recipients and vendors identified as likely engaging in fraud. Texas was one of nine states awarded grants to fund new and expanded strategies for reducing recipient fraud.

Preventing fraud, waste and abuse before it happens

One strategic goal for the OIG is to prevent FWA from occurring. In FY 21 the OIG achieved nearly $156 million in cost avoidance, which deterred potentially questionable spending before it could occur. This was achieved through front-end claims denials, client disqualifications, Medicaid provider exclusions, the Pharmacy Lock-In Program and WIC vendor monitoring.

The OIG's prevention strategy also includes raising awareness of emerging issues in health care through education and engagement with Medicaid providers, Medicaid clients and HHS staff. The pandemic necessitated a comprehensive response. The OIG led information-sharing sessions with stakeholders as part of the agency's COVID-19 Fraud, Waste and Abuse Initiative. In the coming months, this prevention effort will focus on stakeholder engagement, data analytics and policy analysis. Working with HHS staff will produce educational materials and offer guidance to HHSC to clarify Medicaid policy.

The OIG continues to leverage social media channels to amplify the agency's warning about potentially fraudulent activity relating to the pandemic; information is targeted to providers and clients. The OIG produced articles in stakeholder association publications and delivered fraud prevention advisories and information through the OIG website, ReportTexasFraud.com

For an expanded discussion about the OIG's FWA prevention strategy, see the Program Integrity Spotlight article on page 32.

More Texas providers proactively self-report issues

Medicaid providers are continuing to use the OIG's self-report process to resolve cases. Self-reports in FY 21 lead to the resolution of 45 cases. This is compared to 33 cases resolved through self-reporting in fiscal year 2020 and 14 self-reports in fiscal year 2019. Twenty-eight of the resolved self-reports in 2021 resulted in settlements totaling $8,171,252.

The provider types that utilized the self-report process include clinics, hospitals, home health agencies and mental health rehabilitative services. Providers and managed care organizations may use the OIG Fraud Hotline or website at any time to report any compliance or overpayment matters relating to themselves. The OIG considers self-reporting as a potential mitigating factor that may warrant less severe or restrictive administrative action or sanction.

Collaborating to improve TPL

OIG Third Party Recoveries (TPR) collaborated with HHS and Texas Medicaid's claims administrator on implementation of the following initiatives to help improve MCOs' performance of Third Party Liability activities. Third party recovery involves any individual, entity or program, including health insurance, that may be legally liable to pay all or part of a client's medical costs before Medicaid dollars are spent. These enhancements, along with updates to MCO contract requirements, assist MCOs in maximizing cost avoidance and cost recovery efforts:

- An improved data match process was implemented in October 2020 to increase identification of other insurance and provide more accurate and timely other-insurance

data. The new data match process increased cost avoidance by 32 percent, to $25,196,255, for FY 21.

- A clean-up project of pharmacy records was implemented in December 2020. The ongoing project identifies other-insurance policy information and voids duplicate and invalid records, resulting in improvements to the quality of data in the pharmacy system.

Litigation sees results with new efficiencies

The Chief Counsel Division continued to prioritize managing cases more efficiently during this fiscal year. Litigation obtained several new full-time employees to assist in day-to-day case management. As a result, Litigation's productivity in terms of case resolutions and recoveries increased noticeably during this fiscal year.

WIC team achieves results with process improvements

Productivity in the WIC Vendor Monitoring Unit (VMU) increased this year as inventory reviews increased by 66 percent. The unit adopted a mapping process to assess the WIC landscape in terms of fundamental daily operations while mapping critical tasks.

The process helped WIC VMU increase inventory reviews (IRs) for the year. IRs compare a vendor's paid claims and their purchase invoices for WIC food items to determine if the vendor had a sufficient inventory of WIC items to justify their submitted claims. Only 40 IRs were completed in fiscal year 2019. For fiscal year 2020, WIC completed 134 IRs as field operations were curtailed due to Covid-19. Although field operations resumed in FY21, WIC VMU completed 227 IRs. The team also exceeded the number of USDA-mandated annual on-site store review visits in only three months.

Inspections improvements

In FY 21, the OIG Inspections Team more than quadrupled its output from two published reports the previous year to nine. Inspections also implemented new procedures to continue ensuring compliance with standards, including developing a quality control function, standardized report templates, and project tracking tools. The first inspection under the new procedures, "Supplemental Nutrition Assistance Program: Second Level Review Process," was published in August.

More efficient audits

Process improvements helped OIG Audit reduce their completion time for audits by almost 40 percent. Assessing their workflow led the unit to add more time to up-front planning, which resulted in less time needed through the field work and report publishing process. From planning through publication, audits are now completed in under eight months, compared to over 13 months in FY 19.

Update on OIG Lock-In Program

The Lock-In Program helps prevent the overprescribing and potential misuse of controlled substances. MCO referrals to the Lock-In Program increased 228 percent since fiscal year 2020. The increased referrals have resulted in more than $4.8 million in cost savings in FY 21 to Texas taxpayers. This represents the acute care services and prescriptions cost avoided by restricting Medicaid recipients to designated providers. The Lock-In Program, in coordination with the MCOs Automatic Lock-In process, improved cost avoidance per member per month (PMPM) from approximately $110 in FY 2019 to $217 in FY 21. The Lock-In Program will host a series of MCO one-on-one meetings this fall to better understand how MCOs have been successful in increasing referrals. These meetings will assist in identifying effective practices to disseminate and continue to prompt the highest level of participation and performance from each MCO.

HUR completes two managed care reviews

The OIG Hospital Utilization Review (HUR) team performs retrospective utilization review of paid inpatient hospital claims for services provided to

Medicaid recipients. The risk categories include short stay, newborns with an associated significant condition, complex and premature deliveries, freestanding psychiatric admissions, and readmissions. HUR completed the first managed care sample reviewing 1,442 STAR program encounters with dates of service from March 2016 through May 2016. HUR completed the second managed care sample reviewing 2,554 STAR and STAR+PLUS program encounters with dates of service June 2016 through November 2016. The results of the reviews are being analyzed to identify specific misconduct and trends, provide education, and summarize findings for both samples. The OIG intends to continue this review effort and utilize findings to support future OIG work in coordination with other OIG audits, investigations or inspection programs.

OIG enhances internal training

The OIG training team promotes professional development by working with each division to map out annual training plans and review curricula to ensure each training has sound objectives and relevant content. This fiscal year, the OIG recorded 151 training courses, surpassing Legislative Budget Board key measure by 121, as well as 2022's target of 150.

The agency is also creating a library of computer-based and on-demand training opportunities. The digital library currently contains a variety of content relating to COVID-19, leadership skills, and other workplace topics. The agency plans to move other educational opportunities such as new employee orientation, Medicaid basics and other HHS topics to the virtual platform.

In FY 21 Benefits Program Integrity implemented an Investigator Training Academy to help benefits investigators develop the core skills necessary to perform their respective job functions. The curriculum is designed to provide all new investigators with training tailored to their level of experience with HHS benefits programs and

IV. Quarter 4 Results

Dollars recovered

Audit and Inspections	
Audit collections	$80,850

Investigations and Reviews	
Provider overpayments	$1,926,819
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$15,440,556
Voluntary repayments by beneficiaries	$45,594
Acute care provider overpayments	$2,780,361
Hospital overpayments	$1,269,721
Nursing facility overpayments	$94,784
Recovery Audit Contractor recoveries	$22,033,922
WIC collections	$45
Provider underpayments	$[44,899]
Total division recoveries	**$43,546,903**

Third Party Recoveries	
TPR recoveries	$76,094,025

Peace Officers	
EBT trafficking retailer overpayments	$174,921
Total dollars recovered	**$119,896,699**

Dollars identified for recovery

Audit and Inspections	
Provider overpayments	$2,144,014

Investigations and Reviews	
MCO identified overpayments	$6,105,576
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, WIC)	$15,321,821
Acute care provider overpayments	$3,026,296
Hospital overpayments	$2,862,183
Nursing facility overpayments	$1,194,845
Recovery Audit Contractor identified	$26,622,571
WIC vendor monitoring	$79
Total identified recoveries	**$55,133,371**

Third Party Recoveries	
TPR identified recoveries	$449,733,174

Peace Officers	
EBT trafficking	$326,112
SCIT	$15,651
Total dollars identified for recovery	**$507,352,322**

Cost avoidance

Investigations and Reviews	
Medicaid provider exclusions	$6,646,705
Client disqualifications	$1,956,014
WIC vendor monitoring	$0
Pharmacy Lock-In	$2,045,791

Third Party Recoveries	
Front-end claims denials	$33,612,846

Peace Officers	
EBT recipient avoidance	$151,776
Total cost avoidance	**$44,413,132**

Liquidated damages

LDs collected	$17,300

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.

V. Trends

Provider Investigations

Investigations & Reviews (I&R) continues to receive hotline referrals and managed care organization referrals related to personal care attendants. For the quarter, 40 percent of preliminary referrals were for attendants billing for services not rendered, falsifying documentation and billing for attendant care while the client is an inpatient at a hospital or nursing facility. The OIG continues to investigate attendant care cases and recommend enforcement action based on findings.

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

- **Private duty nursing settlements.** As part of an OIG initiative, investigators identified providers in San Antonio and Converse who were billing over the daily allowable amount for private duty nursing, and in some instances, submitting duplicate claims. Settlements in the fourth quarter resulted in $86,531 in repayments for the two cases.
- **Dental settlements.** The OIG settled four cases involving dental providers. The providers' most common errors were upcoding services, providing medically unnecessary services and not maintaining appropriate medical records. A Houston provider agreed to a settlement of $44,236, a San Antonio dentist agreed to repay $25,881, and an Arlington provider agreed to pay $13,303. A fourth investigation resulted in a provider located in Tyler agreeing to repay $19,422.

Benefits Program Integrity

The Benefits Program Integrity (BPI) division completed 5,172 investigations involving some form of benefit recipient overpayment or fraud allegation. Ninety percent of all investigations completed involved unreported income or an issue with the reported household composition. Household composition cases usually deal with an

Provider Investigations

Referral sources for cases

Source	Percent
MCO/DMO	30%
Government agency	28%
Public	20%
Provider	10%
Anonymous	5%
OIG initiated	7%

Types of preliminary investigations opened

Type	Percent
Attendants	40%
Physician (individual/group/clinic)	18%
Dental	7%
Home health agency	6%
Nursing facility	6%
Pharmacy	4%
Durable medical equipment	4%
Hospital	3%
Lab-Radiology-X-ray	2%
Adult day care	2%
Federally qualified health center	1%
Therapy (physical/occupational/social)	1%
Assisted living	1%
10 other categories at less than 1%	

Types of full investigations opened

Type	Percent
Physician (individual/group/clinic)	26%
Attendants	12%
Durable medical equipment	12%
Home health agency	9%
Hospital	9%
Nursing facility	7%
Pharmacy	7%
Adult day care	5%
Dental	3%
Managed care organization	3%
Rehabilitation center	3%
Case management	2%
Therapy (physical/occupational/social)	2%

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. For this quarter, BPI referred 20 investigations for prosecution and 181 investigations for administrative disqualification hearing.

Sample cases worked by BPI this quarter include:

- **Unreported income on SNAP applications.** BPI resolved a trio of cases in South Texas, each involving a different SNAP recipient who failed to include her husband and his income as part of her household on her benefits application. Investigators compiled witness statements, driver license information, Department of Motor Vehicle records, property deed information, and payroll information to prove their cases. The clients in all three cases waived their rights to an administrative hearing to contest the findings, and each was disqualified from SNAP for 12 months. The client in Pecos County had received a total of $24,405 in excessive benefits over a 20-month period and agreed to repay that amount. The client in Hidalgo County agreed to repay $22,525, and the client in Bexar County agreed to pay $34,661.

Electronic Benefits Transfer

EBT Trafficking data analysis identified a trend of recipients who receive high dollar amounts of Pandemic Supplemental Nutritional Assistance Program (PSNAP) benefits using social media to sell their excess benefits. Reports show some recipients receive several thousand dollars in monthly benefits and sell them for fifty cents on the dollar. The OIG is currently opening investigations into several cases.

EBT Trafficking continues to receive a high volume of referrals regarding mobile vendors in the Houston area. Recipients complain that mobile vendors remove benefits from recipient accounts through unauthorized transactions. EBT Trafficking is investigating several mobile vendor retailers.

A sample of cases worked by EBT this quarter include:

- **SNAP retailer permanently disqualified.** The EBT Trafficking Unit completed an investigation of a retailer in the Fort Worth area allegedly accepting SNAP benefits without authorization. Undercover operations revealed the retailer was illegally accepting SNAP benefits by using a Point of Sale device authorized for a second store owned by the same person. The retailer defrauded the SNAP program in the amount of $135,191. A search warrant was executed in June where the Point of Sale device and several other electronic devices were seized. A second warrant was served to search those devices for evidence, which is pending. The retailer was permanently disqualified from the SNAP Program, and the case has been referred to the Tarrant County District Attorney's Office.
- **USDA referral.** EBT Trafficking received dispositions on four investigations referred to the USDA Food and Nutrition Service for retailer disqualification. Three SNAP program retailers were disqualified from participation for one year and the fourth permanently disqualified. The successful EBT investigations and resulting disqualifications prevented the fraudulent use of $335,076 in SNAP benefits.

Internal Affairs

Internal Affairs (IA) worked 52 active investigations and closed 39 investigations in the fourth quarter. IA processed 109 referrals this quarter and investigated 56 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. IA has demonstrated efficiency by maintaining an average open case age under 60 days. IA has maintained a case completion average of only 69 days. Trend identified by IA:

- **Open DFPS cases.** The majority of IA's open cases involve DFPS. Many relate to allegations of caseworkers falsifying documents. This may be the result of DFPS management establishing quality assurance processes to identify misconduct by employees and reporting these cases to IA, as well as a greater number of clients alleging caseworker misconduct.

A sample of cases concluded by IA this quarter:

- **Falsifying case documentation.** IA received information from a Child Protective Service (CPS) program director that an investigator falsified case documentation. IA determined that the CPS investigator fabricated client names and falsely documented they had conducted face-to-face visits with clients. The CPS investigator resigned in lieu of disciplinary action, and IA has referred the case to the Harris County District Attorney's Office for prosecutorial review.
- **Submitting false travel records.** A Family Based Service specialist was accused of submitting false travel vouchers. The specialist resigned prior to the completion of the investigation, and IA has referred the case to the Taylor County district attorney for prosecutorial review. The investigation identified a $697 loss to the state.

State Center Investigations Team

The OIG's State Center Investigations Team (SCIT) opened 124 investigations and completed 134 investigations in the fourth quarter of fiscal year 2021, with an average completion time of 19 days. This compares to 144 opened investigations and 129 completed investigations in the fourth quarter of fiscal year 2020.

SCIT received court dispositions on two cases in the fourth quarter involving injuries to patients at North Texas State Hospital-Vernon. In one case, an employee was accused of striking the patient with an object. The other involved a different employee, who was accused of pushing a patient who was in a wheelchair, causing the patient to fall onto the floor, which resulted in an injury. Both cases were referred to the Wilbarger County district attorney for prosecution. The court accepted a guilty plea of injury to a disabled individual in the first case and a guilty plea of criminal negligence in the second. The employee in each case received 150 hours of community service with court costs and fines imposed.

Another SCIT case involved an injury to a client at the Corpus Christi State Supported Living Center. An employee was accused of striking a client, causing the client to fall onto the floor, which resulted in an injury. The case was referred to the Nueces County District Attorney for prosecution.

Open IA cases by type

Type	Percent
Falsifying information/documents	60%
Unprofessional conduct	10%
Privacy incident/breach	8%
Tampering with Governmental record	6%
Unauthorized release of information	4%
Other	12%

VI. Policy Recommendations

Ensure TIERS controls are sufficient, consistent, and in alignment with Medicaid policy

The OIG conducted an audit of the Texas Integrated Eligibility Redesign System (TIERS), which is the system that contains records of applications processed, approved and denied. TIERS is a critical Texas Health and Human Services Commission (HHSC) system because it processes eligibility information to determine whether individuals are eligible to receive services, including Medicaid.

While TIERS had system and process controls in place, those controls should be strengthened to reasonably ensure that Medicaid eligibility determinations are accurate based on selected eligibility elements. HHSC did not maintain current design documentation for TIERS screens related to citizenship, residency and identification of deceased individuals. The design documentation provided by HHSC IT Social Services Applications conflicted with Medicaid policy found in the Texas Works Handbook and had not been updated since at least December 2016. The accuracy of eligibility determinations is dependent on the accuracy of applicant information entered into TIERS. Inaccurate or incomplete eligibility information increases the risk that Medicaid benefits could be incorrectly approved for ineligible individuals or incorrectly denied for eligible individuals.

Accurate and current design documentation would allow HHSC to review existing controls within TIERS for adequacy and alignment with Medicaid eligibility policy. The lack of current design documentation increases the risk that automated controls within TIERS are not sufficient to ensure eligibility information entered into TIERS is accurate, complete and aligns with Medicaid eligibility policy.

HHSC Access and Eligibility Services should work with HHSC IT Social Services Applications to strengthen and update automated controls to ensure (a) the integrity of eligibility information entered into TIERS and (b) alignment with Medicaid policy and IT best practices. HHSC IT Social Services Applications should document and update, as necessary, TIERS design documentation to allow HHSC to review existing controls for adequacy and alignment with Medicaid eligibility policy.

Ensure TIERS access is appropriate

The OIG conducted an audit of the Texas Integrated Eligibility Redesign System (TIERS), which is the system that contains records of applications processed, approved, and denied. TIERS is a critical Texas Health and Human Services Commission (HHSC) system because it processes eligibility information to determine whether individuals are eligible to receive services, including Medicaid. Access to TIERS and the eligibility information contained within must be limited to authorized users. In order to meet security requirements, information system accounts must be reviewed every 180 days for compliance with account management requirements, such as valid access appropriateness and intended system usage, and all accounts must be certified annually.

HHSC Access and Eligibility Services had a process in place to complete periodic access reviews of TIERS user accounts; however, that process was not effective to identify inappropriate access and did not align with requirements described in state and federal requirements. Inappropriate access to TIERS increases the risk for misuse or unauthorized changes to federally protected personal health information and personally identifiable information. HHSC IT Social Services Applications and HHSC Access and Eligibility Services should strengthen controls related to ensuring access to TIERS is appropriate.

Determine whether retroactive capitation payments should have been made to MCOs for periods in which fee-for-service payments were made

The OIG conducted an audit of Texas Health and Human Services Commission Information Technology (HHSC IT). The audit focused on risks related to fee-for-service payments for services covered by managed care organizations (MCOs). During fiscal year 2019, fee-for-service represented approximately six percent of the 4.3 million individuals enrolled in Texas Medicaid. The audit objective was to evaluate the effectiveness of processes and controls designed to prevent fee-for-service claims from being paid for services covered by MCOs.

Managed care enrollment information was not confirmed or transmitted within 60 days for 1,788 of 19,698 (9 percent) individuals in the Medicaid for Pregnant Women program during the scope of this audit; however, 17,910 of 19,698 (91 percent) individuals in the Medicaid for Pregnant Women program were enrolled into managed care timely.

In some cases, HHSC paid fee-for-service claims for pregnant women enrolled in Medicaid and then also made capitation payments to MCOs for months in which those fee-for-service claims were paid. OIG Audit worked with HHSC IT, Medicaid and CHIP Services (MCS) and HHSC Access and Eligibility Services (AES) staff to identify why fee-for-service payments were made for periods for which capitation payments were also made. Working with HHSC, OIG Audit was able to identify some control weaknesses that contributed to delays in enrolling pregnant women in managed care.

Delays in transmitting enrollment information were primarily caused by errors in the processing of enrollment information within Texas Integrated Eligibility Redesign System (TIERS) and transfers between TIERS and other business partners. Additional causes included business logic rules that were not clearly defined for unique and unexpected situations, such as changes to Medicare coverage and other types of unusual situations that caused unanticipated results. Other control weaknesses may have contributed to these errors; however, those potential weaknesses require further research by HHSC IT, MCS and AES staff.

HHSC IT, in coordination with MCS and AES, should identify and address control weaknesses in TIERS data interfaces with the enrollment broker or TMHP that caused delays in enrollment information for pregnant women being transmitted to the HHSC claims administrator and the Premiums Payable System. MCS, in coordination with AES and HHSC IT, should evaluate business rules and process flows around Medicaid for Pregnant Women to determine if there are adequate controls to support the business objectives for eligibility and enrollment processes.

VII. Agency Highlights

OIG resolves a case against Houston Area hospitals

The OIG settled cases in June against Houston area hospitals. Between January 2012 and May 2021, six hospitals had been improperly reimbursed for the administration of injections and infusions in the outpatient emergency department; injections and infusions are included in an emergency room service charge and are not reimbursed separately. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $13,049,894.

OIG settles cases with home health providers

The OIG settled cases in the fourth quarter related to private duty nursing and home health care. Private duty nursing providers in Houston and San Antonio had both been improperly reimbursed for more than the maximum allowable amount of 96 units of private duty nursing services for one client on one date of service. In each case, the provider worked collaboratively with OIG Litigation to resolve these issues and agreed to settlements of $108,567 and $73,916, respectively.

OIG settles case with a North Texas pediatric clinic

The OIG settled a case in July against a Mesquite pediatric care provider. The provider's error involved separately billing for audiometry services that were included as a bundled component of a globally billed Texas Health Steps preventative care visit, as required by the Texas Medicaid Provider Procedures Manual (TMPPM). The provider worked collaboratively and cooperatively with the OIG to identify the extent of the error, heighten its understanding of the applicable TMPPM provisions, and institute measures to prevent the error from occurring in the future. To resolve the case, the provider additionally agreed to a settlement of $330,000.

Quarter 4 performance

Audit reports issued	21
Audits in progress	12
Inspections reports issued	5
Inspections in progress	-
Total investigations opened	5,185
Total investigations completed	5,949
Client investigations completed	5,172
EBT retailer investigations completed	66
Internal Affairs investigations completed	39
State center investigations completed	134
Medicaid provider investigations completed	
Preliminary	499
Full-scale	39
PI cases transferred to full-scale investigation	57
PI cases referred to Medicaid Fraud Control Unit	158
Hospital claims reviewed	4,121
Nursing facility reviews completed	113
Medicaid and CHIP provider enrollment screenings performed	25,520
Medicaid providers excluded	59
Fraud hotline calls answered	9,104

OIG excludes a Hidalgo County pharmacist

In June, the OIG agreed to a term of exclusion of eight years with a Mission pharmacist. The pharmacist was the principal and pharmacist-in-charge of a pharmacy that had issues with billing invoices not adequately explaining the quantities billed to Medicaid, as well as allegations of billing for services not rendered.

OIG settles case with a North Texas pediatric dental care provider

The OIG settled a case in July against an Arlington pediatric care provider. The case focused on allegations of Medicaid client solicitation and erroneous billing for resin-based, dental procedures. The provider closed the practice in question at the end of 2019 and worked with the OIG to improve his understanding of applicable statutes and Texas Medicaid policies and provisions to prevent recurrence of the errors identified. To resolve the case, the provider also agreed to a settlement of $50,000, of which $15,000 was for penalties.

DME provider sentenced to prison

The OIG assisted the FBI's South Texas Task Force investigation of a durable medical equipment provider. According to the indictment, the provider billed Texas Medicaid more than $1 million between 2010 and 2016 for claims that were supported by either false or missing documentation. The case was referred to the U.S. Attorney's Office for prosecution. The owner and operator of the DME pled guilty to conspiracy to submit false statements relating to health matters, was sentenced to 24 months in federal prison and agreed to make $385,574 in restitution to Medicaid.

Telehealth Fraud Detection Operation

Investigations and Reviews also advanced work on an FDO executed in August. The collaboration with the OIG's fraud analytics team focused on occupational and/or physical therapy providers. The FDO team selected the three providers billing as outliers among their peers for inclusion in the FDO. At the end of the fourth quarter, investigators were conducting provider and client interviews and collecting and reviewing records to determine whether any violations exist; full-scale investigations will be opened, if needed.

TDA honors OIG's Chief Dental Officer

Dr. Janice Reardon, Chief Dental Officer of the Office of Inspector General, has been honored with the Lifetime Membership Award by the Texas Dental Association. The award recognizes her 30 years of continuous membership in TDA.

A graduate of the University of Texas Health Science Center at Houston Dental Branch, Dr. Reardon spent many years in private practice before choosing to seek work at clinics serving populations with limited access to health care services. During that time, she also became an adjunct clinical professor with the University of Texas School of Dentistry, supervising residents and senior dental students doing rotations at a non-profit clinic.

Dr. Reardon joined the OIG in December 2015 and became Chief Dental Officer in 2017. In her role as the OIG's dental subject matter expert, she ensures dental investigation record reviews are completed accurately and timely, and she performs highly advanced consultative dental work and provides expert testimony as needed. Under her direction and as part of investigations, the OIG dental team performs clinical exams of Medicaid beneficiaries, assists with inspections of dental offices, and works in conjunction with the Texas Attorney General's Medicaid Fraud Control Unit and the FBI. Dr. Reardon also works with the HHS Medicaid/CHIP Division to recommend improvements to state dental policies to help reduce and eliminate fraud, waste and abuse.

OIG passes CJIS audit

The Department of Public Safety's Criminal Justice Information Services (CJIS) Security Office conducted its biennial audit of the OIG in August. The purpose of the audit is to ensure compliance with the technical aspects of the FBI CJIS Division's policies and regulations. The federal government has set minimum security requirements to access FBI CJIS Division systems and information and to protect and safeguard criminal justice information. CJIS compliance ensures that law enforcement institutions like the OIG properly handle sensitive intelligence data. The audit determined the agency was fully compliant with the CJIS security requirements.

OIG centralized risk review update

The OIG regularly identifies key areas of risk for FWA across the entire HHS system and the programs, systems and services delivered by Texas Medicaid providers and contractors. This data-driven process identifies potential areas of focus for the topic and data strategies the OIG may consider for OIG future audits, inspections, investigations and reviews.

Skilled policy and data analysis staff conduct a preliminary examination of a topic. The review considers known and emerging risks on each topic based on a number of factors, including other state and federal agency reports, initial data reviews to determine the impact within Texas, and interviews with HHS staff to estimate the potential impact of a topic. Analysis focuses on compliance, health and safety, data integrity and unusual service use.

In the fourth quarter, the review of prioritized topics culminated in an audit and inspections work plan for fiscal year 2022, facilitating strategic allocation and deployment of OIG resources; the work plan is available on the OIG's website.

WIC vendor trends across the state

Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) has seen a significant increase in WIC labeling violations throughout Traditional Women, Infants and Children (TWIC) vendors. This increase corresponds with the current USDA waiver in place, which prevents vendors from being cited for such violations during the nationwide pandemic. This has directly impacted the amount of recoveries normally collected by the WIC VMU. The WIC VMU assessed a lower number of civil monetary penalties in the fourth quarter, as well as the entire year.

WIC compliance activities

During a series of covert compliance buy activities in the Dallas area, WIC VMU identified four stores who violated WIC policy by failing to prominently display the shelf prices of all WIC authorized foods within each store's commercial area. In this case, the stores were cited for failure to post prices for all WIC products. The WIC stores are pending further action from the HHS WIC program.

A WIC VMU covert compliance buy activity at a WIC vendor located in Boerne identified a violation involving transactions which indicate charging for food not received. During the process of completing a store transaction, an agency auditor was charged for an item they did not receive. The WIC store is pending further action from the HHS WIC program.

During several covert compliance buys with WIC vendors in Hidalgo County, an agency auditor tested the accuracy of baby food transaction scanning. Several vendors included in the covert compliance buy activities initially failed to properly execute and complete the transactions. Subsequently, the WIC VMU used educational letters to notify and advise WIC vendors of these deficiencies. After OIG WIC sent the educational letters, follow up visits to the WIC vendors in question indicated proper completion of transactions in accordance with WIC policy and procedures.

Streamlining BPI investigations

In the fourth quarter of fiscal year 2021, BPI consolidated its claims investigators under one director. A lead claims investigator was hired to investigate all claim-related complaints that would require a disqualification hearing. This helps promote efficiency by allowing other claims investigators to focus on non-fraud claims, improve consistency in disqualification hearings resulting from claims investigations, and streamline workflow and training efforts. This change does not affect field investigations, which account for the majority of fraud complaints.

Completed Reports

Audit

Co-Treatment Therapy Billing: MindWorks Rehabilitation Center. The OIG conducted an audit of co-treatment therapy billing to ensure co-treatment services performed were billed correctly by MindWorks Rehabilitation Center (MindWorks) in McAllen. Co-treatment therapy services occur when two or more therapy disciplines are performed concurrently to improve a patient's health. A primary therapist must be designated and authorized to bill for co-therapy. The secondary therapist will not be reimbursed. A modifier code must be included on any co-treatment claims. As a therapy provider, MindWorks is authorized but not required to perform co-treatment therapy if the services would benefit the patient and if MindWorks complies with certain requirements related to billing. MindWorks informed the OIG that it has not performed co-treatment therapy since the billing guidelines were implemented in 2016.

For selected patients from September 1, 2018 to May 31, 2020, documentation supports occupational and speech therapy sessions were conducted separately and not as co-treatment. Additionally, auditors contacted selected guardians of patients, who confirmed sessions were conducted separately. As a result, no issues or recommendations were identified for this audit.

Women, Infants, and Children's Nutrition Program (WIC): City of Laredo Health Department. The OIG conducted an audit of the City of Laredo Health Department's Women, Infants, and Children's Nutrition Program (WIC) contracts. The audit objective was to determine if the City of Laredo Health Department's WIC program had financial processes and controls to ensure compliance with federal and state program rules, guidelines, and contractual requirements for the Texas Health and Human Services Commission (HHSC) WIC program. The audit scope was from October 1, 2019 through February 28, 2021. The City of Laredo Health Department is contracted with HHSC through September 30, 2025 to provide nutrition education and counseling to qualified women, infants and children in eight Texas counties. This audit focused exclusively on the City of Laredo Health Department's WIC program and was limited to (a) a review of accounting and financial controls over the City of Laredo Health Department's WIC funds and (b) testing a risk-based sample of transactions of those funds.

The OIG determined that the City of Laredo Health Department complied with (a) WIC accounting policies and procedures, (b) HHSC WIC contract requirements and (c) City of Laredo accounting procedures and fiscal internal controls. As a result, no issues or recommendations were identified for this audit.

Acadian Ambulance Services. The OIG conducted an audit of ground emergency ambulance services at Acadian Ambulance Service of Texas, LLC (Acadian). Emergency ambulance services are allowable when the client has an emergency medical condition. For this audit, auditors examined payments from three selected managed care organizations (MCOs). The audit objective was to determine whether Acadian billed Superior HealthPlan, Texas Children's Health Plan and UnitedHealthcare for claims for ground emergency ambulance services in accordance with applicable statutes, rules and procedures in the managed care environment for the period from September 1, 2018 through May 31, 2020.

Acadian met most of the requirements tested. For all 180 ground emergency transport claims tested for all three MCOs, Acadian recorded accurate client and receiving facility data, accurately calculated mileage from pick-up to destination, and transported patients to an appropriate facility such as a hospital. However, Acadian did not always report transports correctly or maintain all needed support for claims. Specifically:

- Four of 180 (2.2 percent) claims tested were not medically necessary according to documentation in Acadian's billing system. The claims were billed although Acadian determined that they were not medically necessary.
- Acadian billed 8 of 176 applicable claims (4.5 percent) tested for a higher level of service than should have been charged based on services documented in medical records. Incorrectly classifying claims at a higher level of service can lead to overpayment for services.
- Acadian did not provide sufficient support for one out of 134 (0.7 percent) transports tested for patients that did not have a corresponding receiving facility claim, which makes the claim not supported for payment under Medicaid rules.

By extrapolating the results of each of the three samples to the appropriate population of claims within the scope of the audit, the OIG determined that the exceptions represented an overpayment for the populations of $43,037. In addition to overpayments identified in statistical samples, auditors identified one overpayment of $888 in a non-statistical sample. Acadian should (a) code non-medically necessary encounters appropriately, (b) ensure it maintains sufficient support for all claims and (c) repay $43,925.

Data Processing and Integrity of Medicaid Eligibility Determinations Texas Integrated Eligibility Redesign System. The OIG conducted an audit of the Texas Integrated Eligibility Redesign System (TIERS), which is the system that contains records of applications processed, approved, and denied. TIERS is a critical Texas Health and Human Services Commission (HHSC) system because it processes eligibility information to determine whether individuals are eligible to receive services, including Medicaid. The audit objective was to determine whether TIERS system and process controls were adequate to reasonably ensure that Medicaid eligibility determinations were accurate based on selected eligibility elements, including citizenship, residency, and identification of deceased individuals.

While TIERS had system and process controls in place, those controls should be strengthened to reasonably ensure that Medicaid eligibility determinations are accurate based on selected eligibility elements. Specifically:

- Automated controls within TIERS were not always adequate to ensure all eligibility records were closed as required for applicable deceased individuals. This resulted in managed care capitation payments totaling $660,721 for individuals who were deceased.
- Controls were not always adequate to reasonably ensure that information used to determine Medicaid eligibility was accurate, complete, and in alignment with Medicaid policy.

The OIG made recommendations to HHSC to identify deceased individuals and close Medicaid eligibility; ensure TIERS automated controls are sufficient, consistent, and aligned with Medicaid policy; ensure access to TIERS and controls related to TIERS access is appropriate; and to recover the $660,721 managed care capitation payments for the deceased individuals.

Fee-For-Service Claim Payments for Pregnant Women with Medicaid Managed Care Eligibility. The OIG conducted an audit of Texas Health and Human Services Commission Information Technology (HHSC IT). The audit focused on risks related to fee-for-service payments for services covered by managed care organizations (MCOs). During fiscal year 2019, fee-for-service represented approximately six percent of the 4.3 million individuals enrolled in Texas Medicaid. The audit objective was to evaluate the effectiveness of processes and controls designed to prevent fee-for-service claims from being paid for services covered by MCOs.

In certain situations involving the Medicaid for Pregnant Women program, the transmittal of managed care enrollment information between the Texas Integrated Eligibility Redesign System

(TIERS) and either the enrollment broker or the Texas Medicaid and Healthcare Partnership (TMHP) did not occur as expected. Unanticipated events delayed transmittal of enrollment information, which resulted in (a) the avoidable payment of fee-for-service claims for months in which costs for health care services should have been paid by an MCO and (b) retroactive capitation payments made to an MCO for months in which fee-for-service claims were paid.

The OIG recommended that Medicaid and CHIP Services should determine (a) whether retroactive capitation payments should have been made to MCOs for periods in which fee-for-service payments were made and (b) if there are adequate controls to support the business objectives for eligibility and enrollment processes. Additionally, HHSC Information Technology should identify and address control weaknesses in TIERS data interfaces with the enrollment broker or TMHP.

Managed Care Pharmacy Claims Paid to Rx Plus Pharmacy of Live Oak: A Managed Care Network Provider Contracted Under Superior HealthPlan. The OIG conducted an audit of Medicaid managed care claims paid to Rx Plus Pharmacy of Live Oak (Rx Plus) by Superior HealthPlan, Inc., a managed care organization. During the period from June 1, 2017 through August 31, 2019, Rx Plus was paid $3.3 million for 27,462 Medicaid managed care claims for prescriptions dispensed to Superior members. The audit objectives were to determine whether Rx Plus (a) properly billed for paid claims associated with Medicaid members enrolled with Superior and (b) complied with applicable contractual, state and federal requirements.

Rx Plus properly billed for claims and complied with applicable contractual and Texas Administrative Code requirements for all refill claims and most initial fill claims selected for testing as part of this audit. However, for two initial fill claims, Rx Plus did not properly bill for the claim or consistently comply with applicable requirements for Medicaid managed care pharmacy claims. Specifically: (a) for one of 120 initial fill claims tested, the medication dosage direction on the prescription did not agree with the medication dosage direction dispensed and (b) for one of 120 initial fill claims tested, Rx Plus submitted the claim with an incorrect issuance date, although the prescription was still valid.

As a result, Rx Plus received Medicaid overpayments totaling $61 which it should repay to the state of Texas.

Security Controls Over Confidential HHS Information: Scott and White Health Plan. The OIG completed an audit of Scott and White Health Plan (Scott and White). 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 Scott and While, as well as business continuity and disaster recovery plans for operations relating to the processing and storage of confidential HHS System information by Scott and White.

Access to confidential HHS System information must be managed in accordance with HHS iInformation sSecurity cControls (IS-controls). Scott and White did not comply with certain information security requirements applicable to confidential HHS System information. However, Scott and White complied with most of the information security requirements tested and established procedures to ensure continuation of the operations necessary to deliver services to Medicaid members in the event of an emergency or disaster. The OIG offered recommendations to Scott and White, 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.

Cenikor Foundation: Region 4 Substance Use Disorder Treatment Provider. The OIG conducted an audit of services Cenikor Foundation (Cenikor) provided under two adult treatment contracts for its Region 4 facility in Tyler. The OIG initiated this audit as a result of a previous audit of Cenikor facilities in Region 7, which found Cenikor did not meet most contractual requirements tested

and did not provide support that it consistently delivered key services for which it received payment.

During the audit scope of September 2019 through December 2020, HHSC paid Cenikor $1,135,494 for adult treatment services it provided to 513 clients in Region 4. The audit objective was to evaluate whether Cenikor's Region 4 residential withdrawal management and intensive residential treatment services (a) were provided in accordance with selected regulations and contractual requirements and (b) supported the payment received.

While Cenikor met some Texas Administrative Code (TAC) and contractual requirements tested, Cenikor did not meet several key contractual requirements tested and did not provide support that it consistently delivered services for which it received payment. Specifically, Cenikor did not consistently provide support that it performed required (a) monitoring activities for clients admitted to its residential withdrawal management service type or (b) counseling services for clients admitted to its intensive residential service type. Cenikor did not provide evidence that it delivered all required monitoring or counseling services to the following clients tested:

- 96 percent of clients admitted into withdrawal management. Of those clients, Cenikor did not perform 50 percent or more of required monitoring for 9 percent of the clients tested. As a result, the OIG identified an extrapolated recovery of $14,808.
- 48 percent of clients admitted into its intensive residential service.
- Maintain evidence to support performance of, and compliance with, program and contractual requirements related to medical, clinical, opioid consent, and referral and referral follow-up activities.

In addition, testing identified 73 occurrences where Cenikor billed for both withdrawal management and intensive residential on the same day, resulting in an additional dollar-for-dollar overpayment of $8,090.

The OIG identified a total overpayment of $22,898 that should be returned to the state of Texas. The OIG offered recommendations to Cenikor, which, if implemented, will correct deficiencies in compliance with TAC and contractual requirements.

Cenikor Foundation: Region 11 Substance Use Disorder Treatment Provider. The OIG conducted an audit of services Cenikor Foundation (Cenikor) provided under two adult treatment contracts for its Region 11 facility in Corpus Christi. The OIG initiated this audit as a result of a previous audit of Cenikor facilities in Region 7, which found Cenikor did not meet most contractual requirements tested and did not provide support that it consistently delivered key services for which it received payment.

HHSC paid Cenikor $2.5 million for services to 1,265 clients under the contract during the audit scope, which included the period September 1, 2019 through December 31, 2020. The audit objective was to evaluate whether Cenikor's Region 11 residential withdrawal management and intensive residential treatment services (a) were provided in accordance with selected regulations and contractual requirements and (b) supported the payment received.

Cenikor did not consistently comply with core contractual requirements for providing adult substance use disorder program services in Region 11. Specifically, Cenikor did not:

- Consistently provide support that it performed required (a) monitoring activities for clients admitted to its residential withdrawal management service type or (b) counseling services for clients admitted to its intensive residential service type. Cenikor did not provide evidence that it delivered all required monitoring or counseling services to the following clients tested:
    - ◊ 91 percent of clients admitted into its residential withdrawal management.

Cenikor did not perform 50 percent or more of the monitoring required for 13 percent of the clients tested. As a result, the OIG identified an extrapolated recovery of $194,205.

    - ◊ 12 percent of clients admitted into its intensive residential service.

- Maintain evidence to support performance of, and compliance with, program and contractual requirements related to medical, clinical, opioid consent, and referral and referral follow-up activities.

In addition, audit testing identified 31 occurrences in which Cenikor billed for both withdrawal management and intensive residential on the same day and one instance in which it billed for a day the client was not at the facility, resulting in an additional dollar-for-dollar overpayment of $10,802.

The OIG identified a total overpayment of $205,007 that should be returned to the state of Texas. The OIG offered recommendations to Cenikor, which, if implemented, will correct deficiencies in compliance with TAC and contractual requirements.

Benchmark Family Services: A Former Texas Department of Family Protective Services Contractor. The OIG conducted an audit of Benchmark Family Services (Benchmark), a child placing agency formerly under a residential child care contract with the Texas Department of Family and Protective Services (DFPS). The contract was terminated May 31, 2021. The audit objective was to determine whether Benchmark had processes and controls in place to ensure it provided foster care services in accordance with selected contract terms and applicable requirements. The audit scope included a review of non-payroll expenditures (excluding foster parent payments) for the period from July 1, 2018 through June 30, 2019, and foster parent payments, service plans and foster home monitoring for the period of September 1, 2019 through August 31, 2020 at the Dallas and San Antonio offices.

Benchmark did not have effective processes and controls related to completing service plans and foster home quarterly monitoring visits to ensure it consistently provided foster care services in accordance with selected contract terms. Specifically, Benchmark did not provide documentation to support that it consistently (a) completed service plans as required or (b) monitored foster homes adequately. The non-payroll expenditures tested were allowable, supported, and accurately recorded in accordance with cost reporting requirements. Additionally, for the samples tested, Benchmark ensured that foster parents were paid in accordance with DFPS requirements. Benchmark is no longer a contractor with DFPS; therefore, the OIG did not make any recommendations in this report.

Aetna Better Health of Texas: Special Investigative Unit. The OIG Audit Division conducted an audit of special investigative unit (SIU) activities at Aetna Better Health of Texas (Aetna), a Medicaid and Children's Health Insurance Program (CHIP) managed care organization (MCO).

MCOs are required to establish an SIU to investigate fraudulent claims and other program waste and abuse by members and service providers. Aetna received $297 million in 2019 and $313 million in 2020 to administer Texas managed care programs for an average of 86,888 and 87,797 members per month, respectively. The audit objective was to determine if, for the period from September 1, 2018 through August 31, 2020, Aetna's SIU was in compliance with state and contractual requirements related to (a) preventing, detecting, and investigating fraud, waste and abuse and (b) reporting reliable information on SIU activities, results and recoveries to HHSC.

Aetna complied with most state and contractual requirements related to preventing, detecting and investigating fraud, waste and abuse, and reporting reliable information on SIU activities, results and recoveries to HHSC. During the audit period, Aetna's SIU had required staff, conducted

required training and monitored provider and member service patterns. Furthermore, it ensured all required elements of a preliminary investigation and extensive investigation were completed, maintained a log of incidences of suspected fraud, waste and abuse, and submitted required reports and referrals to the OIG within required deadlines. However, Aetna's SIU did not comply with timeframes for completing required preliminary and extensive investigation activities listed in Texas Administrative Code, including those for (a) completing preliminary investigations and timelines for selecting a sample of provider claims, (b) making requests for medical records and encounter data and (c) completing the review of requested records and data for extensive investigations.

The OIG recommended to Aetna that it should implement processes to ensure all required elements of preliminary and extensive investigations are completed timely and are sufficiently documented.

Health and Safety of Medicaid Beneficiaries in the HHSC Home and Community-Based Services Program: Kenmar Residential HCS Services. The OIG conducted an audit of Kenmar Residential HCS Services, Inc. (Kenmar) in response to an audit report issued by the United States Department of Health and Human Services Office of Inspector General that identified oversight issues regarding the Texas Health and Human Services Commission's (HHSC's) waiver programs for home and community-based services (HCS). The objective of the audit was to evaluate whether Kenmar provided Medicaid beneficiaries living in three- and four-person residences (homes) with safe and healthy living environments. Kenmar is an HCS program provider that operates 26 homes serving 58 Medicaid beneficiaries. In fiscal year 2020, Kenmar received $2,488,062 to deliver supervised living and residential support services to Medicaid beneficiaries under its care.

Kenmar complied with most of the HHSC's health and safety requirements during the OIG's unannounced site visits to four three- and four-person homes. Specifically, for the four homes visited by the OIG, Kenmar fully complied with requirements concerning the quality of essential features of each home's exterior and interior; emergency evacuation plans; fire safety standards; and abuse, neglect, and exploitation protocols. One home fully complied with all requirements concerning medications. However, Kenmar did not consistently comply with requirements concerning medications and infection control policies, and the OIG identified instances of noncompliance at each visited home.

The OIG made recommendations to Kenmar, which, if implemented, will ensure that Community Options strengthens its controls to ensure that it provides safe and healthy living environments.

NorthgateArinso. NorthgateArinso, Inc. (NGA) became the outsourced human resources and payroll contractor for the Texas Health and Human Services Commission (HHSC) on May 1, 2013. Under the contract, NGA provides human resource services; shared services; payroll and financial services; and service center and call center services. HHSC paid NGA $11.9 million for 2019 and $13.3 million for 2020. The OIG conducted this audit at the request of HHSC. The audit objectives were to determine whether (a) the Retrospective Cost Settlement statements for the unaudited periods of the original contract, as amended, with HHSC, contract years 2019 and 2020, were reasonably stated and (b) NGA was in compliance with a selected renewal contract requirement for information security.

NGA reported costs on the 2019 and 2020 Retrospective Cost Settlement statements that were unsupported and unallowable. However, the total incurred costs exceeded the fee ceiling for each contract year; therefore, no refund is due to HHS. The OIG identified $370,064 in 2019 and $543,690 in 2020 in overstated expenses on the RCS statements.

The OIG offered recommendations to NGA, which, if implemented, will (a) mitigate the risk of errors caused by manual report preparation, (b) ensure

only actual allowable costs are reported on the Retrospective Cost Settlement statements and (c) prevent incurred costs from disallowance due to insufficient support.

Health and Safety of Medicaid Beneficiaries in the HHSC Home and Community-Based Services Program: Community Options. The OIG conducted an audit of Community Options, Inc. (Community Options) in response to an audit report issued by the United States Department of Health and Human Services Office of Inspector General that identified oversight issues regarding the Texas Health and Human Services Commission's (HHSC's) waiver programs for home and community-based services (HCS). The objective of the audit was to evaluate whether Community Options provided Medicaid beneficiaries living in three- and four-person residences (homes) with safe and healthy living environments. Community Options is an HCS program provider that operates 56 homes serving 194 Medicaid beneficiaries. In fiscal year 2020, Community Options received $10,854,468 to deliver supervised living and residential support services to Medicaid beneficiaries.

Community Options inconsistently complied with HHSC's health and safety requirements during the OIG's unannounced site visits to six three- and four-person residences (homes). One home fully complied with all applicable health and safety requirements. The five remaining homes fully complied with (a) requirements concerning abuse, neglect, and exploitation protocols and (b) various other categories on a home-by-home basis. However, the OIG identified instances of noncompliance at five homes. Specifically, Community Options did not always eliminate hazards from interior and outside areas, maintain accurate medication records, comply with infection control requirements, or comply with emergency evacuation or fire safety rules.

The OIG made recommendations to Community Options, which, if implemented, will ensure that Community Options strengthens its controls to ensure that it provides safe and healthy living environments.

Co-Treatment Therapy Billing: Rebound. The OIG conducted an audit of co-treatment therapy billing to determine whether Rebound Sports and Physical Therapy Center (Rebound) billed correctly for co-treatment services performed in three of its locations in Texas. Co-treatment therapy services occur when two or more therapy disciplines are performed concurrently to improve a patient's health. A primary therapist must be designated and authorized to bill for co-therapy. The secondary therapist will not be reimbursed. A modifier code must be included on any co-treatment claims. The audit objective was to determine if Rebound performed co-treatment services and if so, billed for co-treatment services in accordance with applicable statutes, rules, and procedures. The audit scope included physical, speech, and occupational claims paid by Superior HealthPlan and UnitedHealthcare from September 1, 2018 through May 31, 2020.

During the audit scope, Rebound did not follow required guidelines for submitting claims for co-treatment therapy billing, although documentation for therapy sessions was otherwise available and complete. For all claims tested, Rebound maintained required documentation in the patient's medical record, including detailed progress notes for all dates of services requested for selected therapy sessions. However, Rebound did not follow all billing requirements by submitting claims for more than one therapist performing concurrent treatment without including the required modifier.

As a result of not designating a primary therapist and both performing therapists having been paid for sessions determined to have been performed as co-treatment, Rebound received overpayments of $6,617 from claims not supported for payment under Medicaid rules in the sample tested. Overpayments identified for the statistically valid sample of claims was used to calculate an error rate, which was applied to the respective MCO claims populations using extrapolation. The total extrapolated overpayment is amount is

$474,783, which should be repaid to HHSC. The estimated overpayment amount was calculated by extrapolating the dollar value of the errors across the appropriate sample population.

The OIG made recommendations to Rebound which, if implemented, will ensure its claims for co-treatment therapy comply with rules in the Texas Medicaid Provider Procedures Manual.

Documentation of Reductions to Authorized Levels of Care: Local Mental Health Authorities in Texas. The OIG conducted an inspection of local mental health authorities (LMHAs). The inspection objective was to determine whether the reduction of Medicaid members' mental health services by LMHAs was documented and in compliance with Texas Administrative Code and Texas Resilience and Recovery Utilization Management Guidelines: Adult Mental Health Services. The inspection scope covered the period from September 1, 2017 through August 31, 2018.

LMHA staff documented the reason for deviating member services from Level of Care 4 to Level of Care 1S in 256 (99.2 percent) of the 258 member files reviewed; however, 17 of 31 LHMAs did not always meet documentation requirements for other types of required information. Of the 258 member files reviewed, 116 (45 percent) of the 258 members did not include documentation of all required information, such as provider credentials and signature, or an explanation of Level of Care 4 services, culminating in 159 unique instances of missing information. Most significantly:

- 33 of the 159 instances of missing information (20.8 percent) were treatment plans or incomplete treatment plans.
- 58 of the 159 instances of missing information (36.5 percent) were documentation to verify that LMHA staff provided the member with the information necessary to make an informed decision about mental health services.

Additionally, 186 (72.1 percent) of 258 members refused the recommended Level of Care 4 services offered by LMHAs. The OIG offered recommendations to LMHAs, which, if implemented, will correct documentation deficiencies and may result in increased insight as to why services are refused.

The National Correct Coding Initiative in Texas Medicaid: Informational Report. The OIG conducted research on Medicaid National Correct Coding Initiative (NCCI) methodologies, edits and guidelines for managed care organizations (MCOs). The objective was to understand whether MCOs have processes in place for deployment of current NCCI edits and how often those edits are updated. The scope of this project was January 2021 through May 2021. Due to the nature of this project, the OIG selected the most current guidance available, which may differ from the scope period. After conducting two surveys and speaking with HHSC staff, the OIG observed that:

- HHSC's role with the MCOs in the use of NCCI edits is not clearly defined or understood by the MCOs.
- Contracted MCO vendors retrieve NCCI edits from Medicaid.gov rather than from the secure portal, RISSNET, as required.
- HHSC MCS has not made NCCI edits from RISSNET available to the MCOs through TexMedCentral since the third quarter of fiscal year 2016. MCS asserted it will work with MCOs to determine the impact of changing the process and provide guidance and revise policies as appropriate after evaluating the impact.

By using the edits available on Medicaid.gov rather than obtaining edits through RISSNET, the MCOs are not using the most accurate information to adjudicate their claims. The determination of the actual impact to claims processed using edits from Medicaid.gov was beyond the scope of this inspection.

Inspections

Mental Health Targeted Case Management and Mental Health Rehabilitative Services in Managed Care: Local Mental Health Authorities and Local Behavioral Health Authorities in Texas Medicaid. The OIG conducted an inspection of mental health targeted case management and mental health rehabilitative services in managed care. The inspection objectives were to determine whether local mental health authorities (LMHAs) or local behavioral health authority (LBHA) contracted providers:

- Provided members in Texas Medicaid programs with the opportunity to receive services.
- Met select Texas Administrative Code requirements when providing mental health targeted case management and mental health rehabilitative services to Texas Medicaid members.
- Communicated member's mental health assessment results to the applicable managed care organization (MCO) for service coordination.
- Identified potential causes for Texas Medicaid members not receiving mental health targeted case management and mental health rehabilitative services.

The inspection scope covered Texas Medicaid recipients enrolled in the State of Texas Access Reform Plus (STAR+PLUS) program through an MCO who were assessed during the period from March 1, 2019 through May 31, 2019 but had not received recommended core services as of November 30, 2019.

LMHAs and LBHA contracted providers reviewed as part of this inspection have policies and procedures to share mental health information with each member's MCO.

However, LMHAs and LBHA contracted providers reviewed as part of this inspection did not always meet documentation requirements for some types of required information. Specifically:

- 35 of the 115 member files reviewed did not contain the required treatment plan.
- 58 of the 115 member files reviewed did not include documentation that the eligible members refused recommended core services and the member did not receive services.
- 38 of the 115 member files reviewed did not include the mental health assessor's documentation to indicate that core services were discussed with the member so an informed decision could be made.

The OIG offered recommendations to LMHAs and LBHA contracted providers, which, if implemented, will correct deficiencies in compliance with Texas Administrative Code and Texas Resilience and Recovery Utilization Management Guidelines: Adult Mental Health Services for documentation in member files to (a) develop written treatment plans, (b) identify why eligible members did not receive core services and (c) document that core services were discussed with the member.

Supplemental Nutrition Assistance Program: Second Level Review Process. The OIG completed an inspection to determine if Health and Human Services Commission Access and Eligibility Services (HHSC AES) second level review process for the Supplemental Nutrition Assistance Program (SNAP) detects errors and prevents distribution of ineligible SNAP benefits. A representative sample of 30 unique SNAP cases was tested during this inspection. The OIG determined the second level review process is operating effectively to detect errors and prevent distribution of ineligible SNAP benefits. As a result, no observations were identified for this inspection.

However, the OIG identified an opportunity for improvement during the inspection. HHSC AES policies and procedures provide limited guidance for the second level review process, which could cause inconsistent reviews and may weaken the effectiveness of the second level review process as a control.

Delivery Supplemental Payments: Medicaid CHIP Services-Financial Reporting and Audit Coordination. The OIG conducted an inspection of delivery supplemental payments processed by Medicaid and CHIP Services (MCS)—Financial Reporting and Audit Coordination (FRAC). The Texas Health and Human Services Commission (HHSC) contracts with managed care organizations (MCOs) to facilitate the delivery of healthcare services for which the MCOs receive a capitation rate per member per month. MCOs participating in State of Texas Access Reform (STAR), Children's Health Insurance Program (CHIP), and CHIP perinatal programs submit and receive payments for qualified delivery supplemental payment claims to cover hospital expenses for the delivery of a child. Delivery supplemental payments are intended to make costs associated with a pregnancy equitable, in particular when a pregnant MCO member transfers to a different plan toward the end of pregnancy. The inspection objectives were to determine whether FRAC:

- Periodically verifies that claims are valid and adequately supported.
- Conducts retrospective reviews of delivery supplemental payment claims and reprocesses claims as necessary to adjust identified overpayments and underpayments due to eligibility, changes including those identified in the 2016 audit.
- Implemented policies and procedures to ensure delivery supplemental payment claims are processed timely and accurately.

The inspection scope covered current processes and claims in the period from January 1, 2021 through March 31, 2021. The inspection scope additionally covered actions taken since the 2016 audit to address the inspection objectives.

In 2016, the OIG audited delivery supplemental payments to evaluate the effectiveness of processes and controls intended to ensure delivery supplemental payment claims and appeals were processed timely and accurately. The 2016 OIG audit report identified issues with claims processing, appeals administration and the control environment related to delivery supplemental payments. The audit recommended transferring the delivery supplemental payment process from HHSC Strategic Decision Support to MCS—FRAC to help ensure delivery supplemental payment claims and appeals are administered in accordance with policy and contract requirements. In addition, the audit contained the following recommendations relevant to the inspection objectives:

- MCS should periodically verify that claims are supported by data.
- Delivery supplemental payment claims procedures should be updated to perform periodic retrospective reviews to identify whether retroactive eligibility changes affected claim adjudications.
- MCS should establish detailed written policies and procedures for processing delivery supplemental payment claims in accordance with the Uniformed Managed Care Contract and Uniform Managed Care Manual requirements.

Since the 2016 audit of delivery supplemental payments, FRAC has created and implemented policies and procedures to ensure delivery supplemental payment claims are processed timely and accurately in accordance with contractual requirements. FRAC continues to improve and update the delivery supplemental payment application and has taken action to help eliminate acceptance of claims based on insufficient or invalid diagnosis codes by revising the list of eligible diagnosis codes and increasing the number of codes required to validate a delivery; however, not all pertinent diagnosis codes are included. Additionally, FRAC has not implemented all the recommendations from the 2016 audit. Specifically, FRAC does not perform retrospective reviews of delivery supplemental payment claims.

The OIG offered recommendations to FRAC, which, if implemented, will improve the validation of paid delivery supplemental payments and assist in identifying ineligible delivery supplemental payment claims submitted by MCOs.

Stakeholder Outreach

Texas Fraud Prevention Partnership update

During the fourth quarter, the OIG held Texas Fraud Prevention Partnership (TFPP) Special Investigative Unit (SIU) one-on-one meetings with Community Health Choice, DentaQuest, MCNA, Superior, and UnitedHealthcare to discuss their pending investigations, referrals, and current fraud, waste and abuse trends. Attorney General Medicaid Fraud Control Unit (MFCU) staff also participated in the meetings and discussed pending referrals and requests for information.

A TFPP Special Investigative Unit SIU meeting held in June included SIU staff from managed care organizations and dental maintenance organizations, along with MFCU. The OIG shared information on their latest Fraud Detection Operation (FDO) on day activity and health services, and United Healthcare presented a fraud scheme related to adult daycare overbilling.

MCO Cost Avoidance Workgroup

The OIG has reconvened the MCO Cost Avoidance Workgroup, which includes representatives from MCOs/DMOs, the Texas Association of Health Plans and the Texas Association of Community Health Plans. Previous work by the group included developing a framework to define, categorize and measure MCO cost avoidance activities. This group will further the OIG's review of MCO cost avoidance and waste prevention activities that promote program integrity in Medicaid and CHIP services delivery.

Conferences and Presentations

- Benefits Program Integrity (BPI) staff participated in Fighting Fraud Using Critical Thinking training in May. The two-day course focused on using critical thinking to conduct more objective investigations while recognizing and overcoming cognitive bias. The information presented in the course is expected to help BPI investigators identify information and context to narrow down which leads to follow during an investigation and then make independent decisions informed exclusively by available evidence.
- Four Internal Affairs employees attended a 28-hour course on Managing and Conducting Internal Affairs Investigations, hosted by the FBI-Law Enforcement Executive Development Association in Pharr. The attending staff will present training information from the course to the remaining IA investigators in the coming months.
- Medical Services provided virtual staff education in Hospital Utilization Review in August. Training topics included utilization review policies and procedures, medical records review, coding, quality control and issues in managed care. Individual managed care training was held upon request for the Lock-In Program criteria and procedures.
- The Lock-In Program held follow-up webinars throughout the quarter for managed care organizations. Topics included reviewing automatic lock-in criteria, referral processes and MCO annual survey responses.

Training summary

Trainings conducted this quarter	13

VIII. Program Integrity Spotlight

Working together to prevent fraud, waste and abuse

Recognizing that prevention is a key part of its mission, the OIG initiated a formal process to enhance the OIG Prevention Strategy. This process facilitates increased coordination in identifying potential issues and executing prevention activities across health and human services. The OIG regularly participates in targeted prevention activities, some of which are highlighted below.

Stakeholder engagement

The OIG routinely engages with stakeholders and program integrity partners, including contractors, providers and staff from across health and human service agencies. During the second and third quarters of the fiscal year, the OIG met with stakeholders for information sharing sessions as part of the agency's COVID-19 Fraud, Waste and Abuse Initiative. Over the coming months, the OIG will continue to focus on this prevention effort through:

- Additional stakeholder discussions.
- Continued research through data analytics and policy analysis.
- Ongoing monitoring of flexibilities associated with the pandemic to strengthen program integrity of those that are likely to be more permanent, such an increase in certain services provided via teleheath.
- Continued collaboration with stakeholders and HHS staff to develop educational materials and clarify policy.

Feedback loop

Another major prevention activity involves providing feedback to impacted program areas of health and human services agencies. Through the course of their work, OIG staff can observe potential program integrity vulnerabilities. When a vulnerability is identified, the OIG initiates an analysis of the issue, which can ultimately lead to policy or contract recommendations.

Texas Fraud Prevention Partnership

The OIG continues to prioritize formal discussions with the Texas Medicaid and CHIP MCOs through the Texas Fraud Prevention Partnership (TFPP). Sharing information between the OIG and the MCOs in group meetings and individual 1:1 sessions promotes collaboration around program integrity work and supports evaluating areas for future improvements and coordination.

OIG leadership met with executive leadership from MCOs three times during FY 21 to discuss current initiatives and combined efforts to prevent, detect and investigate fraud, waste, and abuse. These meetings covered such topics as: fraud, waste and abuse trends associated with the COVID-19 pandemic; issues related to current and upcoming OIG audits; updates on hospital and nursing facility utilization reviews; and discussions around data requests and related technical assistance.

The OIG also held individual meetings with executive leadership from each MCO and DMO. The meetings included discussions regarding the operation of each MCO's compliance program; special investigative unit organizational structure and resources; and challenges and best practices in identifying fraud, waste and abuse.

TFPP SIU meetings are held three times each year with MCO Special Investigative Units (SIUs) and the Attorney General Medicaid Fraud Control Unit to share insights and information. The OIG also holds one-on-one meetings with SIU staff at the largest MCOs to discuss their investigations and current trends in fraud, waste and abuse.

Educational materials

The OIG worked with provider associations on several outreach and prevention activities. These included speaking engagements with the Inspector General and other OIG staff and partnering to disseminate educational material. For example, the OIG submitted an issue brief to nursing facility associations detailing concerns the

OIG identified with IV infusions at long-term care facilities. The OIG also produced digital media content to educate the public and providers about the emerging issue. Engagement and education on a variety of subjects included more than 60 social media posts and featured news articles during the fourth quarter of FY 2021 alone.

The OIG Communications Team produced educational articles for health care association magazines and newsletters throughout the year. Articles for the Texas Medical Association were devoted to billing concerns around telemedicine and common coding errors; material for the Texas Association of Home Care and Hospice covered how the OIG investigates fraud in home health.

The Texas Pharmacy Association published OIG articles focused on making reports to the OIG Fraud Hotline, avoiding typical billing errors, audit results of several pharmacy benefit managers, and future audit topics. The OIG provided content requested by the Texas Dental Association about illegal Medicaid dental solicitation, as well as the results of a data-driven fraud detection operation, common violations found in OIG investigations, and guidance for maintaining accurate patient records. Collaborating with associations on provider education is one way the OIG helps prevent fraud, waste and abuse from the outset. Additional articles are planned for publication in fiscal year 2022.

IX. Division Performance

Strategy

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

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** unit 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	215
Data requests completed	194
Algorithms executed	94
New algorithms developed	17

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.

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	187,461
Communications materials produced	88

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

- Documentation of Reductions to Authorized Levels of Care: Local Mental Health Authorities in Texas
- The National Correct Coding Initiative in Texas Medicaid: Informational Report
- Mental Health Targeted Case Management and Mental Health Rehabilitative Services in Managed Care: Local Mental Health Authorities and Local Behavioral Health Authorities in Texas Medicaid
- Supplemental Nutrition Assistance Program: Second Level Review Process
- Delivery Supplemental Payments: Medicaid CHIP Services—Financial Reporting and Audit Coordination

Inspections in progress

- Overlapping Long-Term Care Claims During Hospital Stays

Audit performance

Overpayments recovered	$80,850
Overpayments identified	$2,144,014
Audit reports issued by contractors	1

Audit reports issued

- Co-Treatment Therapy Billing: MindWorks Rehabilitation Center
- Women, Infants, and Children's Nutrition Program (WIC): City of Laredo Health Department
- Acadian Ambulance Services
- Healthy Texas Women and Family Planning Program Contract Compliance: The Heidi Group
- Data Processing and Integrity of Medicaid Eligibility Determinations Texas Integrated Eligibility Redesign System
- Fee-For-Service Claim Payments for Pregnant Women with Medicaid Managed Care Eligibility
- Security Controls Over Confidential HHS Information: Scott and White Health Plan
- Cenikor Region 4
- Cenikor Region 11
- Benchmark Family Services: A Former Texas Department of Family Protective Services Contractor
- Aetna Better Health of Texas: Special Investigative Unit (expected by 8/31/2021)
- Health and Safety of Medicaid Beneficiaries in the HHSC Home and Community-Based Services Program: Kenmar Residential HCS Services
- NorthgateArinso
- Health and Safety of Medicaid Beneficiaries in the HHSC Home and Community-Based Services Program: Community Options
- Co-Treatment Therapy Billing: Rebound
- Managed Care Pharmacy Claims Paid to Rx Plus Pharmacy of Live Oak: A Managed Care Network Provider Contracted Under Superior HealthPlan

Audits in progress

- Selected Home and Community Support Services Agencies
- Medicaid and CHIP Enrollment Broker
- Selected HHSC Grant Recipients
- Selected Home and Community Based Services Providers
- Selected Durable Medical Equipment Providers
- Selected Home Delivered Meals 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	507
Preliminary investigations completed	499
Full-scale investigations completed	39
Cases transferred to full-scale investigation	57
Cases referred to AG's Medicaid Fraud Control Unit	158
Open/active full-scale cases at end of quarter	104

Medical Services performance

Acute care provider recoveries	$2,780,361
Acute care services identified overpayments	$3,026,296
Hospital and nursing home UR recoveries	$1,319,606
Hospital UR claims reviewed	4,121
Nursing facility reviews completed	113
Average number of Lock-in Program clients	3,132

Benefits Program Integrity performance

Overpayments recovered	$15,440,556
Cases completed	5,172
Cases opened	4,376
Cases referred for prosecution	20
Cases referred for Administrative Disqualification Hearings	181

PEIS performance

Provider enrollment inventory (applications and informal desk reviews) processed	7,734
Individual screenings processed	25,520

EBT Trafficking Unit performance

Overpayments recovered	$174,921
Cases opened	64
Cases completed	66

Peace Officers performance

EBT recipient avoidance	$151,776

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.

Internal Affairs performance

Investigations opened	56
Investigations completed	39

State Centers Investigations Team performance

Cases opened	518
Cases completed	547

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.

Operations

The Operations Division is comprised of six core functions.

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

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

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

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

Third Party Recoveries works to ensure that Medicaid is the payer of last resort, which requires that Medicaid recipients use all other resources available to them (e.g., private health insurance, automobile insurance) to pay for all or part of their medical care before billing Medicaid. TPR also operates the Medicaid Estate Recovery Program.

Fraud Hotline performance

Fraud Hotline calls answered	9,104
Fraud Hotline referrals within OIG	
Benefit recipients	2,071
Medicaid provider	129
HHS employee/contractor	37
EBT retailer	36
State Supported Living Center/State Hospital	1

Third Party Recoveries performance

Dollars recovered	$76,094,025
Identified recoveries	$73,956,054
Cost avoidance	$33,612,846

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

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@hhs.texas.gov

To report fraud, waste or abuse

OIG Fraud Hotline: 800-436-6184 **Online:** oig.hhs.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, staff

Content contributors: Rose Barrera, Mo Brantley, Alex Buelna, Jim Day, Merrie Duflot, Jill Heath, Derek Johnson, Dirk Johnson, Steve Johnson, Jen Kauffman, Nikki Kline, Andreana Ledesma, Tiesha Miller, Katie Reyes, Diane Salisbury, Deeana Tilly, Jill Townsend, Stephen Tran, 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)