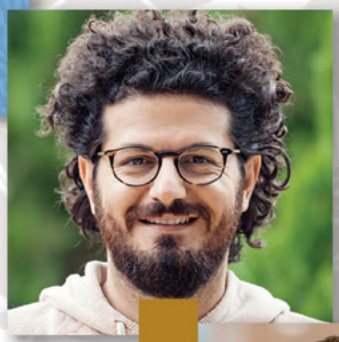
Inspector General

Texas Health and Human Services



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OIG

Quarterly Report

Quarter 1 Fiscal Year 2022

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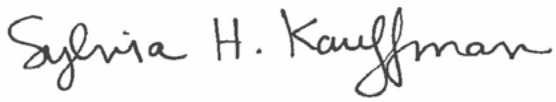
I. Executive Summary

I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas the first quarterly report for fiscal year 2022, summarizing the excellent work this office has performed during this period.

From September 1 to November 30, 2021, the Office of Inspector General recovered just over $112 million. In addition, we identified more than $202 million in potential future recoveries and achieved more than $38 million in cost avoidance by deterring potentially questionable spending before it could occur.

The agency's quarterly report has been redesigned to better communicate our work to strengthen Texas' capacity to combat fraud, waste and abuse in publicly funded, state-run health and human services programs. We recategorized the report's content to reflect our efforts in provider integrity, client accountability, retailer monitoring and health and human services oversight. The report also has a section about our engagement with critical stakeholders. A new section titled "OIG in Focus" takes a deeper dive into a wide range of pertinent topics relevant to the OIG's mission.

As we head toward the new calendar year, the OIG team will continue to follow its core values – Accountability, Integrity, Collaboration and Excellence – in performing our work on behalf of Texas taxpayers. We will not only ensure program integrity but also prevent fraud, waste and abuse from happening in the first place. I am honored to work with this outstanding team.



Sylvia Hernandez Kauffman
Inspector General

II. Quarterly Metrics

Dollars recovered

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

Total dollars recovered	$112,151,254
Audit and Inspections	
Audit collections	**$ 75,000**
Investigations and Reviews	
Provider overpayments	$15,916,256
Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	$9,880,512
Voluntary repayments by beneficiaries	$ 44,648
Acute Care provider overpayments	$ 834,035
Hospital overpayments	$ 2,481,409
Nursing facility overpayment	$ 155,806
Recovery Audit Contractor recoveries	$ 17,278,343
WIC collections	$ 5,042
SCIT Recoveries	$ 940
Hospital underpayment	$ (6,373)
Nursing faciltiy underpayments	$ (557)
Total Investigation and Reviews Recoveries	**$ 46,590,061**
Third Party Recoveries	**$ 65,323,096**
Peace Officers	
EBT trafficking retailer overpayments	**$ 163,097**

Dollars identified for recovery

This is a measure of the total potential overpayments resulting from OIG activities. 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.

Total dollars identified for recovery	$ 202,265,458
Audit and Inspections	
Provider overpayments	**$ 24,712**
Investigations and Reviews	
MCO identified overpayments	$6,275,929
Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, CHIP, WIC)	$16,472,553
Acute Care provider overpayments	$310,380
Hospital overpayments	$4,247,160
Nursing facility overpayment	$1,129,987
Recovery Audit Contractor recoveries	$21,252,953
WIC collections	$26,724
Total Investigation and Reviews Identified Recoveries	**$ 49,715,686**
Third Party Identified Recoveries	**$ 152,220,184**
Peace Officers	
EBT trafficking	$ 304,426
SCIT	$ 450
Total Peace Officers Identified Recoveries	**$ 304,876**

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.

Total cost avoidance	$ 38,267,487
Investigations and Reviews	
Medicaid provider exclusions	$ 315,538
Client disqualifications	$ 1,439,711
WIC vendor monitoring	$ 0
Pharmacy Lock-In	$ 1,909,217
Third Party Recoveries	
Front-end claims denials	**$ 34,349,905**
Peace Officers	
EBT recipient avoidance	**$ 253,116**

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 and/or DMO's nonperformance.

Total liquidated damages	$ 85,050

III. Provider Integrity

Trends

Investigations and Reviews (I&R) continues to receive complaints related to physicians, which includes individual, groups and clinics. Complainants report a lack of documentation for services billed, upcoding office visits and billing for unnecessary services. The OIG continues to conduct preliminary or full investigations involving physicians and recommend administrative action based on findings.

Provider Investigations performance

Preliminary investigations opened	401
Preliminary investigations completed	451
Full investigations completed	35
Cases transferred to full investigation	64
Cases referred to AG's Medicaid Fraud Control Unit	155
Open/active full cases at end of quarter	132

Case Highlights

Settlement reached with South Texas pediatrician

The OIG settled a case in September against a Weslaco pediatric office. Over a four-year period, the provider was improperly submitting claims for molecular strep tests which were medically unnecessary and being billed with an incorrect date of service. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $445,500.

OIG resolves a case against Northeast Texas hospital

The OIG resolved a case in September against a Greenville hospital. The provider 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 case involved claims from January 1, 2012 to October 1, 2019. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $628,192.

Surveillance Utilization Review Team

Acute care provider recoveries	$834,035
Acute care services identified overpayments	$310,380
Hospital and nursing home UR recoveries	$2,630,285
Hospital UR claims reviewed	8,361
Nursing facility reviews completed	78
Average number of Lock-in Program clients	3,220

Provider enrollment and exclusions

Provider enrollment inventory processed	
Applications and informal desk reviews	7,914
Individual screenings processed	28,301
Medicaid providers excluded	45

Fraud, Waste and Abuse Research and Analytics performance

Data requests received	232
Data requests completed	211
Algorithms executed	42
New algorithms developed	16

Self-report leads to settlement with North Texas home health provider

The OIG settled a case in October with a Duncanville home health provider who through an internal investigation discovered that a caregiver employee billed for services not rendered on certain days between September 3, 2020 through February 6, 2021. The provider proactively self-reported the incident and collaborated with the OIG to resolve the situation. The provider correctly reported that it owed Medicaid $7,787.

OIG reaches settlement with Dallas personal care attendant

The OIG settled a case in October against a Dallas personal care attendant. The attendent was improperly submitting her time for services to her client during the investigation period of June 3, 2021 through June 6, 2021. The attendent was clocking in and out while her client was incarcerated, violating her employer's internal employee policy. The attendent worked collaboratively with OIG Litigation to resolve the issue, and the client agreed to a penalty of $500.

OIG excludes Northeast Texas nurse

In October, the OIG excluded a Mount Pleasant nurse from participating in Medicaid. The nurse falsely documented skilled nursing notes when she did not conduct the visits with her patient. After engaging the nurse, the OIG learned mitigating factors via an informal resolution meeting. The provider accepted a settlement agreement to be excluded from Medicaid for one year starting in October after she had completed the requirements imposed by her licensing board.

Provider Investigations case summary

Referral sources for cases	
MCO/DMO	27%
Government agency	26%
Public	23%
Provider	8%
Anonymous	5%
OIG initiated	11%

Types of preliminary investigations opened	
Attendants	40%
Home health agency	14%
Physician (individual/group/clinic)	13%
Dental	6%
Hospital	4%
Pharmacy	4%
Therapy (counseling)	3%
Nursing facility	3%
Lab - radiology - x-ray	3%
Therapy (physical/occupational/Social)	2%
Assisted living	2%
Durable medical equipment	2%
Rehabilitation center	1%
6 other categories at less than 1%	*2%*

Types of full investigations opened	
Home health agency	35%
Attendants	15%
Hospital	11%
Nursing facility	10%
Physician (individual/group/clinic)	9%
Dental	5%
Therapy (counseling)	5%
Therapy (physical/occupational/social)	5%
Pharmacy	3%
Adult day care	2%

OIG settles case with North Texas dental provider

The OIG settled a case in September against a Richardson dental provider. The dentist billed Medicaid for services not rendered by altering treatment charts and illegally solicited Medicaid clients by using gift cards. The provider agreed to pay $4,066 in overpayment and $8,133 in penalty to resolve this case.

OIG settles case with Houston area ENT specialist

The OIG settled a case in September against a Pasadena physician within the specialty of otorhinolaryngology (Ear, Nose & Throat or ENT). The provider's most common error was billing for procedures that were not medically necessary, especially diagnostic nasal endoscopies. The provider worked collaboratively with the OIG. To resolve the case, the provider agreed to a settlement of $24,000.

OIG and transportation provider reach a settlement agreement

The OIG settled a case in October with a Houston area transportation provider. The provider transported Medicaid beneficiaries via an ambulance when these individuals did not have the requisite medical or physical limitations to necessitate transportation by ambulance. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $80,000.

Agency highlights

MCO contract changes take effect

The OIG recommended amendments to the Texas Medicaid and CHIP managed care contracts that went into effect September 1. The amendments updated language related to 1 Tex. Admin. Code § 353.505 to clarify MCOs are to refer waste identified in provider and client activities to the OIG and clarified language related to Third Party Liabilities and Recoveries and the meaning of non-health insurance claims. The OIG made these recommendations to strengthen MCO requirements to provide sufficient information to assist in the detection of fraud, waste and abuse and prevention activities.

Fraud Detection Operation examines telehealth

The OIG Fraud Detection Operation (FDO) team identified three occupational therapy/physical therapy (OT/PT) service providers with claims indicating services were provided via telehealth. With the increase in telehealth as a service delivery vehicle since the COVID-19 pandemic began, the FDO team determined a review of billing from providers utilizing this option was appropriate. An FDO utilizes data points to review billing data to narrow areas of possible concern in the billing. Providers are allowed to provide and bill for certain OT/PT services utilizing telehealth; however, there have been reports that the services did not occur, or the time, duration and scope of the service did not meet the program policy and billing requirements. Policy requires providers must document and perform the service to the same level as they would in a face-to-face setting.

The record reviews for all three FDO identified providers were completed in September, which resulted in a referral to full-scale investigation on one provider. Referral to full-scale will allow for a broader look at the provider's billing and documentation patterns to determine if a violation of Medicaid policies or rules has occurred.

Data analysts are also currently reviewing behavioral health services delivered during the COVID-19 pandemic and will also look at durable medical equipment and laboratory services in the next two quarters of the fiscal year.

OIG completes audit series of Home and Community-based Services Program

The OIG completed a series of three audits of Texas Health and Human Services (HHS) Home and Community-based Services Program providers regarding the health and safety of Medicaid clients. The three audited providers, Community Options Inc., EduCare Community Living Corporation – Texas, and Kenmar Residential HSC Services Inc., each operate between 26 and 172 three- and four-person residences that allow Medicaid beneficiaries with intellectual and developmental disabilities to live in community-based settings and avoid institutionalization in intermediate care facilities. The providers served between 58 and 564 residents during the audit scope, for which they received reimbursement for claims ranging between $2.5 million and $36.7 million in 2020. The OIG identified issues with medication storage, administration and lack of consistent compliance with COVID-19 safety rules in all three audits. The OIG also identified some provider residences with issues regarding emergency plans, fire safety or physical hazards in the interior or exterior of the homes. The OIG is planning an audit for 2022 of HHS oversight of the Home and Community-based Services Program.

OIG collaborates with MCOs to improve third party liability

OIG Third Party Recoveries (TPR) continues to advance third party liability (TPL) activities performed by managed care organizations (MCOs). TPR recovers payments from third parties that are responsible for paying towards a medical claim for services rendered to a Texas Medicaid client. Medicaid pays only after the third party has met its legal obligation to pay.

During September 2021, TPR began gathering feedback from several MCOs for improvements in receiving accurate and timely insurance data. Upon completion of the evaluation, TPR developed an escalation process for MCOs to provide TPL other-insurance information for their enrolled members. This data includes information that differs from, or is not included, in the TPL other-insurance file that HHSC provides to each MCO daily and monthly. This new process should assist the MCOs in maximizing cost avoidance and recovery efforts, while reducing obstacles Medicaid beneficiaries may encounter while attempting to receive services.

Completed reports

Cenikor Foundation: Region 6 Substance Use Disorder Treatment Provider

The OIG conducted an audit of services Cenikor Foundation (Cenikor) provided under two adult treatment contracts for its Region 6 facility in Houston. 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 $1.3 million for services to 574 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 6 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 6. 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 its residential withdrawal management.
    - ◊ 87 percent of clients admitted into its intensive residential service. Cenikor did not perform 50 percent or more of the monitoring required for 11 percent of the clients tested. As a result, the OIG identified an extrapolated recovery of $19,795.
- 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 seven occurrences in which Cenikor billed for both withdrawal management and intensive residential on the same day, billed for six withdrawal management days when the client was not present, and billed for four intensive residential days when the client was not present, resulting in an additional dollar-for-dollar overpayment of $1,354.

The OIG identified a total overpayment of $21,150 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. Click here to read the full report.

Audits in progress 19

- Selected Home and Community Support Services Agencies
- Medicaid and CHIP Enrollment Broker
- MCO Special Investigation Units
- Psychiatric Care Hospitals
- Selected DSHS Contracts
- MCO Financial Reporting
- MCO IT Security Controls and Business Continuity and Disaster Recovery Processes
- Telemedicine Providers
- Memory Care Centers
- Home and Community-Based Services Oversight

Audit performance

Overpayments recovered	$ 75,000
Overpayments identified	$ 24,712
Audit reports issued by OIG	5
Audit reports issued by contractors	0

Inspections in progress 2

- Selected MCOs' Clinical Laboratory Improvement Amendments (CLIA) Certification
- Nursing Facility Staffing

Managed Care Claims Submitted by Cook Children's Home Health and Paid by Cook Children's Health Plan: A Texas Medicaid Durable Medical Equipment and Supplies Provider

The Texas Health and Human Services (HHS) Office of Inspector General Audit and Inspections Division (OIG Audit) conducted an audit of durable medical equipment (DME) in managed care at Cook Children's Home Health. Through its Medicaid provider contract with Cook Children's Health Plan, Cook Children's Home Health received Texas Medicaid reimbursements of $13.6 million for DME and supplies delivered to 8,242 Medicaid beneficiaries during the period from September 1, 2018 through August 31, 2020.
The audit objective was to determine whether documentation to support the authorization and delivery

of DME and supplies associated with Medicaid claims submitted by and paid to Cook Children's Home Health by Cook Children's Health Plan existed and was completed in accordance with applicable state laws, rules and guidelines.

Cook Children's Home Health had processes and controls to ensure most required documentation was complete and met requirements to support the authorization and delivery of DME and supplies associated with claims paid by Cook Children's Health Plan. Cook Children's Home Health ensured that selected DME and supplies claims were authorized by Cook Children's Health Plan unless Cook Children's Health Plan indicated prior authorization was not required. Documentation supported that members were seen by a physician within six months prior to the start of service. In addition, all claims tested were for members not residing in a hospital or a facility at the time of delivery, and Cook Children's Home Health ensured that no prescribing physicians were listed in the United States Department of Health and Human Services Office of Inspector General exclusions database.

However, Cook Children's Home Health did not consistently comply with requirements for documentation and deliveries for three of 90 DME and supplies claims selected for testing in a statistically valid random sample. Specifically:

- Two claims did not include a signature from the member or caregiver on the documents to confirm receipt of deliveries made by Cook Children's Home Health.
- One claim stated a quantity on the delivery documentation that was greater than the quantity ordered and authorized.

In addition, for 15 DME and supplies claims tested in a non-statistical, risk-based sample, Cook Children's Home Health erroneously submitted and was paid for a total of eight DME and supply deliveries claims when only four deliveries were authorized.

As a result, Cook Children's Home Health should return $3,429 in overpaid or unsupported claims to the state of Texas. Click here to read the full report.

Health and Safety of Medicaid Beneficiaries in HHSC Home and Community Based Services Program EduCare Community Living Corporation Texas

The OIG conducted an audit of EduCare Community Living Coproration – Texas (EduCare) 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) Home and Community-Based Services (HCS) program. The objective of the audit was to evaluate whether EduCare provided Medicaid beneficiaries living in three- and four-person residences (homes) with safe and healthy living environments. EduCare is an HCS program provider that operates 172 homes serving 564 Medicaid beneficiaries. In fiscal year 2020, EduCare received $36.7 million to deliver supervised living and residential support services to Medicaid beneficiaries under its care.

EduCare inconsistently complied with HHSC's health and safety requirements during the OIG's unannounced site visits to 15 three- and four-person residences (homes). The OIG identified instances of noncompliance at 13 homes. Specifically:

- 6 of 15 visited homes did not eliminate hazards from interior areas.
- One of 15 visited homes did not eliminate hazards from outside areas.
- One of 15 visited homes did not appropriately store medications.
- 3 of 15 visited homes did not maintain complete medication administration records.
- 10 of 15 visited homes did not maintain verifiable evidence of medication administration.
- Three of 15 visited homes had assigned staff members who did not have sufficient knowledge of how to either identify, report or prevent the abuse, neglect, and exploitation of residents.
- Six of 15 visited homes did not comply with HHSC's COVID-19 emergency rules for the Home and Community-Based Services program.
- Two of 15 visited homes did not maintain adequate on-site emergency plans.
- One of 15 visited homes had assigned a staff member who could not sufficiently articulate how to evacuate each resident in the event of an emergency.
- One of nine visited homes with four beds did not have a fully operational fire alarm system.

The OIG made recommendations to EduCare, which, if implemented, will ensure it strengthens its controls to ensure it provides safe and healthy living environments. Click here to read the full report.

El Paso City-County Nutrition Program: A Texas Home-Delivered Meals Program Provider

The OIG Audit conducted an audit of the El Paso City-County Nutrition Program (El Paso County). During the audit scope, which covered the period from October 1, 2019 through December 31, 2020, the Texas Health and Human Services Commission paid El Paso County $5.31 per meal, totaling $2.3 million for 435,995 meals.

The audit objective was to determine El Paso County had processes in place and complied with certain selected requirements of the Home-Delivered Meals program administered by HHSC. Specifically, El Paso County (a) implemented service changes as required, (b) resolved complaints timely, (c) ensured meals were prepared and stored at the appropriate temperatures and (d) ensured menus were appropriately approved.

However, because auditors could not validate (a) El Paso County's unsuccessful delivery attempts and (b) the accuracy of El Paso County's billings for unsuccessful delivery attempts submitted to HHSC, the OIG could not determine if billing errors occurred.

Additionally, El Paso County did not always comply with certain requirements related to (a) communication with program participants, (b) initiation of home-delivered meal services and (c) communication to HHSC for meals that could not be delivered. Specifically, El Paso County did not consistently:

- Perform the required contacts with participants on the HHSC-approved waiver.
- Initiate home-delivered meal services for new participants within the required 10-day time frame.
- Notify HHSC timely when services did not begin within 10 calendar days for certain new participants.
- Communicate timely with HHSC regarding unsuccessful delivery attempts.

The OIG offered recommendations to El Paso County which, if implemented, will help ensure compliance with all applicable requirements. Additionally, El Paso County should work with HHSC to determine if

repayment is required for potential overbilling for home-delivered meal services. Click here to read the full report.

Visiting Nurses Association of Texas: A Texas Home-Delivered Meals Program Provider

The OIG conducted an audit of the Visiting Nurse Association of Texas (VNA). During the audit scope, which covered the period from October 1, 2019 through December 31, 2020, HHSC paid VNA $5.31 per meal, totaling some $2.5 million for 479,431 meals.

The audit objective was to determine if VNA provided and billed for services in compliance with selected requirements. VNA had processes in place and complied with certain selected requirements of the Home Delivered Meals program administered by HHSC.

However, VNA did not always comply with certain requirements related to initiation of home delivered meal services and billing and communication to HHSC for meals that could not be delivered. Specifically, VNA did not consistently:

- Initiate home delivered meal services for new participants within the required time frame.
- Notify HHSC within the required time frames when services did not begin within ten calendar days for certain new participants.
- Communicate timely with HHSC regarding unsuccessful delivery attempts.
- Additionally, VNA overbilled HHSC for meals that could not be delivered.

VNA should return a total of $132.75 to the state of Texas and work with HHSC to determine if there were additional instances of overbilling for home delivered meal services that require repayment. Click here to read the full report.

IV. Client Accountability

Trends

The Benefits Program Integrity (BPI) division completed 4,385 investigations involving some form of benefit overpayment or fraud allegation. Ninety-one percent of all investigations completed involved unreported income or an issue with the reported household composition. Household composition cases usually deal with an unreported household member who has income or could also include a reported household member who does not actually live in the same residence. Both instances cause the household to receive more benefits than they are eligible for. For this quarter, BPI referred 8 investigations for prosecution and 141 investigations for administrative disqualification hearing.

Benefits Program Integrity performance

Overpayments recovered	$ 9,880,512
Cases completed	4,385
Cases opened	3,726
Cases referred for prosecution	8
Cases referred for Administrative Disqualification Hearings	141

The OIG's EBT Trafficking Unit used data analysis to identify a trend of clients who are receiving high dollar amounts of Pandemic Supplemental Nutritional Assistance Program benefits using social media outlets to sell their excess benefits. Reports show some clients are being awarded several thousand dollars of monthly benefits and selling them for fifty cents on the dollar. EBT is currently investigating these cases.

Case highlights

Harrison County client concealed household income

BPI investigated a client in Harrison County who committed an intentional program violation by concealing the father of her children and his associated income as part of their household on benefits applications from December 2016 to January 2020. During the investigation, the investigator obtained witness statements and evidence that proved the father was living in the home and receiving income. The client waived her rights to an administrative hearing to contest the findings. In September, the client was disqualified from SNAP for 12 months and ordered to pay back $36,453 in SNAP benefits and $2,158 in TANF benefits.

BPI collaborates with federal agents in South Texas to help arrest shooting suspect

A U.S. Marshal contacted a BPI investigator regarding a suspect involved in an August shooting in Weslaco where a 75-year-old man was shot and killed in his home while he slept. Deputies examined video surveillance footage and saw a dark-colored truck driving by the victim's home. Law enforcement contacted BPI when they identified the suspect's vehicle at a local convenience store minutes prior to the shooting. The suspect used an EBT card for his purchase, and authorities obtained a copy of his receipt. The BPI investigator identified a name for the EBT card and provided an address to law enforcement. Authorities arrested a 35-year-old man, who confessed that while driving, he shot his gun towards the victim's street with no intention of shooting the victim. The suspect was charged with manslaughter and was transported to the Hidalgo County jail.

Bexar County SNAP client disqualification

In November, BPI resolved a case in Bexar County where a client committed fraud by failing to report her children's father and his associated income as part of her SNAP benefits applications. From March 2019 to February 2021, the client received a total of $24,011 in excessive SNAP benefits. After being presented with the evidence proving the father and his income should have been reported on the applications, the client signed a waiver of disqualification hearing, agreed to pay $24,011, and was disqualified from the SNAP program for 12 months.

V. Retailer Monitoring

Trends

The EBT Trafficking Unit continues to receive a high volume of referrals regarding mobile vendors in the Houston area. Clients report mobile vendors are removing benefits from their accounts through unauthorized transactions. The OIG is currently investigating several mobile vendor retailers in the area.

Electronic Benefits Transfer Trafficking Unit performance

Overpayments Recovered	$163,097
Cases opened	59
Cases completed	74

Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) monitoring and oversight activities conducted at numerous outlets of a major WIC vendor resulted in a significant reduction in cited violations over this quarter. This improvement is attributed to diligent monitoring and communication among the WIC VMU, WIC vendor management, and associated WIC outlet managers.

WIC VMU increased efficiencies in its case management process. Specifically, faster processing of WIC on-site store reviews improved quality control activities. The efficiencies resulted from technical improvements in the case management system after WIC VMU's collaboration with the OIG's data team.

Case highlights

South Texas retailer disqualified

EBT trafficking investigators are working a case involving a retailer in Pharr that was already disqualified by Food and Nutrition Services for trafficking benefits. Even though the retailer was disqualified, investigators have identified over 20 SNAP clients that have questionable transactions with the retailer. The suspected fraud adds up to more than $20,000 in misused benefits. Administrative investigations are in progress.

Undercover operation in Austin finds fraud

EBT trafficking investigators conducted undercover operations involving an owner of a food truck in the Austin area. The business owner was accused of purchasing EBT SNAP benefits, then using SNAP to purchase inventory for the food truck. The owner purchased $458 of EBT SNAP benefits, paying the undercover EBT investigators $200 in cash. The EBT SNAP card was left in the possession of the food truck owner. Transactions on the card showed purchases at a large retailer. Investigators obtained surveillance video and transaction receipts of the purchases. Investigators also reviewed the food truck owner's account at the retailer and discovered 80 different EBT SNAP cards were used. This case was referred to the Travis County District Attorney's Office for prosecution.

WIC compliance activities

Six WIC vendor outlets in the Dallas-Fort Worth metroplex and Boerne areas associated with a major WIC vendor were sanctioned for violations. Five vendor outlets were cited for failing to post prices for all WIC food items, and one vendor outlet was cited for charging for food not received. The cumulative civil monetary penalties for these sanctions total $26,696 in dollars identified for recovery.

VI. HHS Oversight

Trends

Internal Affairs (IA) worked 36 active investigations and closed 42 investigations in the first quarter. IA processed 76 referrals this quarter and investigated 23 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.

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

Internal Affairs performance

Investigations opened	23
Investigations completed	42

Open Internal Affairs cases by type

Falsifying information/documents	30%
Tampering with governmental record	23%
Privacy incident/breach	10%
Unprofessional conduct	7%
Workplace harassment	7%
Conflict of interest	7%
Other	16%

State Centers Investigations Team performance

Cases opened	139
Cases completed	135

The OIG's State Center Investigations Team (SCIT) opened 139 investigations and completed 135 investigations in the first quarter, with an average completion time of 18.80 days. This compares to 140 opened investigations and 149 completed investigations in the fourth quarter of fiscal year 2021. SCIT conducts criminal investigations of allegations of abuse, neglect and exploitation at state supported living centers and state hospitals.

Case highlights

HHS employee terminated for privacy breach

A Texas Works advisor allegedly viewed a client's Texas Integrated Eligibility Redesign System (TIERS) benefits case without a business need and disclosed the information to an unauthorized individual. IA interviewed the client, the staff member's direct supervisor, the program director and the alleged recipient of the information. The investigation revealed the employee accessed the client's TIERS information 14 times. The subject was terminated in August.

Employee resigns after OIG discovered travel fraud

A CPS Family Based Safety Services (FBSS) supervisor alleged a former specialist falsified home visits in a DFPS database and submitted falsified travel vouchers from November 2020 to March 2021. IA obtained the travel vouchers and interviewed 11 of 17 CPS clients affected. The FBSS specialist resigned from CPS and refused an interview. The criminal case was sustained for tampering with a governmental record and presented to the Lubbock County district attorney for prosecution.

Tampering with a governmental record

A CPS program director alleged a CPS investigator falsified six case reports and claimed mileage reimbursement for travel to CPS clients' residences that did not occur. The investigation determined the CPS investigator made ten entries that falsely indicated he saw the case children and was reimbursed $70 in unsubstantiated travel. The criminal case was sustained for tampering with a governmental record and presented to the Harris County district attorney for prosecution.

Client injured at East Texas facility

A recent SCIT case involved an injury to a client at the Lufkin State Supported Living Center. An employee was accused of striking a client multiple times, which resulted in injuries. The case was referred to the Angelina County District Attorney's Office for prosecution.

Agency highlights

OIG Internal Affairs helps develop new curriculum

An internal affairs investigator collaborated with an FBI-Law Enforcement Executive Development Association (FBI-LEEDA) instructor to construct a model to help teach how to best interview employees during cases. The information will be implemented and used nationally by the instructors of FBI-LEEDA, specifically, in the instruction of internal affairs. FBI-LEEDA's mission is to advance the science and art of law enforcement leadership and promote the exchange of information to improve law enforcement management practices through training, education and networking among police professionals across the United States and beyond.

Collaborating with HHS to improve WIC program

The OIG's WIC VMU collaborated with the HHS WIC program to develop a plan which corresponds to the OIG's monitoring and oversight activities and with HHS's educational and training standards. Going forward, WIC vendors will receive technical visits from HHS addressing the violations noted in the OIG's monitoring and oversight activities. This will be coordinated by the WIC VMU submitting activity summaries after every WIC VMU travel week detailing WIC vendors visited and violations cited. HHS will be responsible for the process of assessing WIC vendors sanctions. This change aligns WIC VMU activities with the Code of Federal Regulations. This will result in more effective communication and improved implementation of the WIC program by vendors.

VII. Stakeholder Engagement

OIG educates HHS staff to prevent FWA

With more HHS staff transitioning to some teleworking on a permanent basis, the OIG took steps to remind staff of agency policies designed to prevent potentially unethical behavior. During the first quarter of fiscal year 2022, the OIG collaborated with HHS Communications to produce an educational video covering telework policies, accurate time/leave entry, and moonlighting. The video featuring Inspector General Kauffman was circulated among HHS staff members.

TFPP MCO leadership meeting

Texas Fraud Prevention Partnership (TFPP) meetings encourage all Texas Medicaid and CHIP managed care organizations (MCOs) to collaborate with the OIG to strengthen the Medicaid and CHIP programs in Texas.

In September, the OIG held a TFPP MCO leadership meeting. These meetings offer the opportunity for OIG and MCO leadership to discuss current initiatives and the combined efforts to prevent, detect and investigate fraud, waste and abuse in health care delivery. The agenda for the September meeting included discussions of fraud, waste and abuse trends; a COVID-19 fraud prevention initiative; updates related to MCO cost avoidance; and updates on ongoing and upcoming OIG audits and nursing facility utilization reviews. The next TFPP MCO leadership meeting will be held in January.

Fraud Hotline performance

Fraud Hotline calls answered	5,640
Fraud Hotline referrals within OIG	
Benefit recipients	1,411
Medicaid provider	127
HHS employee/contractor	32
EBT retailer	33
State Supported Living Center/State Hospital	1

Training summary

Trainings conducted this quarter	45

External Relations performance

Communication products produced	82
Website page views	154,064

Special Investigative Unit update

A TFPP Special Investigative Unit (SIU) meeting held in November included SIU staff from MCOs and dental maintenance organizations, along with the Texas Medicaid Fraud Control Unit. The OIG shared an overview of the Fraud Detection Operations conducted during fiscal year 2021, and Amerigroup presented a fraud, waste and abuse scheme related to wheelchair component billing.

Medical Services Lock-In Program meets with MCOs

Medical Services Lock-In Program restricts or locks a Medicaid member to a designated pharmacy or provider if it finds that 1) the member used Medicaid services, including drugs, at a frequency or amount that is duplicative, excessive, contraindicated or conflicting or 2) the member's actions indicate abuse, misuse or fraud.

Medical Services Lock-In Program held individual meetings throughout the quarter with MCOs. Topics included reviewing Lock-In staff updates, MCO policy and procedure review results, fiscal year 2021 MCO Lock-In Program survey results, OIG Lock-In external policy and procedures, and MCO referrals submitted to the Lock-In Program in the last 12 months.

Medical Services meets with stakeholders

Medical Services continues to educate and inform stakeholders of utilization review activities and updates. The unit held virtual quarterly meetings in September for Nursing Facility Utilization Reviews (NFUR) and in October for Hospital Utilization Review (HUR).

NFUR discussions included updates on authority to access nursing facilities, onsite reviews, activities of daily living coding, therapy coding, delayed certifications for therapy, retention of electronic records

onsite, change of ownership review, long-term care Medicaid information guide and quality control monitoring.

HUR discussions included updates on releasing the second sample managed care encounters back to the health plans, initiating the next fee-for-service samples, responding to requests for medical records using SharePoint and diagnosis-related group education for 2022 International Classification of Diseases changes.

OIG publishes educational articles for providers

OIG Chief Dental Officer Dr. Janice Reardon collaborated with OIG Communications Team on the article "Records Requests in an OIG Investigation," featured in the September newsletter of Texas Dental Association. The article outlined the general process of an OIG investigation and the requirements related to maintaining accurate and complete patient records. The OIG dental team examines records to verify patient consent and that the dentist documented everything they did—whether it was an exam or a procedure—how the problem was detected, and whether the treatment was medically necessary; the OIG checks for the proper permits if sedation is involved. More than recouping improper Medicaid payments, the OIG also ensures proper patient care and safety.

OIG Chief Pharmacy Officer Catherine Coney, R. Ph. collaborated with OIG Communications, Provider Investigations and the data analytics teams to publish an article in Texas Pharmacy, the official magazine for the Texas Pharmacy Association. The article entitled "Data Supports OIG Pharmacy Invoice Initiative" shared the results of an initiative to highlight pharmacies with unusual billing patterns. The data-driven approach was designed to determine if pharmacies billed the Medicaid program for prescription quantities that exceeded their inventory. The article also included links to resources to help pharmacies prevent billing errors.

OIG survey data helps strengthen cost avoidance

The OIG has continued to collaborate with the MCO Cost Avoidance Workgroup, which includes representatives from all Texas MCOs and dental maintenance organizations (DMOs), the Texas Association of Health Plans and the Texas Association of Community Health Plans. The workgroup completed the 2021 HHS OIG Cost Avoidance and Waste Prevention Activities Survey. The survey catalogs all MCO and DMO cost avoidance and waste prevention activities that promote program integrity in Medicaid and CHIP service delivery. A detailed report with the survey results and other insights from the workgroup will be available in 2022.

Finding the next generation of auditors and inspectors

The OIG Audit and Inspections Division established partnerships with Austin area higher education institutions' accounting and business programs to develop and recruit the next generation of auditors and inspectors. OIG leaders have established an internship program with The University of Texas at Austin internal auditing program and accounting programs at St. Edward's University and Austin Community College. OIG leaders and team members recently spoke to classes about the importance of a career in public service and participated in the Texas Association of Certified Public Accountants Austin chapter's career fair and have more presentations scheduled over the next several months.

Conferences, Presentations and Trainings

- In November, Inspector General Kauffman attended the annual Texas Association of Health Plans conference in Austin. The inspector general gave a presentation that detailed the OIG's efforts and coordination with managed care organizations to ensure program integrity. The presentation also featured information about the agency's priorities this fiscal year and efforts to prevent fraud, waste and abuse from happening in the first place.

- Policy and Strategic Initiatives staff presented a training for Department of State Health Services (DSHS) related to illegal Medicaid solicitation. The training was designed to prepare DSHS regional staff to share information with Texas Health Steps dental providers about solicitation. The training included an overview of the OIG and its oversight activities, as well as details about the behavior and potential penalties associated with dental solicitation. Learn more about this prevention effort in the OIG in Focus article at the end of this report.

- Staff from the Policy and Strategic Initiatives Unit attended several virtual trainings and conferences, including the National Health Care Anti-Fraud Association Annual Training Conference; the Pharmacy Innovations for Medicaid, Medicare & Duals Plans; National Academy for State Health Policy Conference; and the National Association of Medicaid Program Integrity annual conference. Some of the key topics covered included maximizing program integrity outcomes, trending schemes, Medicaid utilization and costs, prescription drug costs, and collaboration between the OIG and the Texas Medicaid Fraud Control Unit and provider investigation units.

- In October, the State Centers Investigative Team conducted its biannual peace officer training. The training consisted of eyewitness evidence/identification, state and federal law updates, baton and tourniquet refresher, high profile case reviews, and firearms training and tactics.

- The OIG has further developed training designed to build leadership consistency across the agency. New trainings include courses that improve knowledge, skills and abilities in the art and science of leadership. Trainings include: Manager Orientation; Coaching & Counseling; Performance Management Basics; First, Break All the Rules; GRIT; Trust in Organizations; Managing Change; and Motivating Staff. The agency provides trainings through on-demand audio courses with topics including: Managing Multiple Projects; Managing a Diverse Staff; Managing Unacceptable Behavior; and Communicating for Results.

- In September, four BPI team members attended the United Council on Welfare Fraud's annual conference held in Wichita, Kansas. In addition to presenting with HHS's Access and Eligibility Services' team on how Texas is making good use of SNAP Fraud Framework Grant funds awarded by USDA-Food and Nutrition Service, the BPI team participated in several learning opportunities, including Strategies for Detecting SNAP Trafficking Ethics in Investigations, and COVID Fraud Trends, to name a few.

- Medical Services provided virtual education for Nursing Facility Utilization Reviews staff in September and Hospital Utilization Review staff in November. Training topics included utilization review policies and procedures, medical records review and quality control.

VIII. OIG in Focus

OIG expands illegal dental solicitation education effort

The Texas Health and Human Services Office of Inspector General proactively works with dental providers to prevent fraud, waste and abuse in Texas Medicaid delivery. In its latest endeavor, the OIG is collaborating with the Texas Department of State Health Services (DSHS) to share information about illegal dental solicitation with dentists who participate in Texas Health Steps, which provides free dental and medical checkups to children with Medicaid.

The outreach effort with DSHS Regional and Local Health Operations is currently underway. OIG staff is training DSHS staff in public health regions across the state, giving them a solid understanding of illegal dental solicitation and the OIG's role in detecting and preventing it. The OIG Communications Team produced educational material to remind Medicaid dentists and their staff of the prohibition against patient solicitation; the material outlines the prohibited behavior and the penalties involved. DSHS will share the information with providers across Texas through a variety of communication avenues.

Solicitation basics

The OIG enforces 1 Texas Administrative Code §371.1669, which prohibits a person from offering any cash, gifts or other items that may influence a potential client's selection of a Medicaid service provider. Providers may not offer, and clients may not accept:

- Cash, cash equivalents or gift cards in any amount.
- Free or discounted services for a family member to influence their health care decisions.
- Transportation, unless it's properly arranged with the client's managed care organization or the Texas Health and Human Services Commission.

The OIG may investigate providers who advertise free transportation on their website or providers who hire people to canvass neighborhoods looking for Medicaid-eligible children and pay drivers to transport children for Medicaid services. Providing goods or services of any value could be considered a violation, but that would typically not be the case for non-cash, low-cost items such as a toothbrush valued less than $10.

Solicitation penalties

If a provider solicits Medicaid clients, the provider may be found guilty of a Class A misdemeanor and a third-degree felony if the dentist was previously convicted of illegal dental solicitation or was employed by the federal, state or local government at the time. The provider may be subject to disciplinary action by the Texas State Board of Dental Examiners, an injunction, civil penalties of up to $10,000 and possible exclusion as a provider from the Medicaid and CHIP programs.

Learn more

The OIG created a brochure to educate providers about the signs and consequences of illegal dental solicitation in Medicaid. Providers may download it from https://tinyurl.com/OIGsolicitation and share it with their staff.

Texas Health and Human Services Office of Inspector General

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

Website: ReportTexasFraud.com

OIG on LinkedIn: hhsc-office-of-inspector-general

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