



Inspector General

Texas Health and Human Services



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OIG

Quarterly Report

Quarter 3 Fiscal Year 2022

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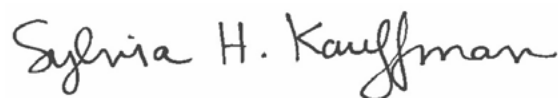
I. Executive Summary

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

The Texas Health and Human Services Office of Inspector General recovered nearly \$162 million this quarter. In addition, we identified almost \$220 million in potential future recoveries and achieved \$43 million in cost avoidance by deterring potentially questionable spending before it could occur.

This quarterly report features examples of how the agency protects the integrity of state health and human services. Case highlights demonstrate the important work we are doing to secure SNAP benefits. More and more Texas providers are proactively engaging with the OIG to self-report errors and overpayments. This report also details how investigators are collaborating with our federal and state partners to pursue Medicaid fraud. We are working with HHS to address program integrity issues in telemedicine, telehealth, medical nutrition counselling, preventative care, and behavior therapy, to name a few. Our auditors continue their excellent work addressing compliance issues, and our inspectors remain focused on systemic issues and risk assessment.

The OIG team follows its core values – Accountability, Integrity, Collaboration and Excellence – in performing our work in service to the people of Texas. I am proud of this dedicated team of professionals and all who bring their skills, intelligence and heart to the OIG every day.



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	\$161,722,871
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Audit and Inspections

Audit collections	\$696,123
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Investigations and Reviews

Provider overpayments	\$10,437,053
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Data review overpayments	\$2,076,744
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Beneficiary collections (SNAP, TANF, Medicaid, CHIP, WIC)	\$20,952,182
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Voluntary repayments by beneficiaries	\$31,846
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Acute Care provider overpayments	\$227,911
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Hospital overpayments	\$4,141,851
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Hospital underpayment	(\$6,364)
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Nursing facility overpayment	\$99,718
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Nursing facility underpayments	(\$6,659)
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Recovery Audit Contractor recoveries	\$12,033,172
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WIC collections	\$0
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Total Investigation and Reviews Recoveries	\$49,987,454
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Third Party Recoveries	\$110,767,015
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Peace Officers

Electronic Benefits Transfer trafficking retailer overpayments	\$272,279
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State Centers Investigations Team recoveries	\$0
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Total Peace Officers Recoveries	\$272,279
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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	\$219,889,429
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Audit and Inspections

Provider overpayments	\$3,373
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Investigations and Reviews

MCO identified overpayments	\$4,912,434
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Data review overpayments	\$2,185,163
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Beneficiary claims in process of recovery (SNAP, TANF, Medicaid, CHIP, WIC)	\$16,002,236
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Acute Care provider overpayments	\$290,591
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Hospital overpayments	\$6,276,769
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Nursing facility overpayments	\$951,849
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Recovery Audit Contractor recoveries	\$10,055,372
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WIC collections	\$4
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Total Investigation and Reviews Identified Recoveries	\$40,674,418
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Third Party Identified Recoveries	\$178,774,759
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Peace Officers

Electronic Benefits Transfer trafficking retailer overpayments	\$436,879
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State Centers Investigations Team recoveries	\$0
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Total Peace Officers Identified Recoveries	\$436,879
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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

\$42,829,708

Investigations and Reviews

Medicaid provider exclusions	\$5,322,115
Client disqualifications	\$1,715,139
WIC vendor monitoring	\$0
Pharmacy Lock-In	\$2,026,733

Third Party Recoveries

Fee-for-service front-end claims denials	\$33,650,833
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Peace Officers

Disqualification of Electronic Benefits Transfer recipients	\$114,888
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III. Provider Integrity

Trends

Provider Field Investigations (PFI) continues to harness data analytics to detect fraud, waste and abuse. A recent data initiative detected a trend among some home health agencies inappropriately billing Medicaid using a modifier reserved for patients who have a tracheostomy or are ventilator-dependent, when the patients did not have either condition. Billing and client data analysis identified potential overpayment based on the modifier's higher reimbursement rate.

Provider Investigations performance

Preliminary investigations opened	545
Preliminary investigations completed	498
Full investigations completed	68
Cases transferred to full investigation	51
Cases referred to OAG's Medicaid Fraud Control Unit	195
Open/active full-scale cases at end of quarter	118

Case Highlights

Texas providers are encouraged to self-report overpayments

Providers continue to voluntarily participate in the OIG self-report process. The OIG developed guidance for health care providers who voluntarily disclose irregularities related to Medicaid claims and other HHS programs. The OIG views the program as a way to collaborate with providers, allowing the state to reduce fraud, waste and abuse while offering providers an opportunity to potentially reduce their legal and financial exposure. Working with the OIG may also increase providers' understanding of the OIG's audit and investigatory processes.

The following are examples of self-reported cases during the third quarter:

- The OIG settled a case in March with a Richardson home health care provider who, through an internal investigation, discovered that a caregiver employee billed for services not rendered between August and November 2021. The provider correctly reported that it owed the Medicaid program \$2,010 and agreed to repay the overpayment.
- In May, the OIG settled a self-reported case with a hospital in Beaumont. This case involves incorrectly billing for injections and infusions when they are already included in an emergency room service charge and are not reimbursed separately. The provider worked collaboratively with OIG Litigation to negotiate a final settlement of \$8,738.

Surveillance Utilization Review Team

Acute care provider recoveries	\$227,911
Acute care services identified overpayments	\$290,591
Hospital and nursing home (UR) recoveries	\$4,228,546
Hospital (UR) claims reviewed	6,107
Nursing facility reviews completed	98
Average number of Lock-in Program clients	3,599

Provider enrollment and exclusions

Provider enrollment inventory (applications and informal desk reviews) processed	3,123
Individual screenings processed	6,162
Medicaid providers excluded	39

Fraud Analytics and Data Operations

Data requests received	215
Data requests completed	176
Algorithms executed	103
New algorithms developed	9

OIG assists with task force investigation

As a partner in the FBI's McAllen Criminal Investigations Division Task Force, the OIG assisted with a durable medical equipment provider investigation. According to the indictment, the provider billed Medicaid more than \$4 million between 2006 and 2013 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 provider pled guilty to conspiracy to commit health care fraud and agreed to make \$3,652,195 in restitution.

OIG settles case with Galveston County pharmacy

The OIG settled a case in April with a Dickinson pharmacy. The provider lacked documentation to support the medication quantities billed to the Texas Medicaid program compared to medications purchased from vendors over a four-year period. The provider worked collaboratively with the OIG to resolve these issues, and the OIG agreed to a settlement of \$1,333,660.

OIG settles case with Harris County pharmacy

In March, the OIG settled a case with a Houston pharmacy. The provider lacked documentation to support the medication quantities billed to Medicaid compared to medications purchased from vendors. The provider worked collaboratively with the OIG to resolve these issues, and the OIG agreed to a settlement of \$42,521.

Settlement reached with Fort Worth home health agency

The OIG settled a case in March with a Fort Worth home health agency. Following an OIG Medicaid Program Integrity initiative focused on private duty nursing (PDN), the provider was discovered to have billed and been reimbursed for more than the allowable 96 units of PDN for one client on one day of service; 96 units is equal to 24 hours of PDN care. The provider produced documentation showing that the billing errors were due to billing software that had since been replaced. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of \$95,918.

OIG settles upcoding case with Houston home health agency

In March, the OIG settled a case with a Houston home health agency that offers PDN services. From January 2015 to June 2021, the home health agency billed Medicaid for PDN using a modifier reserved for patients who have a tracheostomy or are ventilator-dependent, when the patients did not have a tracheostomy and were not ventilator-dependent, which resulted in an upcode. The provider agreed to pay \$400,000 to resolve the case.

Provider Investigations case summary

Referral sources for cases

MCO/DMO	28%
Government agency	27%
Public	20%
Provider	10%
Anonymous	8%
OIG initiated	7%

Types of preliminary investigations opened

Attendants	39%
Physician (individual/group/clinic)	17%
Home health agency	10%
Hospital	8%
Dental	5%
Therapy (physical/occupational/social)	6%
Nursing facility	4%
Durable medical equipment	2%
Lab-radiology-x-ray	2%
Pharmacy	2%
12 other categories at less than 1%	5%

Types of full investigations opened

Hospital	62%
Physician (individual/group/clinic)	17%
Therapy (physical/occupational/social)	6%
Assisted living	5%
Home health agency	4%
Dental	2%
Nursing facility	2%
Pharmacy	2%

*rounded to nearest whole number

Settlement reached involving EEG services

In March, OIG Litigation reached a settlement with a Houston neurology clinic. During the period between September 2013 and May 2019, the provider submitted multiple claims and was reimbursed for electroencephalogram (EEG) monitoring of cerebral seizures. The provider submitted claims for EEG services that require the capacity to intervene and test or alter care by a clinician throughout the 24-hour recording period; however, the services provided were unattended, ambulatory EEGs. The provider worked collaboratively with OIG Litigation to resolve the issue and agreed to a settlement of \$184,980.

Texas laboratory agrees to settlement

The OIG settled a case in May with an Irving independent laboratory. An OIG data analysis indicated that the provider billed MCOs for non-reimbursable genetic testing laboratory services. The provider accepted responsibility, implemented corrective measures and worked collaboratively with OIG Litigation to resolve these issues, agreeing to repay the overpayment of \$46,287.

San Antonio counselor settles case involving data breach

In May, the OIG settled a case with a San Antonio licensed professional counselor. The provider was investigated for billing for individual therapy sessions but actually providing group therapy. During the investigation, it was discovered that the provider had a privacy data breach. A former employee lost flash drives containing patient files and records. The provider accepted responsibility, implemented corrective measures and worked collaboratively with OIG Litigation to resolve these issues, agreeing to repay the overpayment amount of \$126,012.

OIG audit leads to settlement with Central Texas behavioral health provider

The OIG settled an audit case in April with an Austin behavioral health provider. The provider's most common error was failing to have adequate and correct documentation, including failing to document the required time component to support the procedure code billed, listing the incorrect servicing provider on the claim, billing with incorrect modifiers, and filing claims with missing or late informed consents. The provider worked collaboratively with the OIG to address the audit report findings and agreed to a settlement of \$50,000.

Personal care attendant excluded from Medicaid

The OIG excluded a personal care attendant for ten years. From December 2017 to May 2020, the provider billed and was reimbursed for personal attendant services which were not rendered for two patients. The attendant in Weslaco claimed to be providing personal care services to both patients simultaneously. The exclusion began in March.

San Antonio speech therapist excluded from Medicaid

From July 2015 through June 2019, the therapist billed and was reimbursed for therapy services that were never rendered to multiple clients. The therapist also failed to provide complete client records with supporting documentation that therapy services were provided. The OIG excluded the speech therapist for ten years, beginning in March.

Agency highlights

Fraud detection operation examines DME providers

An OIG Fraud Detection Operation (FDO) focused on indicators for potential fraud, waste and abuse among durable medical equipment (DME) providers. DME includes medical equipment and supplies such as incontinence supplies, shower/bath chairs, blood pressure monitors and enteral feeding supplies.

The four providers examined in the FDO were selected based on the results of algorithms generated by the OIG's data team, which looked for the following:

- Clients who may not be receiving the required physician visits within six months prior to distribution of equipment or supplies.
- High use of miscellaneous billing codes, which could indicate a provider is billing a higher amount for a product than is allowed or is billing for a product not allowed by Medicaid.

An FDO is the result of multiple OIG divisions reviewing and analyzing large volumes of data to identify providers that appear as statistical outliers among their peers. Investigators, through coordinated field work and research, evaluate additional evidence and information to determine if an outlier's status is attributable to possible fraud, waste or abuse or program violation. Providers are required to supply records requested by OIG investigators, to make staff available for interviews and to generally cooperate with the investigative operation.

The record review for the four FDO-identified providers is still in process. Based on the review findings, providers maybe referred for full investigation, which will allow for a closer look at the provider's billing and documentation patterns and other evidence.

OIG Audit receives highest rating in peer review

The OIG Audit Division received a rating of "pass" on its peer review, which is the highest possible rating. The review was conducted from January to March of this year and covered the period of September 1, 2020, to August 31, 2021. Organizations can receive a rating of "pass," "pass with deficiencies" or "fail."

Agency auditors conduct audits in accordance with the U.S. Government Accountability Office's professional standards (Yellow Book). The Yellow Book provides a framework to conduct high-quality audit work with competence, integrity, objectivity, accountability and independence.

Each audit organization conducting engagements in accordance with the Yellow Book must obtain an external peer review conducted by reviewers independent of the audit organization being reviewed every three years. The Yellow Book also requires that the audit organization make its most recent peer review report publicly available. The most recent external quality assurance review letter is available on the [agency's website](#).

Completed reports - Audit

The Center for Comprehensive Mental Health: A Texas Medicaid Provider

The OIG conducted an audit of psychiatric services billing to ensure the Center for Comprehensive Mental Health (the Center) in McAllen billed correctly for telemedicine services performed. Telemedicine is a health care service that is (a) delivered by a physician licensed in the state of Texas, or a health care professional acting under the delegation and supervision of a physician licensed in Texas, acting within the scope of the physician's or health care professional's license, (b) provided to a patient at a different physical location than the physician or health care professional, and (c) provided using telecommunications or information technology.

The COVID-19 pandemic prompted an increased use of telemedicine to connect providers with their patients, and the state of Texas adopted waivers and changes to ease technology restrictions and expand the number of Medicaid services available through telemedicine. The Center's physician, who is licensed to provide medical services in Texas, provided behavioral health services in the same manner as those in a traditional in-person setting as required. However, the Center did not always bill the appropriate Current Procedural Terminology (CPT) codes based on time duration for telemedicine evaluation and management services with add-on psychotherapy services. As a result of the Center's incorrect billing, it was overpaid and must return \$936 for telemedicine evaluation and management services with add-on psychotherapy services. Additionally, the Center did not provide its patients with written or electronic privacy practice notifications prior to evaluation or treatment as required.

In addition to returning \$936 to the state of Texas, the Center should implement processes to ensure that (a) claims for services billed as time-based CPT codes are based on the actual length of services provided and (b) medical records include documentation to support the CPT codes billed. Additionally, the Center should provide patients with written or electronic notification of its privacy practices prior to evaluation or treatment via telemedicine services.

Community First Health Plan Special Investigative Unit: A Texas Medicaid Managed Care Provider

The OIG conducted an audit of special investigative unit (SIU) activities at Community First Health Plans, Inc. (Community First), a Medicaid and 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. Community First received \$526 million in 2019 and \$571 million in 2020 to administer Texas managed care programs. The audit objective was to determine if, for the period from September 1, 2019, through August 31, 2020, Community First'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.

Community First did not consistently comply with certain state and contractual requirements. During the audit period, Community First met certain requirements related to staffing the SIU, training, monitoring service patterns and remitting funds recovered. However, Community First has opportunities to improve the timing and documentation of its SIU efforts in both preliminary and extensive investigations, reporting to the OIG, and its fraud, waste and abuse training. Specifically, Community First did not consistently:

- Ensure preliminary investigations contained required elements and met required timelines.
- Include the date of the allegation on its log of incidences of suspected fraud, waste and abuse.
- Ensure sample sizes for extensive investigations met requirements.

Audits issued

6

- The Center for Comprehensive Mental Health: A Texas Medicaid Provider
- Community First Health Plan Special Investigative Unit: A Texas Medicaid Managed Care Provider
- Deaf Blind with Multiple Disabilities Program: Mission Road Developmental Center
- Medcare Clinics PLLC: A Texas Medicaid and CHIP Provider
- Selected Memory Care Facilities: Le Rêve Rehabilitation and Memory Care
- Deaf Blind with Multiple Disabilities Program: Lighthouse for the Blind of Houston

Audits in progress

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- Selected Emergency Ambulance Providers
- Selected Pharmacy Providers
- Selected Health, Developmental, and Independence Services Contract
- Selected Home and Community Support Services Agencies
- Medicaid and CHIP Enrollment Broker
- Psychiatric Care Hospitals
- Selected DSHS Contracts
- MCO Financial Reporting
- MCO IT Security Controls and Business Continuity and Disaster Recovery Processes
- Memory Care Centers
- Home- and Community-Based Services Oversight

Audit performance

Overpayments recovered	\$696,123
Overpayments identified	\$3,373
Audit reports issued by OIG	6
Audit reports issued by contractors	0

Inspections in progress

10

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

- Meet or sufficiently document all timeline requirements for extensive investigations.
- Include all opened investigations on the Monthly Open Case List Report.
- Refer all extensive investigations of possible acts of fraud, waste or abuse to OIG, or document why those extensive investigations with findings and recoveries were not referred to OIG.
- Remit to OIG half of all amounts recovered as the result of a fraud and abuse determination.
- Submit referrals for possible acts of fraud, waste or abuse to OIG within the required timeframe.
- Ensure staff and subcontractors completed fraud, waste and abuse training within the required timeframes.

The OIG made recommendations to Community First that, if implemented, will correct these issues.

Deaf Blind with Multiple Disabilities Program: Mission Road Developmental Center

The OIG reviewed the conditions of three of Mission Road Developmental Center's (Mission Road's) four assisted living facilities in San Antonio during on-site visits to determine whether they provided a safe living environment; were sufficiently secured, modified, clean and maintained in good repair; and had fire and other hazard detection and safety systems in place. Mission Road operated and provided residential Deaf Blind with Multiple Disabilities program services at its assisted living facilities largely in compliance with applicable contractual requirements, laws, rules and guidelines. The OIG made recommendations which, if implemented, would improve Mission Road's process to identify and mitigate hazards in its facilities and would ensure carbon monoxide detectors are installed in resident bedrooms.

Medcare Clinics PLLC: A Texas Medicaid and CHIP Provider

The OIG conducted an audit of psychiatric services billing to ensure Medcare Clinics PLLC (Medcare) in Houston billed correctly for telemedicine services performed. Telemedicine is a health care service that is (a) delivered by a physician licensed in the state of Texas, or a health care professional acting under the delegation and supervision of a physician licensed in Texas, acting within the scope of the physician's or health care professional's license, (b) provided to a patient at a different physical location than the physician or health care professional, and (c) provided using telecommunications or information technology.

The COVID-19 pandemic prompted an increased use of telemedicine to connect providers with their patients, and the state of Texas adopted waivers and changes to ease technology restrictions and expand the number of Medicaid services available through telemedicine. Medcare provided psychiatric services to its patients via telemedicine; however, Medcare incorrectly billed for services that it provided for evaluation and management and add-on psychotherapy services. As a result, Medcare was overpaid and must return a total of \$2,437 to the state of Texas.

In addition to returning \$2,437, Medcare should implement processes to ensure that (a) claims for services billed as time-based CPT codes are based on the actual length of services provided and (b) medical records include documentation to support the CPT codes billed.

Selected Memory Care Facilities: Le Rêve Rehabilitation and Memory Care

The OIG conducted an audit of Le Rêve Rehabilitation and Memory Care (Le Rêve), a nursing living facility licensed by HHSC that provides nursing services to short-term rehabilitation residents and long-term residents, including those with Alzheimer's disease or a related diagnosis. The OIG's annual audit risk assessment included identification of risks regarding assisted living facilities advertising as providing memory care services without disclosing whether the facility holds a certification to serve residents with Alzheimer's disease.

Le Rêve complied with most of HHSC’s health and safety requirements tested during the OIG’s unannounced site visit, including the condition of residents’ rooms and storage of medication. Based on additional testing completed after the unannounced site visit, Le Rêve also complied with the required licensed nursing staff-to-resident ratios. However, Le Rêve did not comply with all selected requirements. Specifically, Le Rêve did not:

- Provide a written notice disclosing the facility is not certified to provide specialized care and treatment for residents with Alzheimer’s disease and related disorders, as required, to each resident, as well as each prospective resident or their next of kin or guardian.
- Ensure adequate front desk staffing to (a) reduce the risk of residents leaving the facility unattended and (b) fully comply with COVID-19 emergency rules.
- Have a process to ensure staff completed all required training prior to caring for residents.

Le Rêve should ensure that (a) it prepares a written disclosure notice, (b) residents and prospective residents and their next of kin or guardian receive the written disclosure notice, and (c) the front desk at the entrance of the facility is sufficiently staffed. Additionally, the facility should develop a process to ensure direct care staff comply with applicable training requirements.

Deaf Blind with Multiple Disabilities Program: Lighthouse for the Blind of Houston

During on-site visits to two of four Lighthouse for the Blind of Houston (Lighthouse) assisted living facilities in Houston, the OIG reviewed conditions to determine whether they provided a safe living environment; were sufficiently secured, modified, clean, and maintained in good repair; and had fire and other hazard detection and safety systems in place. Lighthouse operated and provided residential Deaf Blind with Multiple Disabilities program services at its assisted living facilities in compliance with almost all applicable contractual requirements, laws, rules and guidelines. The OIG made a recommendation which, if implemented, ensures carbon monoxide detectors are installed in resident bedrooms.

IV. Client Accountability

Trends

The Benefits Program Integrity (BPI) division completed 3,657 investigations involving some form of benefit recipient overpayment or fraud allegation. Ninety-four 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 11 investigations for prosecution and 85 investigations for administrative disqualification hearing.

Benefits Program Integrity performance

Overpayments recovered	\$20,952,182
Cases completed	3,657
Cases opened	3,448
Cases referred for prosecution	11
Cases referred for Administrative Disqualification Hearings	85

Case highlights

Dallas County client disqualified from SNAP

BPI investigated a Dallas County client who failed to disclose his income when applying for SNAP and Medicaid benefits. During the investigation, the investigator obtained evidence that the client failed to report his self-employment income, unemployment income and four accounts with three different banks. According to the evidence, the client's self-employment income came from the development of a gift card liquidation business, resulting in tax-free income. After obtaining subpoenas to access the client's bank information, the investigator verified that from 2016 through 2020, the client earned a total gross income of about \$3 million, with an average monthly income of \$60,000. This case was referred to the Dallas County district attorney, and the client subsequently pled guilty in March to the felony charge of securing execution of a document by deception. The client received 30 days of probation, was disqualified from SNAP for 12 months and was ordered to pay \$84,351 at the time of sentencing.

Hidalgo County client pleads guilty

In March, BPI resolved a case in Hidalgo County where a client committed fraud by failing to report her children's father, that they were married, and his associated income when applying for SNAP and Medicaid. From January 2014 to June 2019, the client received \$44,575 in excessive benefits. The client pled guilty to the charge of theft after evidence was presented to the Hidalgo County district attorney. The client was ordered to pay full restitution, complete 240 hours of community service, attend the Theft Offender Intervention Educational Program, and was placed under community supervision for ten years.

Bexar County client disqualified from SNAP

In March, BPI resolved a case in Bexar County where a client committed fraud by failing to report her children's father and his associated income when applying for SNAP. From May 2017 to December 2021, the client received \$27,954 in excessive SNAP benefits. After evidence proved the father and his income should have been reported on the applications, the client signed a waiver of disqualification hearing, agreed to repay \$27,954, and was disqualified from the SNAP program for 12 months.

OIG investigation leads to prison for benefits theft

A Mexican national was sentenced in March as part of a case completed by an BPI investigator. Claiming to be a U.S. citizen, the man applied for and received Medicaid and Social Security Disability Insurance benefits. The BPI investigator determined the man was a Mexican citizen and had fraudulently received \$247,477 in government assistance payments. He was sentenced to 45 months in prison for theft of Social Security benefits and was ordered to pay \$247,477 in restitution.

V. Retailer Monitoring

Trends

The Electronic Benefits Transfer (EBT) Trafficking Unit is experiencing a high volume of complaints regarding clients' EBT cards being cloned or skimmed. Clients are reporting the benefits on their EBT cards are being withdrawn without their consent. A preliminary investigation has shown that

Electronic Benefits Transfer Trafficking Unit performance

Overpayments Recovered	\$272,279
Cases opened	93
Cases completed	94

clients are conducting a transaction with their card, and shortly afterwards, transactions are being reported in other cities and states. Lone Star Services, the card's administrator, is managing reimbursement determinations.

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 investigating several mobile vendor retailers in that area.

During this quarter, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Vendor Monitoring Unit (VMU) conducted 109 compliance buys across the state. A compliance buy is a covert in-store inspection. An OIG inspector poses as a WIC client and uses a WIC EBT food card to make purchases to ensure vendors are following WIC rules. Violations were cited during 30 of the 109 store visits.

The team also completed 72 inventory reviews across the state. An inventory review is a comparison of a vendor's paid claims and their purchase invoices for WIC food items. The purpose of the inventory review is to determine if the vendor had a sufficient inventory of WIC food items to justify their submitted claims. Inventory reviews conducted this quarter resulted in complete compliance for all vendors.

WIC VMU also conducted 17 on-site store inspections. The inspection is an overt in-store assessment where the OIG works with the respective WIC vendor to identify any deficiencies which may or may not exist in association with the sale of authorized WIC products.

Case highlights

OIG conducts undercover investigation

EBT investigators conducted an undercover operation at an Austin food truck where they were able to traffic benefits with the truck's owner. Investigators returned after the undercover operation and interviewed the food truck owner. The owner also admitted to purchasing other individuals' SNAP benefits over a two-year period and using these SNAP benefits at stores to restock his food truck. The owner admitted to trafficking \$163,954 in illegally obtained SNAP benefits. This case is pending prosecution at the Travis County District Attorney's Office.

South Texas retailers disqualified

Two stores in Hidalgo County were permanently disqualified from SNAP participation for violating program rules. Federal Food and Nutrition Service (FNS) investigators determined the retailers were trafficking in EBT benefits, which involves purchasing benefits from SNAP recipients for less than face value, in exchange for cash. FNS referred the case to the OIG to investigate the SNAP recipients who were selling their benefits. The Pharr EBT Trafficking Unit completed 25 administrative disqualification hearing cases totaling \$41,772 in trafficked benefits.

Agency highlights

WIC team responds to baby formula shortage

In mid-February 2022, Abbott Laboratories issued a formula recall notice for many of their products. The HHS WIC Program, in coordination with statewide WIC vendors, expanded its approved products list to allow the sale of non-contract formulas to meet the needs of the WIC population. The WIC VMU has modified its compliance buy procedures and has temporarily ceased monitoring formula in stores. An adjustment to the inventory review process and scope will be necessary next federal fiscal year.

VI. HHS Oversight

Trends

Internal Affairs (IA) worked 61 active investigations and closed 30 investigations in the third quarter. IA processed 119 referrals and investigated 49 of those referrals. The remaining referrals 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.

Half of Internal Affairs' open cases continue to involve CPS client/supervisor allegations of DFPS employees falsifying documents. This may be the result of increased DFPS scrutiny, DFPS management establishing quality assurance processes to identify misconduct, as well as a greater number of clients alleging caseworker misconduct.

The OIG's State Center Investigations Team (SCIT) opened 130 investigations and completed 131 investigations in the third quarter, with an average completion time of 18.7 days. This compares to 145 opened investigations and 139 completed investigations in the third quarter of fiscal year 2021.

Internal Affairs performance

Investigations opened	49
Investigations completed	30

Open Internal Affairs cases by type

Falsifying information/documents	50%
Contract fraud	10%
Unprofessional conduct	22%
IA law enforcement assist	7%
Tampering with a governmental record	7%
Unauthorized release of information	7%
Time/leave abuse	4%
Retaliation	2%
Privacy incident/breach	2%
Other	1%

State Centers Investigations Team performance

Cases opened	130
Cases completed	131

Case highlights

HHS employee terminated for privacy breach

An HHS employee in Austin was accused of accessing a database she was not authorized to use to look up people/license plates unrelated to her duties. The investigation determined the employee accessed personal identifying information via the unauthorized use of the database without a business need. The individual no longer works for the agency, and the case was referred to the Travis County district attorney for prosecution.

Client injured at Corpus Christi facility

A recent SCIT case involved an injury to a client at the Corpus Christi State Supported Living Center. An employee was accused of striking the client, which resulted in injuries. The case was referred to the Nueces County district attorney for prosecution.

Policy recommendations

MCO contract manual changes take effect

The OIG recommended changes to the Texas Medicaid and CHIP Uniform Managed Care Manual (UMCM), Chapter 5.5.1, Deliverable Due to The Office of Inspector General to clarify that only one national provider

identifier (NPI) per referral can be submitted to the OIG when fraud, waste or abuse (FWA) is suspected. The OIG recommended these changes to reinforce procedures MCOs are required to follow when referring potential FWA through the OIG referral system. An amendment to the UMCM, including these changes, took effect on May 30.

OIG provides program integrity feedback on policy changes

House Bill 4 (87th Legislative Session, 2021) requires HHS to allow more services to be delivered using telemedicine, telehealth and audio-only methods on a permanent basis after the public health emergency ends if clinically appropriate and cost-effective. As part of their policy development to implement the bill, HHS requested program integrity feedback from the OIG. The OIG provided comments related to ensuring that the client's agreement to receive services via telemedicine and telehealth is appropriately documented.

OIG reviews draft Medicaid Autism Services policy

The final Medicaid Autism Services policy, including Applied Behavioral Analysis (ABA), was added to the Texas Medicaid Provider Procedures Manual. The OIG reviewed the Healthcare Fraud Prevention Partnership Study on ABA claims and submitted informal program integrity observations and feedback to HHS Medicaid & CHIP Services in April 2022. The feedback was based on the study scenarios and current policy.

VII. Stakeholder Engagement

Texas Fraud Prevention Partnership update

The OIG continues to advance the work of the Texas Fraud Prevention Partnership (TFPP), which encourages all MCOs to collaborate with the OIG to strengthen the Medicaid program in Texas.

In May, the OIG held a TFPP meeting that included OIG and MCO leadership. These meetings offer the opportunity to discuss current initiatives and the combined efforts to prevent, detect and investigate fraud, waste and abuse (FWA) in Texas Medicaid. The agenda for the May meeting included discussion of FWA trends; OIG's data initiatives; and updates on ongoing and upcoming OIG audits, inspections and surveillance utilization reviews. The next TFPP MCO leadership meeting will be held in September.

During the third quarter, the OIG held TFPP Special Investigative Unit one-on-one meetings with staff from various MCOs to discuss their pending investigations, referrals and current FWA schemes. Texas Office of Attorney General Medicaid Fraud Control Unit staff also participated in the meetings and discussed referrals and new trends. MCOs report that they continue to investigate possible upcoding and solicitation related to dental providers, as well as instances of prescriptions being billed for patients who don't have a physician relationship on file.

Fraud Hotline performance

Fraud Hotline contacts handled	6,657
Fraud Hotline referrals within OIG	1,672
Benefit recipients	1,282
Medicaid provider	158
HHS employee/contractor	46
EBT retailer	183
State Supported Living Center/State Hospital	3

Training summary

Trainings conducted this quarter	50
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External Relations performance

Communication products produced	72
Website page views	50,006

OIG continues FWA prevention strategies

The OIG continues to deploy strategies to prevent FWA from happening in the first place through public outreach, education and training. In March, an OIG staff member worked with the HHS Office of Disability Services Coordination to present a training to the Direct Services Workforce Taskforce. The group is comprised of public and private stakeholders focused on non-wage-related recruitment and retention efforts for direct care staff. This presentation focused on FWA trends in personal attendant care and how to proactively address the emerging issues.

OIG staff also presented a training in March to Texas Health Steps Provider Relations, which is dedicated to strengthening the relationship between providers and Texas Health Steps staff. The presentation included information about the OIG's mission and vision, an overview of provider responsibilities and the latest trends in waste and wrongdoing.

The OIG is also utilizing the agency's digital media channels to educate providers and MCOs about self-reporting. Providers and MCOs 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.

Educating providers about how to prevent FWA

OIG Chief Dental Officer, Dr. Janice Reardon collaborated with the communications team to produce an article for the Texas Dental Association's *TDA Today* highlighting the common coding errors found in a dental records review. The most frequent error the OIG observes in reviews is providers submitting billing codes that are not supported by patient records. A typical upcoding error for dentists is billing for a restoration after placing only a sealant or preventive resin; x-rays provide the definitive information to determine whether a resin is into the dentin of a tooth. Coding errors waste taxpayer dollars and are subject to Medicaid repayment. Educating providers about the typical errors found in the course of the OIG's work helps prevent fraud, waste and abuse and assists the providers in avoiding costly mistakes.

Additional OIG articles published during the third quarter include a piece for the Texas Medical Association explaining the documents requested during a claims record review. The Texas Association of Home Care and Hospice published an article about the OIG Fraud Hotline. Readers learned what kind of behavior to report to the OIG and what to expect when making a call. The communications team also produced an article for the Texas Pharmacy Association outlining the process for providers to self-report billing irregularities to the OIG; it included the potential benefits to health care professionals who voluntarily disclose payment errors and potentially avoid a full investigation.

Collaborating with Texas hospitals to discuss recovery audit contractor

This spring, a series of meetings was held with Texas hospitals who are audited by the federal Recovery Audit Contract (RAC) program. Texas Health and Human Services engages a contractor to identify and recover Medicaid fee-for-service overpayments using data analytics and clinical reviews of medical records. The contractor identifies potential improper payments for service dates and provider types determined by the OIG. Hospitals submit documentation to the RAC to substantiate the claims under review. The OIG met with selected participating hospitals to collaborate on ways to decrease technical denials for claims under review, such as claims submitted improperly. The meeting also discussed using an online portal to submit hospital records electronically to the RAC vendor. Increased portal use could support swifter claims resolution for the hospitals and Texas Medicaid.

OIG engages with future investigators

In April, Benefits Program Integrity staff participated in the University of Texas at San Antonio (UTSA) criminology and criminal justice mentoring event in partnership with the Alamo Area Council of Governments Law

Enforcement Academy. The event provided approximately 40 UTSA criminology/criminal justice students an opportunity to discuss the career experiences of criminal justice practitioners throughout the area. This was the first mentoring event sponsored by UTSA in the hopes that the experience will guide students in exploring their educational and career opportunities within the criminal justice field.

Surveillance Utilization Review meets with stakeholders

Surveillance Utilization Review (SUR) continues to educate and inform stakeholders of utilization review activities and updates. The SUR unit held a virtual quarterly meeting in March for Nursing Facility Utilization Reviews (NFUR) and in April for Hospital Utilization Review (HUR). NFUR discussions included updates for on-site reviews, active diagnoses, interviews for mental status, and resident mood interviews conducted after the assessment reference date or outside the look-back period. HUR discussions included updates on quality control, coder education, managed care and fee-for-service updates.

Conferences, Presentations and Trainings

- In April, the State Centers Investigative Team conducted its bi-annual peace officer training. The training consisted of three days of investigative interviewing techniques and firearms training and tactics.
- SUR provided virtual education for Nursing Facility Utilization Reviews staff in April and Hospital Utilization Review staff in May. Training topics included utilization review policies and procedures, medical records review, quality control, medical coding, and InterQual®, an evidence-based clinical decision support solution for payers, providers, and government agencies who want to help ensure clinically appropriate medical-utilization decisions.
- Program Support and Training (PST) developed training to build a more resilient workforce capable of navigating change while maintaining focus on the goals required for OIG success. The first session focuses on the individual's resilience in connection to the OIG's workplace. The second session focuses on how all OIG staff can work together to build a more resilient team. By focusing future course offerings to highlight and develop resilient attributes, PST will continue building the OIG's workplace resilience

VIII. OIG in Focus

Special Investigation Units help prevent fraud, waste and abuse

Collaboration between managed care organizations and dental maintenance organizations (referred to collectively as MCOs) and the OIG plays an important role in detecting and preventing fraud, waste and abuse (FWA) in Texas Medicaid delivery. One tool MCOs use to accomplish this is their Special Investigative Units (SIUs), which investigate potential FWA for all services provided under an MCO's contract with Texas Medicaid. To support the SIUs in their efforts, the OIG has a dedicated SIU coordinator who assists with referrals, investigations and FWA training.

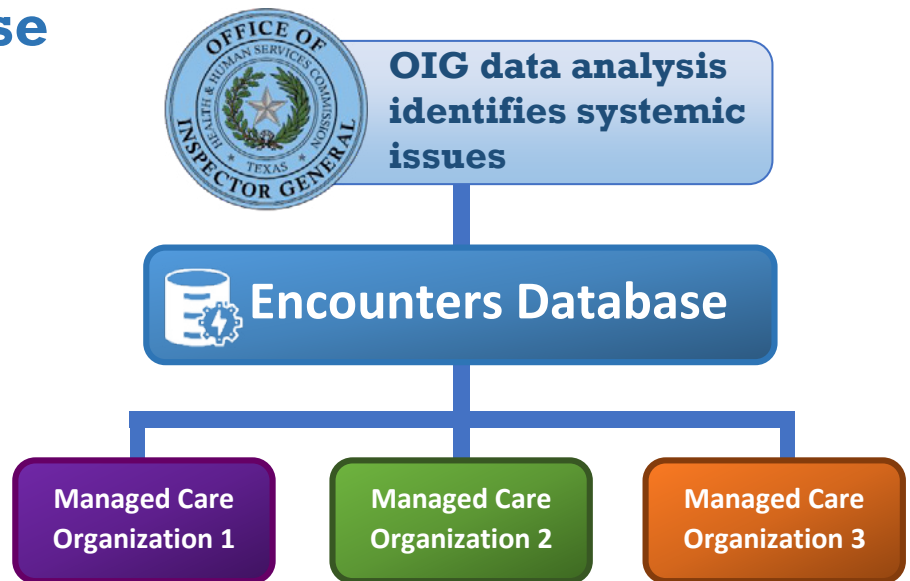
A 2019 contract amendment requires MCOs to maintain a full-time SIU manager and credentialed investigator dedicated to examining improper claims by Texas Medicaid members and service providers. Since that time, the OIG also increased outreach to MCOs through the Texas Fraud Prevention Partnership to assist in identifying, investigating and referring more cases. These changes likely contributed to the 33 percent increase in SIU referrals to the OIG for provider investigation from fiscal year 2020 to 2021.

Referrals can help identify potentially widespread issues. Because the OIG has access to encounter data across all MCOs and programs, the agency can run analytics on a referral to determine if something that looks like a small problem with

one MCO is a repeated problem across the Medicaid program. Data analysts can uncover systemic trends that perhaps are not visible at the MCO level, such as a provider billing for “impossible hours” – meaning a provider may bill for two hours in a day with one MCO but is billing 30 hours a day across several MCOs.

Encounters Database

- **View of entire Medicaid provider network**
- **Millions of claims filed every month combined with other data sources**
- **Analyzing data helps OIG:**
 1. **Identify highest risk providers**
 2. **Focus limited resources on the highest risk to the state**



SIU compliance

The OIG routinely audits SIU activities for compliance with state and contractual requirements. MCOs are contractually required to provide the OIG with:

- Fraudulent practices referrals.
- Fraud, waste and abuse compliance plans.
- Open case list reports.
- Annual lock-in actions reports.
- Annual reports on certain fraud and abuse recoveries.
- Pre-payment review monthly reports.

OIG audits evaluate MCO compliance related to preventing, detecting and investigating FWA and reporting information on SIU activities, results and recoveries to HHS. Audits examine whether MCOs have the required staff, conduct training and monitor provider and member service patterns. Audits also check that SIUs ensure all required elements of their investigations are completed, maintain a log of suspected incidences of FWA, and meet deadlines for submitting required reports and referrals to the OIG.

Recent audits revealed that MCOs did not always meet required timelines for completing required preliminary and extensive investigation activities listed in the Texas Administrative Code, such as:

- Completing preliminary investigations and timelines for selecting a sample of provider claims.
- Making requests for medical records and encounter data.
- Completing the review of requested records and data for extensive investigations.

The OIG makes recommendations to MCOs based on audit findings. Working with MCOs on process improvements related to SIU activities helps maintain efficient and effective fraud prevention and detection.

Texas Fraud Prevention Partnership

The OIG regularly engages with SIUs through the Texas Fraud Prevention Partnership (TFPP). Meetings are held three times each year with all SIUs and the Attorney General Medicaid Fraud Control Unit to share insights and information. The gatherings provide an opportunity for the OIG to discuss referrals, provider and client investigations and compliance best practices. MCO representatives report on the improper billing patterns they observe. The OIG also holds one-on-one meetings with the largest MCOs' SIU staff to discuss their investigations and current FWA trends. Also, the Inspector General and the executive staff periodically meet with the MCOs' executive leadership.

You can explore the audits of various SIUs on the [OIG website](#). Effective SIUs are essential to support overall MCO cost containment efforts and to ensure that state and federal funds spent on managed care are used appropriately.



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

OIG on Twitter: [@TexasOIG](https://twitter.com/TexasOIG)

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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)