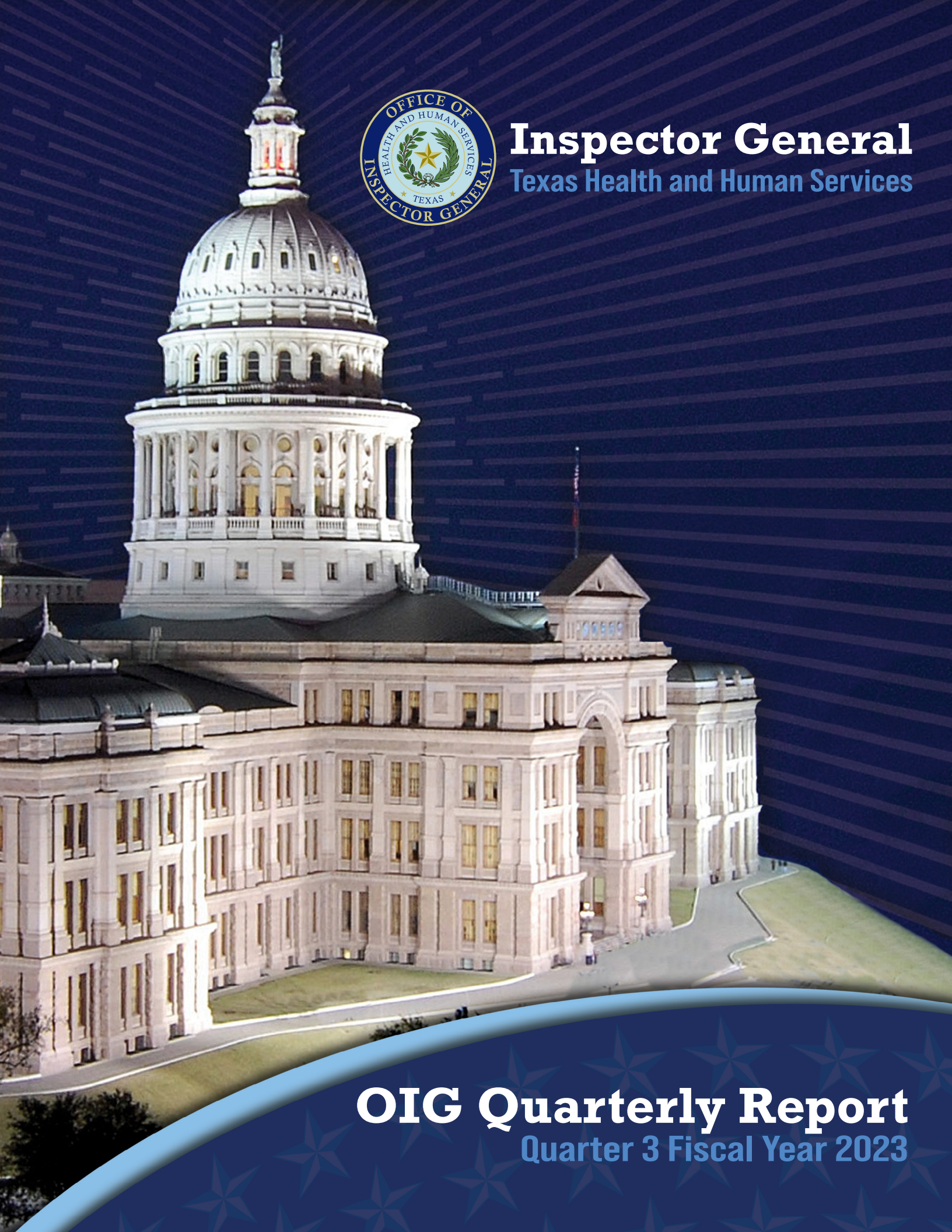


Inspector General

Texas Health and Human Services

OIG Quarterly Report

Quarter 3 Fiscal Year 2023

Table of Contents

I. Executive Summary

I am pleased to present to Governor Greg Abbott, Executive Commissioner Cecile Young, the Texas Legislature and the citizens of Texas, the third quarterly report for fiscal year 2023, summarizing the excellent work the Office of Inspector General (OIG) performed during this period.

From March 1, 2023, to May 31, 2023, the OIG recovered more than $174 million. In addition, we identified more than $254 million in potential future recoveries and achieved more than $36 million in cost avoidance.

With the conclusion of the 88th Regular Texas Legislative Session, I would like to thank our lawmakers for entrusting the OIG with new tools and resources to safeguard Texans from fraud, waste and abuse in health and human services. The OIG requested nine exceptional items, which the legislature fully funded, representing a $26 million increase over the agency's baseline budget.

As the OIG continues to improve its data analytics capabilities, more strong cases are being generated than ever before. Added staffing resources will allow the agency to expand work capacity in several key areas while improving employee recruitment and retention amid a challenging job market. Also, new technology investments will modernize outdated systems, creating more efficient processes that further expand agency capabilities.

Combined with the dedication of our employees, these latest investments will ensure the OIG is in an excellent position to face emerging challenges and build upon our tradition of accomplishment.

You will see numerous examples of those accomplishments in this quarterly report. On page five, a Dallas-area doctor who was excluded from Medicaid and sent to federal prison will no longer be able to defraud taxpayers. On page six, an ongoing fraud detection operation identified potential billing issues for several chemical dependency treatment centers and will ensure tax dollars are used for their intended purposes. On page 12, a successful undercover operation caught a retailer buying SNAP benefits and will prevent further exploitation of program clients.

While only a small sampling of our work, each case, audit and initiative highlighted in the quarterly report reflect important victories for the people of Texas. We are honored to carry out this mission and look forward to the opportunities provided by the latest legislative session.

Sylvia Hernandez Kauffman
Inspector General

II. Quarterly Metrics

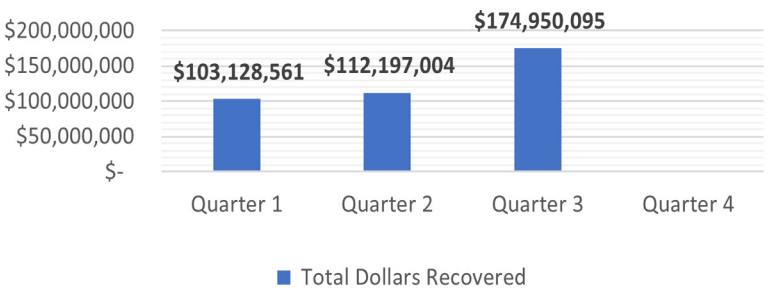
Dollars recovered

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

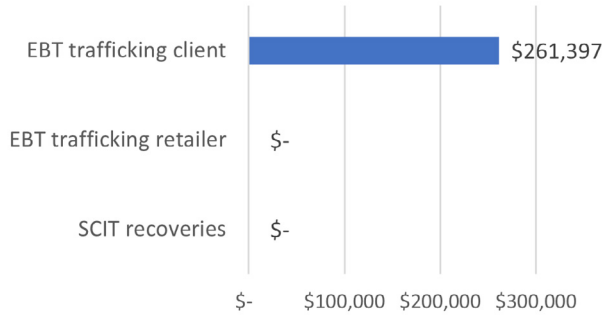
Total dollars recovered — $174,950,095

Providers and Managed Care Organizations	**$152,336,023**
Provider overpayments from audits and inspections	$165,834
Provider overpayments from investigations and MCOs	$6,838,010
Provider overpayments from automated review scenarios	$2,889,628
Acute care provider overpayments	$478,927
Hospital utilization review overpayments	$3,315,622
Hospital utilization review underpayments	($7,317)
Nursing facility utilization review overpayments	$1,442,185
Nursing facility utilization review underpayments	($4,683)
FFS Recovery Audit Contractor provider recoveries	$32,406,382
Third Party Recoveries	$104,811,434
Clients	**$22,614,072**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$22,315,452
Voluntary repayments by beneficiaries	$37,224
Electronic Benefits Transfer trafficking beneficiary overpayments	$261,397
Retailers	**$0**
Electronic Benefits Transfer trafficking retailer recoveries	$0
WIC collections	$0
HHS Employees and Contractors	**$0**
State Centers Investigations Team recoveries	$0

Total Dollars Recovered By Quarter



Peace Officer Recoveries



Dollars identified for recovery

Dollars identified for recovery is a measure of the total potential overpayments resulting from OIG activities. These potential overpayments are estimates pending further analysis or additional information submitted by the subject of the potential recovery. Consequently, these potential overpayments have not been collected (and notice to providers, contractors or managed care organizations may be forthcoming).

Total dollars identified for recovery $254,392,807

Providers and Managed Care Organizations	**$237,474,711**
Provider overpayments from audits and inspections	$0
Provider overpayments from investigations and MCOs	$10,757,478
Provider overpayments from automated scenarios	$3,263,014
Acute care provider overpayments	$708,511
Hospital utilization review overpayments	$5,044,060
Hospital utilization review underpayments	$0
Nursing facility utilization review overpayments	$4,781,502
Nursing facility utilization review underpayments	$0
FFS Recovery Audit Contractor provider recoveries	$39,624,479
Third Party Recoveries	$173,295,666
Clients	**$16,918,096**
Beneficiaries overpayments (SNAP, TANF, Medicaid, CHIP, WIC)	$16,250,765
Voluntary repayments by beneficiaries	$0
Electronic Benefits Transfer trafficking beneficiary overpayments	$667,330
Retailers	**$0**
Electronic Benefits Transfer trafficking retailer recoveries	$0
WIC collections	$0
HHS Employees and Contractors	**$0**
State Centers Investigations Team recoveries	$0

Cost avoidance

Cost avoidance results in resources being used more efficiently, either through an increase in available resources from reductions in inefficient expenditures or through avoidance of unnecessary expenditures for operational, medical, contract or grant costs.

Total cost avoidance $36,587,315

Providers and Managed Care Organizations	**$30,601,482**
Medicaid provider exclusions	$0
Fee-for-service front-end claims denial	$30,601,482
Clients	**$5,985,832**
Client disqualifications	$3,129,821
WIC vendor monitoring	$0
Pharmacy Lock-In	$2,528,917
Disqualification of Electronic Benefits Transfer recipients	$327,094

III. Provider Integrity

Trends

Provider Field Investigations (PFI) continues to examine billing by physicians, clinics or physician groups related to hearing screenings. This review identified a number of providers billing for pure tone audiometry tests on the same date as a Texas HealthSteps well-child checkup for the same patient. This is not allowed by Medicaid rules, as a well-child visit is a comprehensive service that already includes a hearing screening within the checkup. Therefore, audiometry tests cannot be paid separately. Texas HealthSteps is also known as the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, which provides comprehensive and preventive healthcare services for Medicaid clients younger than 21 years of age.

PFI is also currently examining billing for therapy services provided by licensed professional counselors, based on data analytics that indicate a likelihood of billing for services not rendered, billing for an individual therapy session while a family therapy session was provided, and high utilization of therapy services exceeding the maximum allowable hours per day. PFI conducts documentation reviews and client interviews to determine if patients' records support billed services, and PFI identifies reimbursement beyond what is allowed per Medicaid policy.

Provider Investigations Performance

- **559 Preliminary investigations opened**
- **543 Preliminary investigations completed**
- **48 Full-scale investigations completed**
- **55 Cases transferred to full-scale investigation**
- **205 Cases referred to OAG's Medicaid Fraud Control Unit**
- **100 Open/active full-scale cases at end of quarter**

Case highlights

OIG reaches settlement with Houston behavioral health rehabilitation provider

The OIG settled a case in March involving a Houston behavioral health rehabilitation and targeted case management group practice. From February 1, 2016, through January 31, 2020, the provider billed for services not rendered and failed to provide or maintain sufficient medical records to demonstrate that the services billed were necessary and properly performed. The provider worked collaboratively with OIG Litigation to resolve the issue and voluntarily completed a self-audit. The self-audit resulted in a settlement of $493,134 in overpayments for billing for services not rendered and an agreed penalty of $336,921 for inadequate patient records, for a total settlement of $830,046.

Surveillance Utilization Review Team

Acute care provider recoveries	$478,927
Acute care services identified overpayments	$708,511
Hospital and nursing home (UR) recoveries	$3,315,622
Hospital (UR) claims reviewed	4,682
Nursing facility reviews completed	144
Average number of Lock-in Program clients	4,009

Provider Enrollment and Exclusions

Provider enrollment inventory (applications and informal desk reviews) processed	7,903
Individual screenings processed	20,699
Medicaid providers excluded	41

OIG permanently excludes Dallas-area group home and its principals

In March and April, the owner and the manager of a Dallas-area group home were excluded from Medicaid after being individually named in Texas Home Living (TxHmL) and Home and Community-Based Services (HCBS) involuntary contract termination letters. The termination letters cited the individuals' failure to protect the health and safety of the group home's patients. The OIG coordinated with Adult Protective Services, who placed the patients in new facilities.

Doctor excluded by OIG following federal conviction

A Texas doctor was sentenced to federal prison after receiving over $400,000 in illegal kickbacks and being convicted of conspiracy to solicit and receive kickbacks in the United States district court in Fort Worth. The scheme involved gifts to spouses, rent assistance and salary offsets to hide the payments. As a result of the conviction, the provider's medical license was revoked. This resulted in a mandatory exclusion from the Texas Medicaid program for 10 years or until his medical license is reinstated, whichever is greater. The exclusion took effect in May.

OIG settles similar cases with four South Texas pediatric doctors' offices

The OIG settled a case in May with a McAllen pediatric office. The provider improperly submitted claims for molecular strep tests that were billed with an incorrect date of service. Medicaid policy does not allow providers to conduct molecular culture and rapid culture strep tests on the same date of service. The provider worked collaboratively with OIG Litigation to resolve the issues, and the OIG agreed to a settlement of $359,902.

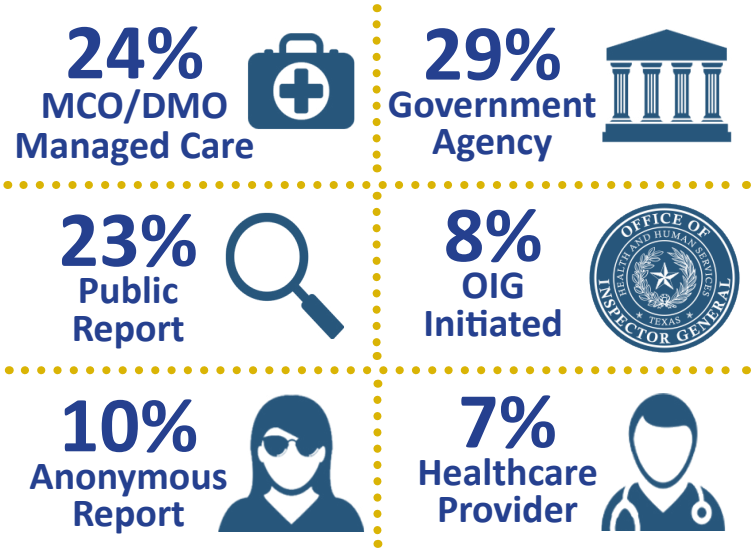
In April, the OIG also settled cases with pediatric offices in Alamo, Los Fresnos and Donna that improperly submitted claims for molecular strep tests with incorrect dates of service. All of the providers cooperated with the OIG investigations. Settlements of $155,417, $110,181 and $66,230 were reached in each case, respectively.

Preliminary Provider Investigations Opened

Attendant	40%
Physician (individual, group and clinic)	14%
Home health agency	10%
Dental	6%
Durable medical equipment	4%
Therapy (physical, occupational and speech)	4%
Hospital	3%
Nursing facility	3%
Pharmacy	3%
Therapy (counseling)	2%
Lab and radiology	2%
Assisted living	1%
Home and community-based services	1%
Parent, guardian and recipient	1%
Adult day care	1%
Case management	1%
Six other categories at less than 1%	4%

Rounded to nearest whole number

Investigation Referral Sources



Types of Full-Scale Provider Investigations

Physician (individual, group and clinic)	29%
Home health agency	24%
Hospital	18%
Attendants	7%
Dental	7%
Durable medical equipment	4%
Therapy (counseling)	4%
Four other categories at less than 2%	7%

Rounded to nearest whole number

OIG settles case with Houston dental provider

The OIG settled a case in April against a Houston dental provider who improperly billed Medicaid for a variety of dental services. Violations included services not rendered, up-coded services, missing or inadequate records to support billing, billing for services not covered, medically unnecessary services, and inadequate quality of care. The provider worked with the OIG by responding to the preliminary findings presented by the investigation. The provider later agreed to repay $24,000 in overpayments over a 24-month period.

OIG reaches settlement with skilled nursing facilities

The OIG reached a settlement in April with a Seguin nursing facility that used a third-party company to administer vitamin and hydration infusions to Medicaid recipients. The initial investigation considered whether the infusions impacted the daily rates paid to the provider for individual residents. Further investigation suggested the facility did not establish sufficient medical necessity for the infusions. Following the OIG's investigations, the provider agreed to pay an administrative penalty of $500 per infusion totaling $80,500.

The OIG also reached a settlement in May with a San Marcos nursing facility for similar violations with third-party vitamin and hydration infusions. As a result of the investigation, the provider agreed to pay an administrative penalty of $500 per infusion totaling $55,500.

OIG settles case with an El Paso rehabilitation provider

In March, the OIG settled a case with an El Paso provider who self-reported employing an excluded individual from August 9, 2022, through February 15, 2023. The provider correctly reported that it owed the Medicaid program $38,819, and the OIG agreed to resolve the claims through settlement.

OIG settles case with Laredo home health provider

The OIG settled a case in May involving a Laredo home health provider that improperly billed Medicaid for personal care attendant services. An attendant employed by the provider admitted to falsifying documentation on a patient's status and care. The provider worked collaboratively with OIG Litigation to resolve these issues, and the OIG agreed to a settlement of $12,232.

OIG settles case with a Pearland pharmacy

The OIG settled a case in March with a Pearland pharmacy after an OIG audit revealed insufficient evidence to show prescriptions billed to Medicaid were accurate. The provider appealed the final audit report but, while it was pending, worked with OIG Litigation to resolve the remaining issues and settled for $9,021.

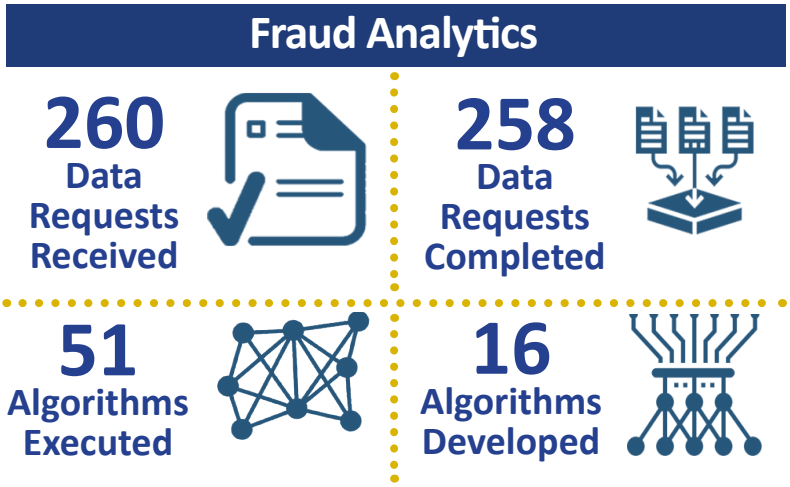
Agency highlights

Fraud detection operation examines chemical dependency treatment facilities

An OIG fraud detection operation (FDO) is a data-driven investigative operation designed to review providers who appear as statistical outliers among their peers and assess whether this status is attributable to any Medicaid program violation or instance of fraud, waste or abuse. Outlier status is not a conclusive indicator of wrongdoing, nor will every outlier reviewed be automatically selected for a full-scale investigation.

The OIG's current FDO is focused on chemical dependency treatment facilities (CDTF) and substance use disorders. The OIG Fraud Analytics team's role in the FDO is to develop algorithms that flag providers who appear to be outliers based on peer analyses and other policy and statistically-based algorithms. The team enhanced 12 existing algorithms and developed seven new algorithms for this FDO.

The OIG FDO team identified several CDTF providers that had billed for substance use disorder residential and outpatient counseling services with claim attributes that triggered outlier status. The FDO team selected these providers based on the results of algorithms generated by OIG's data team, which flagged one or more of the following: clients exceeding outpatient counseling limitations, clients billed for differing types of counseling on the same day, and clients billed for multiple outpatient counseling services per week.



Investigators are currently conducting fieldwork on the selected providers. Each service billed to Medicaid has a set of requirements related to the patient record that should support that the services were provided to the clients as billed. These include a court order or referral for treatment, client assessment, treatment plans, consent to treat, sign-in sheets and counseling notes that include start and stop times. Records review and interviews will be used to determine if these and other requirements have been met.

The next FDO is scheduled for the first quarter of FY 2024 and will focus on pharmacy providers.

DIPT identifies and prevents duplicate payments

The Data Initiatives Project Team (DIPT) continues to examine duplicate payments made to Texas Medicaid providers across a variety of provider types and services. When two providers are reimbursed for the same service delivered to the same member on the same date of service, it is considered a duplicate payment. Texas Medicaid prohibits the payment of duplicate claims. Additionally, certain services are subject to daily rates that can be paid only once per day, regardless of how many times or where the service was provided. In some cases, system edits designed to prevent duplicate payments are circumvented by the use of a modifier on one or both of the claim details. In other cases, payment systems did not prevent the duplicate payment. As DIPT continues to research this initiative and identify overpayments, additional prevention measures, such as education and recommendations for improvements to payment systems, will be addressed with providers and managed care organizations.

Fraud Analytics team advances agency capabilities with new data initiatives

The OIG's Fraud Analytics team performs advanced data analytics to identify trends and patterns that might indicate potential fraud, waste and abuse. The team has been working to advance the maturity of its data analytics capabilities to further transform the OIG into a more data-driven organization through several initiatives, including:

- Using predictive analytics and machine learning for fraud, waste and abuse detection models and algorithms, in which the models identify patterns and are able to improve themselves with experience.
- Developing a roadmap to collect labeled outcome data throughout the OIG for use in supervised learning algorithms. For example, this can involve categorizing claims data based on past findings and incorporating that information into a new analysis to highlight potential claims for review. These learning algorithms can help detect potential fraud, waste or abuse that might be missed by traditional, scenario-based algorithms.
- Deploying open-source analytical tools, including programming languages Python and R, to leverage widely used data science frameworks. These frameworks provide the Fraud Analytics team access to cutting-edge technologies to build advanced fraud detection models for true data-driven lead generation.

Data Reviews promote process efficiencies

In FY 2023, the Targeted Query (TQ) team began electronically faxing provider notices and letters through RightFax instead of using certified mail. Not only is this process faster and less costly for the OIG, but it has also helped ensure that the appropriate provider representatives receive the OIG's notices more quickly, which helps give providers ample time to review the information and exercise their appeal rights, if they so choose.

Audit plans to meet the requirements of Senate Bill 26

In May 2023, the passage of Senate Bill 26 amended Texas Health and Safety Code Section 531.1025 to require the OIG to audit each local behavioral health authority (LBHA) and each local mental health authority (LMHA) at least once every five years. With 37 LMHAs and two LBHAs, this will require the OIG to complete eight LMHA and LBHA audits each year. To meet this requirement, the OIG has already started planning the audits to begin on September 1, 2023. In addition, OIG Audit is already collaborating with other OIG divisions and HHS to develop a streamlined fieldwork testing approach for these audits.

NFUR team initiates recovery process with MCOs

The Nursing Facility Utilization Review (NFUR) team performs retrospective onsite utilization reviews of nursing facility records to evaluate whether facilities correctly assessed and recorded Medicaid residents' healthcare needs. The reviews also determine whether the appropriate level of care was provided and medically necessary. When discrepancies are discovered that result in a Medicaid overpayment to the facility, NFUR will initiate a recovery process to recoup those funds for the State of Texas by notifying the corresponding managed care organization. The MCO will then identify the amount recovered from the facility based on the discrepancy and remit the overpayment to the OIG.

NFUR initiated this recovery process for the latest notice period in April 2023 by sending recovery notices to MCOs participating in the HHS STAR+PLUS Medicaid program. The notices covered review completion dates from May 2019 through June 2022, with remittances due in June 2023. The receipt of the associated overpayment and supporting documentation from the MCOs completes the managed care recovery process for NFUR. The OIG will continue to perform this recurring recoupment process for additional notice periods.

Completed reports

Managed care organization oversight of durable medical equipment providers: Blue Cross and Blue Shield of Texas

The OIG audited Blue Cross and Blue Shield of Texas (BCBSTX) to assess managed care organization (MCO) oversight of durable medical equipment (DME) provider reimbursement. BCBSTX reported approximately $35.5 million in reimbursements to DME providers for equipment and supplies delivered to 7,849 Medicaid and CHIP members during the period from September 1, 2019, through August 31, 2021. Of this amount, BCBSTX reported $10.5 million specifically for DME delivered to 3,328 members. The audit objective was to determine whether BCBSTX conducted oversight activities to ensure its DME claims were

Audit Performance

$165,834
Overpayments Recovered

$0
Overpayments Identified

2
Audit Reports Issued by OIG

34
Audit Reports In Progress

reimbursed in accordance with specific applicable contractual requirements, federal and state laws, rules, guidelines and policies.

Oversight activities performed by BCBSTX helped ensure DME claims were reimbursed in accordance with certain requirements. For example, BCBSTX complied with select pricing, timing and claim payment timeliness requirements when reimbursing DME providers.

However, BCBSTX did not always reimburse DME providers as required. Specifically, BCBSTX did not always conduct oversight to:

- Comply with BCBSTX benefit limits.
- Ensure DME was authorized, medically necessary or received by members.
- Validate or accurately price miscellaneous DME claims.

The issues identified indicate that BCBSTX did not always effectively oversee claim reimbursement processes for DME providers.

As a result, BCBSTX should implement controls to ensure it reimburses providers in a manner consistent with requirements and repay $18,106 to the state of Texas for sample claims reimbursed by BCBSTX that did not follow select requirements.

Audits Issued 2

Managed Care Organization Oversight of Durable Medical Equipment Providers: Blue Cross and Blue Shield of Texas (March 23, 2023)

Sherry Matthews Group: A Texas Health and Human Services Commission Special Supplemental Nutrition Program for Women, Infants and Children (WIC) Contractor (March 31, 2023)

Audits in Progress 34

Selected DSHS Contracts
Selected Women's Protective Services Grantees
Selected Health, Developmental, and Independence Services Contracts
Selected Pharmacy Benefits Managers
Selected Foster Care Providers
MCO Financial Reporting
MCO IT Security Controls and Business Continuity and Disaster Recovery Processes
Selected Telemedicine Providers
MCO Special Investigative Units
Selected Pharmacy Providers
Selected Prescribed Pediatric Extended Care Centers
Selected Family Violence Prevention Program Providers

Inspections in Progress 5

Durable Medical Equipment Wound Care Supplies Billing
Mental Health Private Psychiatric Funds
Emergency Ambulance Claims Oversight

Sherry Matthews Group: A Texas Health and Human Services Commission Special Supplemental Nutrition Program for Women, Infants and Children (WIC) contractor

The OIG audited Sherry Matthews Group (SMG), a national marketing communications agency based in Austin. The OIG initiated this audit to provide audit coverage of non-Medicaid contracts. As of October 2022, SMG had seven active contracts with HHS agencies. During the audit scope, the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), which is administered by the Texas Health and Human Services Commission (HHSC), provided a $5.2 million budget to SMG, and for work performed during the audit scope, SMG billed $5.1 million to HHSC for expenses associated with the WIC contract. The audit objective was to determine whether SMG delivered and billed for selected services in compliance with applicable contract requirements. The audit scope covered the period from July 1, 2021, through August 31, 2022.

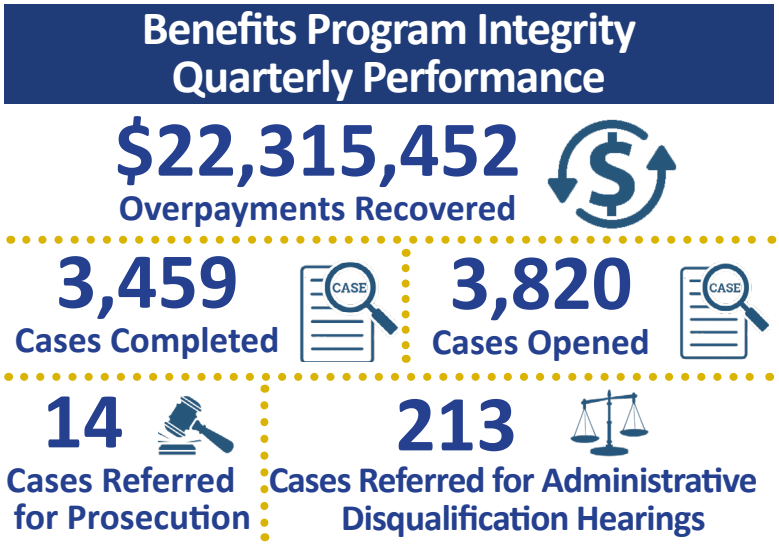
SMG substantially complied with selected contract requirements related to education, marketing and outreach materials and selected reports for the Special Supplemental Nutrition Program for WIC administered by HHSC. However, when billing HHSC for reimbursement of payroll expenses, SMG did not always submit accurate or

supported invoices. Specifically, for 113 payroll expenses tested, SMG billed HHSC for 17 payroll expenses that were inaccurate or unsupported. As a result, SMG was overpaid $1,625, which it should repay to the state of Texas. Additionally, for 11 of 113 payroll expenses tested, SMG billed HHSC for subcontractors, which should have been billed as third-party expenses and were also not in compliance with historically underutilized business (HUB) subcontracting requirements because these subcontractors were not on the list of preapproved subcontractors in the HUB subcontracting plan SMG submitted to HHSC.

IV. Client Accountability

Trends

The Benefits Program Integrity (BPI) division completed 3,417 investigations involving benefit recipient overpayments or fraud allegations. Concerns involving a client's household composition made up 69% of all completed BPI investigations, with an additional 14% involving unreported income. Household composition cases usually involve an unreported household member who has reportable income or a reported household member who does not live in the same residence. Both instances cause the household to receive more benefits than they are eligible for. For this quarter, BPI referred 15 investigations for prosecution and 320 investigations for administrative disqualification hearing.



Case highlights

SNAP recipient who failed to disclose business income disqualified and sentenced to probation

A Hamlin, Texas man pleaded guilty in district court to securing execution of a document by deception. The conviction is the result of an investigation conducted by the OIG and assisted by the United States Department of Housing and Urban Development, Office of Inspector General.

The individual applied to receive Supplemental Nutritional Assistance Program (SNAP) benefits, Medicaid benefits and housing assistance. Eligibility for SNAP, Medicaid and housing assistance is tied to household resources. Therefore, applicants are legally required to provide truthful information regarding income, financial resources and household composition.

In his application, the defendant claimed under penalty of perjury that the household's income was limited to himself as an employee of a local business and that his earnings were only $225 per month. OIG investigators uncovered evidence proving the subject was not just an employee of the stated business but the owner of the business. The business's financial documents were obtained and verified the subject earned considerably more than the reported amount. In total, the defendant obtained $9,674 in SNAP benefits, $15,726 in Medicaid benefits, and $27,811 in housing assistance he was not entitled to.

On April 4, 2023, the defendant was sentenced to 10 years' probation, signed a 12-month SNAP disqualification and was ordered to pay full restitution to Texas Health and Human Services and the U.S. Department of Housing and Urban Development.

South Texas SNAP recipient pays more than $87,000 in restitution

A Donna, Texas woman pleaded guilty in district court to felony theft after an OIG investigation.

The individual applied to receive SNAP and Medicaid benefits but failed to report all of her unearned income. OIG investigators found evidence that the defendant had consistent U.S. currency deposits made into her bank account that she had not reported during the application process. If the defendant had truthfully disclosed her household's income, her eligibility benefits would have been drastically reduced. In total, the defendant obtained more than $87,542 in SNAP and Medicaid benefits she was not entitled to.

On March 8, 2023, the defendant was sentenced to 10 years' probation and ordered to pay $87,542 in restitution to Texas Health and Human Services.

Agency highlights

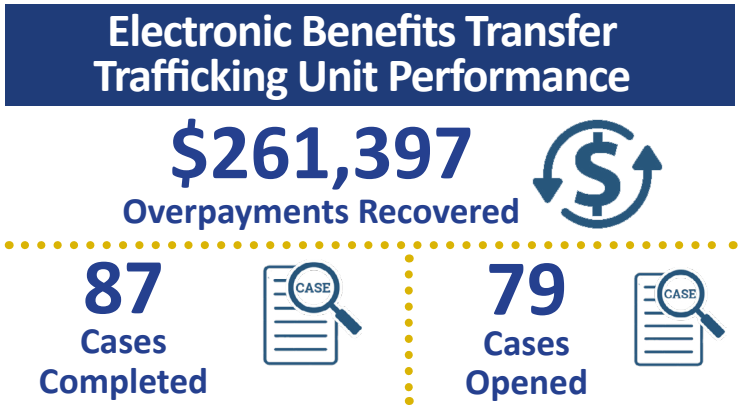
Benefits Program Integrity Unit collaborates with HHS eligibility units

In March and April, the OIG Benefits Program Integrity Unit met with several Health and Human Service eligibility units across the state to discuss fraud detection, prevention and referral topics. This type of collaboration allows the OIG to obtain crucial information that aids investigations and helps eligibility staff better understand how they contribute to the OIG's mission of fighting fraud, waste and abuse. As a result of these efforts, the OIG was able to engage with more than 195 eligibility staff.

V. Retailer Monitoring

Trends

Electronic Benefits Transfer Trafficking Unit



The Electronic Benefits Transfer (EBT) Trafficking Unit continues to receive referrals and initiate investigations into Supplemental Nutrition Assistance Program (SNAP) skimming incidents. Skimming occurs when a criminal illegally modifies a retailer's credit card terminal to capture the card number and other personal information of unsuspecting customers. The data is then placed onto a cloned card that is used to make unauthorized purchases, often across state lines, and deplete the account holder's balance. In March, the OIG released a SNAP Skimming Report with background on the SNAP program and SNAP skimming, as well as analysis of prospective solutions. As indicated in the report, the OIG initiated 108 SNAP skimming investigations in FY 2022 and 34 so far in FY 2023.

The OIG's Fraud Analytics team has also been working with the EBT Trafficking Unit to find patterns that identify

retailers where SNAP skimming fraud is most likely to occur and where stolen benefits are most likely to be used. This analysis will help provide targeted education to retailers to help prevent future theft of the food benefits on which vulnerable families rely.

Texas HHS has received federal approval to reimburse certain SNAP benefits stolen via skimming. Prevention remains a top priority for the OIG, which continues to conduct outreach and provide informational materials to clients, retailers and stakeholders. More information is available on the OIG SNAP skimming webpage.

WIC Vendor Monitoring Unit

The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) Vendor Monitoring Unit (VMU) conducted 141 compliance buys across the state this quarter. 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 follow WIC rules.

The team also completed 75 inventory reviews across the state. An inventory review compares a vendor's paid claims and purchase invoices for WIC food items to determine if the vendor had a sufficient inventory of WIC food items to justify their submitted claims. No deficiencies were identified.

WIC VMU also conducted 81 on-site store inspections. The review 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.

With continued formula shortages across the state, Texas WIC extended several alternative formulas through May 31, 2023. WIC VMU is also reviewing formula inventories to help Texas WIC assess the extent of the problem.

Case highlights

Former long-term care facility owner accused of using patients' SNAP benefits referred for criminal prosecution

The EBT Trafficking Unit received a complaint alleging the owner of an HHS long-term care facility kept and used the EBT SNAP cards and benefits of former patients. A preliminary review revealed a prior order to close the facility issued by HHS due to patient abuse. The investigation determined the owner was the authorized representative for patients but failed to notify the SNAP office that her facility had been shut down and the patients removed, and she continued to use their SNAP benefits. Investigators also found that the owner's sibling used the SNAP benefits. In total, the duo fraudulently spent $5,735 in SNAP benefits. Criminal cases for both the owner and sibling were referred to the local district attorney. An additional referral was made to the Long-Term Care Regulation team at HHS.

Undercover operation catches store owner buying SNAP benefits from customers

The EBT Trafficking Unit initiated an investigation after a transaction history review showed that a retailer had numerous even-dollar and high-dollar transactions, indicating possible fraud. Investigators conducted multiple successful undercover operations where they exchanged SNAP benefits for cash and bought items not eligible to be purchased with SNAP benefits. The SNAP recipients were identified and interviewed regarding their history with the retailer. Two recipients admitted to exchanging their SNAP benefits for cash and purchasing ineligible items. The owner of the store confessed to exchanging cash for SNAP benefits that were then used to purchase store inventory. The case was referred to the local district attorney and could result in third-degree felony charges, punishable by up to 10 years in prison, $10,000 in fines and restitution to the state. The case was also referred to USDA Food Nutrition Services for possible administrative disqualification of the retailer.

VI. HHS Oversight

Trends

Internal Affairs

Internal Affairs (IA) processed 114 referrals this quarter. IA worked on 58 active investigations and closed 47 investigations in the third quarter. The remaining referrals were forwarded to the appropriate business areas, including the Office of the Independent Ombudsman for State Supported Living Centers; the Department of Family and Protective Services (DFPS), Office of Internal Affairs; and HHS Complaint and Incident Intake.

Approximately 35% of Internal Affairs' open cases continue to involve Child Protective Services (CPS) client/supervisor allegations of DFPS employees falsifying documents. Although the percentage has dropped, the number of cases remains consistent. Changes to case numbers over time may be the result of increased DFPS scrutiny and DFPS management establishing quality assurance processes to identify misconduct but can be offset by greater numbers of clients alleging caseworker misconduct.

Internal Affairs Performance

47 Cases Completed

42 Cases Opened

Open Internal Affairs Cases by Type

Falsifying information/documents	24%
Benefits fraud for personal gain	15%
Tampering with a government record	15%
Unprofessional conduct	12%
Law enforcement assist	7%
Contract fraud	7%
Privacy incident/breach	4%
Theft	4%
Time/leave abuse	2%
Moonlighting	2%
Computer misuse	2%
Conflict of interest	2%
Unauthorized release of information	2%
Whistleblower violation	1%
Workplace threat	1%

IA continues to surpass 100 referrals received each quarter with many coming from outside entities not involved with a state agency or HHS. In the third quarter of FY 2023, only 28% of referrals were opened as IA investigations due to an increase in non-agency-related referrals.

State Center Investigations Team

The OIG State Center Investigations Team (SCIT) is comprised of commissioned peace officers who investigate allegations of abuse and other wrongdoing at state hospitals and state supported living centers. In the third quarter of fiscal year 2023, they opened 249 investigations and completed 306 investigations with an average completion time of 25.7 days. This compares to 302 opened investigations and 263 completed investigations in the prior quarter of fiscal year 2023. In the third quarter of 2022, SCIT opened 130 investigations and completed 131 investigations.

State Centers Investigations Team Performance

306 Cases Completed

249 Cases Opened

Case highlights

State hospital employee reimburses state for excess benefits

IA investigated a case involving a Texas State Hospital employee who allegedly committed an intentional program violation by submitting several inaccurate benefits applications. The employee omitted their children's father's income information to qualify for benefits they were not legally entitled to receive. As a result, the employee received over $25,000 in excess benefits. The employee admitted to the conduct, agreed to repay the excess benefits and remains employed at the state hospital.

Employee investigated for using state equipment at home

IA investigated a case involving a State Supported Living Center employee allegedly using an SSLC-owned backhoe at his residence. The employee admitted using the backhoe on numerous occasions, adding that he believed using the backhoe was allowed as long as he did not receive a financial benefit. As a result of a facility supervisory meeting and IA investigation, the employee stated he would no longer take the equipment for personal use. The employee remains employed with the SSLC.

Physical abuse cases investigated at two State Supported Living Centers

Two separate SCIT cases involved alleged physical abuse to clients at State Supported Living Centers in southeast and north central Texas. In each case, subsequent interviews and video reviewed by the SCIT investigators confirmed the allegations. The cases were referred to their respective county district attorney offices for prosecution.

Agency highlights

OIG teams up with HHS Procurement and Contracting Services to educate grant recipients

The OIG fraud, waste and abuse prevention strategy emphasizes stakeholder partnerships and opportunities for collaboration, training, education and raising awareness while developing recommendations to improve HHS programs and inform future OIG work. The OIG recently collaborated with the HHS Procurement and Contracting Services (PCS) division to improve educational materials relating to grant recipients' fiduciary responsibilities over grant funds. OIG staff advised PCS of various audit scenarios and frequently observed issues, including the need to improve processes to ensure program objectives are met, expenditures are allowable and grant activities are appropriately allocated.

Policy recommendations

OIG provides program integrity feedback on policy changes

HHS requested program integrity feedback from the OIG on several behavioral health medical policies related to the remote delivery of the services. The OIG recommended that policy specify that reimbursement for remote (i.e., telemedicine or telehealth) behavioral health services may be recouped if billed as an in-person service. To clarify provider requirements, the OIG also recommended that policy specify whether references to the billing provider means the entity or individual practitioner affiliated with the entity.

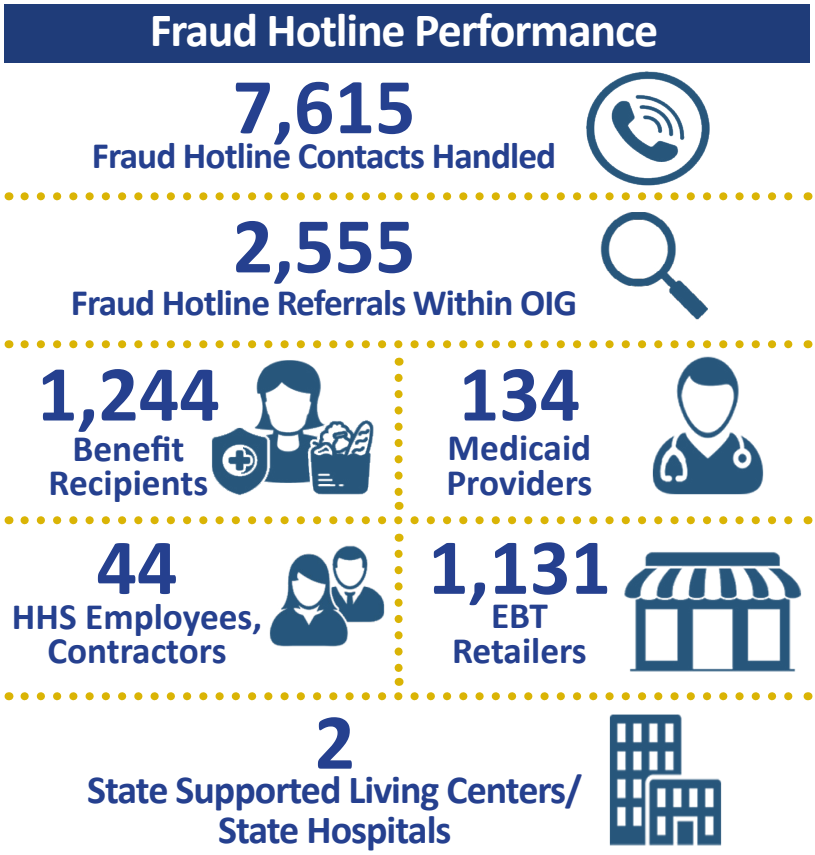
VII. Stakeholder Engagement

88th Texas Legislative Session offers new opportunities

The 2023 Regular Texas Legislative Session ended on May 29. In addition to maintaining the agency's baseline budget, the OIG requested nine exceptional items. All nine were approved representing a $26 million increase over the baseline budget..

The additional funding will be used for a variety of critical projects, including:

- Providing additional positions and improving recruitment and retention for investigators, data analysts, attorneys and auditors to increase work capacity and fully utilize the agency's previous and continuing improvements in data analysis capabilities.
- Replacing the outdated Benefit Provider Integrity case management system (ASOIG) and incorporating automation into the investigative process to optimize efficiency.
- Procuring a case management system for the Special Investigations Unit.
- Replacing the OIG's outdated Waste, Abuse and Fraud Electronic Reporting System (WAFERS) — the online portal used by the public to report allegations to the OIG — will increase data collection and reporting capabilities and increase efficiency, allowing more time to perform intake and investigations.



Several other pieces of legislation will also impact the OIG. These include:

- SB 1342 updates Texas Third Party Liability statutes to reflect recent changes in federal law. As requested by the Center for Medicaid Services, the bill defines third parties, requires third parties to respond to the state's inquiry within 60 days, and requires third parties to accept the state's authorization for items or services covered under the state plan.
- HB 4611 realigns health and human services laws, which moves OIG statutes into the newly created Texas Government Code, Chapter 544. This is part of a Texas Legislative Council project to make the statutes more accessible, understandable and usable. The changes will take effect on April 1, 2025.
- SB 26 requires the OIG to conduct regular performance audits of local mental health authorities (LMHAs). The OIG is directed to establish a schedule to ensure each LMHA is audited at least once every five years. Additionally, the OIG is to ensure that LMHAs undergo a financial audit every three years and submit the results to the OIG.

Surveillance Utilization Review teams meet with stakeholders

External Relations Performance

75 Communication Products

97,156 Page Views

The OIG Surveillance Utilization Review (SUR) team — comprised of the Hospital Utilization Review (HUR) team and Nursing Facility Utilization Review (NFUR) team — performs onsite reviews of nursing facilities and desk reviews of hospital claims to ensure appropriate billing. The teams facilitate recurring meetings with external stakeholders to discuss current initiatives and updates and to increase opportunities for stakeholders to provide input and feedback.

The NFUR unit held its quarterly stakeholder meeting on March 13. The presentation covered updates on the various types of reviews conducted, utilizing the OIG's external data transfer site for record submission and a biannual education session.

The HUR unit held its quarterly stakeholder meeting on April 17. Discussion included medical record request coordination, updates on the latest review sample periods and coding trends.

Texas Fraud Prevention Partnership Special Investigative Unit meetings

Texas Fraud Prevention Partnership (TFPP) Special Investigative Unit (SIU) one-on-one meetings were held with Managed Care Organizations (MCOs) Amerigroup, Community Health Choice, Superior, and United and Dental Maintenance Organizations (DMOs) MCNA, DentaQuest, and United Dental to discuss pending investigations, referrals, and current fraud, waste and abuse schemes. Attorney General Medicaid Fraud Control Unit staff also participated in the meetings.

Conferences, presentations and trainings

State Center Investigations Team peace officer training completed

Training Summary

48 Trainings Conducted This Quarter

In April, SCIT conducted its biannual peace officer training. The training consisted of CPR, first aid and defibrillator recertification along with peer support training, firearms training and tactics.

WIC Vendor Monitoring Unit staff hold conference and training

WIC VMU held its annual staff conference April 26-27. WIC staff discussed changes in WIC policy, completed a training focusing on safety in the field, and reviewed progress to date and team goals.

Benefits Program Integrity investigators train for human trafficking prevention

In May, the Fort Worth and Grand Prairie BPI field investigators attended the Breaking the Chains of Human Trafficking seminar hosted by the Texas Chisholm Trail Crime Prevention Association. The seminar promoted awareness of human trafficking while educating the public and law enforcement on the signs of human trafficking. BPI field investigators spend over 60% of their time in the field conducting investigations and canvassing neighborhoods. This type of training allows them to help identify and report potential human trafficking situations and help stop this horrible crime.

VIII. OIG in Focus: Self-Reporting Errors

The Texas Health and Human Services Office of Inspector General (OIG) developed a protocol to guide healthcare professionals who voluntarily disclose irregularities in their dealings with the Medicaid program. Section 1128J(d)(2) of the Affordable Care Act and 1 TAC § 371.1655 require providers who identify that they have received undue payments from Medicaid are obligated to report and return the overpayments within 60 days. Failure to do so could be considered an independent violation and subject to sanctions.

Self-reports to the OIG in fiscal year 2023 have led to 29 settlements totaling $311,813 in recoveries. For example, the OIG settled seven self-report cases with a home health provider in the third quarter. The North Texas provider discovered personal care attendants had billed for services not rendered. In each case, the provider quickly initiated an internal investigation and accurately self-reported overpayments, which were later reimbursed to the state. The provider's careful monitoring and swift action resulted in a prompt resolution. Collectively, the settlements totaled $3,459.

The process

The protocol for self-reports begins with notifying the OIG of self-identified issues, such as billing errors, services not rendered, or hiring individuals listed in the exclusion database. The provider must provide evidence or data to support the potential amount of the overpayment at issue. The OIG reviews policy, documentation and data to assess whether a violation occurred and if necessary, confirm the potential overpayment amount. Sometimes a provider submits a self-disclosure out of an abundance of caution, and, after OIG completes the review process, a determination is made that there is no overpayment issue. The OIG also has the option to decline a self-report if it relates to an OIG initiative that is already in progress.

Self-disclosing overpayments can allow a provider to potentially avoid prolonged investigation, litigation and costs associated with more formal administrative procedures. The self-report process is open to all providers.

The benefits

After the OIG reviews and accepts the provider's self-reported overpayment, the provider will likely not be subject to additional administrative recoupment, penalties, exclusion, lawsuits or other potential Texas OIG administrative sanctions for the claims it self-reports.

Although the OIG is neither bound by any findings submitted by the self-disclosing provider nor obligated to resolve the matter in any particular manner, the findings made through the self-disclosure process are weighed in determining any enforcement measures and may mitigate possible penalties or sanctions.

The specific resolution of self-disclosures depends upon the individual merits of each case, but the OIG may extend the following benefits to providers who initiate a good-faith self-disclosure:

- Release of self-reported claims.
- Forgiveness or reduction of interest payments (for up to two years).
- Extended repayment terms.
- Waiver of penalties or sanctions.
- Avoidance of exclusion sanctions.
- Recognition of the effectiveness of the provider's compliance program and a decrease in the likelihood of imposition of an OIG Corporate Integrity Agreement.

The OIG may conclude that the disclosure warrants a referral to other county, state or federal authorities for additional civil or criminal enforcement. If the OIG makes a referral, it will indicate the provider's involvement and level of cooperation throughout the disclosure process.

To report

Providers and managed care organizations may use the OIG Fraud Hotline (800-436-6184) or ReportTexasFraud.com at any time to report any compliance or overpayment matters relating to themselves. Additional information about the self-disclosure process and a checklist of information to submit to the OIG can be found in the resources section of the OIG website.

Texas Health and Human Services Office of Inspector General

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To report fraud, waste or abuse

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

Website: ReportTexasFraud.com

OIG on LinkedIn: Company/TxHHS-OIG

OIG on Twitter: @TexasOIG

OIG on Facebook: TxOIG

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